STEP II
CONSENT AGREEMENT
BETWEEN
MAHENDRA KUMAR MAHAJAN, M.D.
AND
THE STATE MEDICAL BOARD OF OHIO

This Consent Agreement is entered into by and between Mahendra Kumar Mahajan, [Dr. Mahajan], and the State Medical Board of Ohio [Board], a state agency charged with enforcing Chapter 4731., Ohio Revised Code.

Dr. Mahajan enters into this Consent Agreement being fully informed of his rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

BASIS FOR ACTION

This Consent Agreement is entered into on the basis of the following stipulations, admissions and understandings:

A. The Board is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for a violation of Section 4731.22(B)(19), Ohio Revised Code, for "[i]nability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including, but not limited to, physical deterioration that adversely affects cognitive, motor, or perceptive skills," and/or for a violation of Section 4731.22(B)(26), Ohio Revised Code, for "impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice."

B. The Board enters into this Consent Agreement in lieu of formal proceedings based upon the violation of Sections 4731.22(B)(19) and 4731.22(B)(26), Ohio Revised Code, as set forth in Paragraph (E) below, and expressly reserves the right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Consent Agreement.

C. Dr. Mahajan is seeking reinstatement of his certificate to practice medicine and surgery, license number 35.043538, which was indefinitely suspended, but not less than 180 days, pursuant to the post-cite Step I Consent Agreement Between Mahendra

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Kumar Mahajan, M.D. and the State Medical Board of Ohio [March 2012 Step I Consent Agreement], effective March 14, 2012.

D. Dr. Mahajan states that he is also licensed to practice medicine and surgery in the State of Indiana and that said license was indefinitely suspended by the Indiana Board on or about July 5, 2012.

E. Dr. Mahajan admits that after entering inpatient treatment for alcohol abuse and major depressive disorder on or about December 6, 2011, at Lindner Center of Hope, a Board approved treatment provider, he was discharged on or about January 10, 2012, upon the treatment team having determined that had successfully completed an appropriate course of treatment.

Dr. Mahajan admits that on or about January 24, 2012, he entered into a continuing aftercare contract with Greene Hall Outpatient Services, a Board approved treatment provider, and subsequently transitioned to an aftercare contract with Bethesda Alcohol and Drug Treatment Program, a Board approved treatment provider, on or about May 30, 2012, due to the closing of Greene Hall Outpatient Services. Dr. Mahajan further states and the Board acknowledges receipt of information to support that Dr. Mahajan has remained compliant with the terms of his aftercare contract.

Dr. Mahajan states and the Board acknowledges that Gregory Collins, M.D., and Raymond Helliman, M.D., physicians approved by the Board to conduct an assessment of Dr. Mahajan relating to his chemical dependency, have each provided written reports opining that Dr. Mahajan's ability to practice medicine has been assessed and that he has been found capable of practicing medicine and surgery according to acceptable and prevailing standards of care, so long as certain treatment and monitoring conditions are in place. Such treatment and monitoring requirements include participation in at least 104 aftercare meetings, participation in an alcohol and drug rehabilitation program, such as A.A. or Caduceus, random urine testing and a reduced work load.

Furthermore, Dr. Mahajan states and the Board acknowledges that Douglas Songer, M.D., and Stephen Noffsinger, M.D., physicians approved by the Board to conduct psychiatric evaluations of Dr. Mahajan, have each provided written reports opining that Dr. Mahajan's ability to practice medicine has been assessed and that he has been found capable of practicing medicine and surgery according to acceptable and prevailing standards of care, so long as certain treatment and monitoring conditions are in place. Such treatment and monitoring conditions include, in addition to those noted above, continued psychiatric treatment related to mood, impulse control, and anger management; refraining from self-prescribing antidepressant medications to self-treat his depression; as well as a reduced work load of initially no more than 20 hours per week for the first three months following Dr. Mahajan's return to practice.

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Additionally, Dr. Mahajan states and the Board acknowledges that his current treating psychiatrist has recommended that Dr. Mahajan continue individual psychotherapy with a licensed mental health care professional on a weekly basis, coordinated with medication management by the psychiatrist at least once every two months.

Dr. Mahajan states and the Board acknowledges receipt of information to support that he has substantially fulfilled the conditions for reinstatement of his certificate to practice medicine and surgery in the State of Ohio, as established in the above referenced March 2012 Step I Consent Agreement.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, the certificate of Dr. Mahajan to practice medicine and surgery in the State of Ohio shall be REINSTATED, and Dr. Mahajan knowingly and voluntarily agrees with the Board to the following PROBATIONARY terms, conditions and limitations:

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

2. Dr. Mahajan shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Consent Agreement. The first quarterly declaration must be received in the Board's offices on the date his quarterly declaration would have been due pursuant to his March 2012 Step I Consent Agreement with the Board, or as otherwise requested by the Board. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. Dr. Mahajan shall appear in person for an interview before the full Board or its designated representative. The first such appearance shall take place on the date his appearance would have been scheduled pursuant to his March 2012 Step I Consent Agreement with the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. Dr. Mahajan shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising

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Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Consent Agreement for occasional periods of absence of fourteen days or less. In the event that Dr. Mahajan resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Mahajan may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Mahajan is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Consent Agreement.

5. In the event Dr. Mahajan is found by the Secretary of the Board to have failed to comply with any provision of this Consent Agreement, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Consent Agreement.

MONITORING OF REHABILITATION AND TREATMENT

Drug Associated Restrictions

6. Dr. Mahajan shall keep a log of all controlled substances prescribed. Such log shall be submitted, in the format approved by the Board, on the date upon which Dr. Mahajan's quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Mahajan shall make his patient records with regard to such prescribing available for review by an agent of the Board immediately upon request.

7. Dr. Mahajan shall not, without prior Board approval, administer, personally furnish, or possess (except as allowed under Paragraph 8 below) any controlled substances as defined by state or federal law. In the event that the Board agrees at a future date to modify this Consent Agreement to allow Dr. Mahajan to administer or personally furnish controlled substances, Dr. Mahajan shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. Mahajan's quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Mahajan shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

Sobriety

8. Dr. Mahajan shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. Mahajan's history of chemical dependency and psychiatric diagnoses. Further, in the event that Dr. Mahajan is so prescribed, dispensed or administered any controlled substance, carisoprodol, or

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tramadol, Dr. Mahajan shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. Mahajan received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Mahajan shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

9. Dr. Mahajan shall abstain completely from the use of alcohol.

Drug and Alcohol Screens/Drug Testing Facility and Collection Site

10. Dr. Mahajan shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. Mahajan shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Mahajan's drug(s) of choice.

    Dr. Mahajan shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Mahajan acknowledges that he understands that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Consent Agreement.

    All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph 11 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

    Dr. Mahajan shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Mahajan shall be negative, except for those substances prescribed, administered, or dispensed to him in

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conformance with the terms, conditions and limitations set forth in this Consent Agreement. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Consent Agreement.

Further, within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Consent Agreement. Further, Dr. Mahajan shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Mahajan and the Board-approved drug testing facility and/or collection site. Dr. Mahajan's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Consent Agreement. However, Dr. Mahajan and the Board further agree that in the event Dr. Mahajan previously entered into the aforementioned financial and contractual agreements pursuant to the requirements of a prior consent agreement with the Board under which Dr. Mahajan is currently participating in an ongoing urine screening process, then this requirement shall be waived under the instant consent agreement.

Dr. Mahajan shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Mahajan and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Mahajan shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Consent Agreement, Dr. Mahajan must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph 11 below, as soon as practicable. Dr. Mahajan shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

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Dr. Mahajan acknowledges that the Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

11. Dr. Mahajan and the Board agree that it is the intent of this Consent Agreement that Dr. Mahajan shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Mahajan, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Mahajan:

    a. Within thirty days of the date upon which Dr. Mahajan is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Mahajan, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Mahajan shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Mahajan's residence or employment location, or to a physician who practices in the same locale as Dr. Mahajan. Dr. Mahajan shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Mahajan acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

    b. Dr. Mahajan shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

    c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Mahajan must immediately notify the Board in writing. Dr. Mahajan shall

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further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Mahajan shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Mahajan.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Mahajan's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the March 2012 Step I Consent Agreement between Dr. Mahajan and the Board, Dr. Mahajan and the Board agree that the entity, facility or person previously approved by the Board to so serve pursuant to the March 2012 Step I Consent Agreement is hereby approved to continue as Dr. Mahajan's designated alternate drug testing facility and collection site or as his supervising physician under this Consent Agreement.

12. All screening reports required under this Consent Agreement from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Mahajan's quarterly declaration. It is Dr. Mahajan's responsibility to ensure that reports are timely submitted.

13. The Board retains the right to require, and Dr. Mahajan agrees to submit, blood, urine, breath, saliva and/or hair specimens for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Mahajan, or for any other purpose, at Dr. Mahajan's expense upon the Board's request and without prior notice. Dr. Mahajan's refusal to submit a specimen upon request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary or Supervising Member of the Board.

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Monitoring Physician

14. Before engaging in any medical practice, Dr. Mahajan shall submit to the Board in writing the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Mahajan and who is engaged in the same or similar practice specialty.

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

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

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

    The Board expressly reserves the right to disapprove any person proposed to serve as Dr. Mahajan's designated monitoring physician, or to withdraw approval of any person previously approved to serve as Dr. Mahajan's designated monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

Rehabilitation Program

15. Dr. Mahajan shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than three times per week. Substitution of any other specific program must receive prior Board approval.

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Dr. Mahajan shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Mahajan's quarterly declarations.

Aftercare

16. Dr. Mahajan shall contact an appropriate impaired physicians committee, approved by the Board, to arrange for assistance in recovery or aftercare.

17. Dr. Mahajan shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Consent Agreement, the terms of this Consent Agreement shall control.

Psychiatric Treatment

18. Dr. Mahajan and the Board agree that the person previously approved by the Board to serve as Dr. Mahajan's treating psychiatrist pursuant to the March 2012 Step I Consent Agreement is hereby approved to continue as his designated treating psychiatrist under this Consent Agreement, unless within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall submit to the Board for its prior approval the name and qualifications of an alternative psychiatrist of his choice. Dr. Mahajan shall undergo and continue psychiatric treatment, including individual psychotherapy, at least weekly or as otherwise directed by the Board. Dr. Mahajan shall comply with his psychiatric treatment plan, including taking medications as prescribed and/or ordered for his psychiatric disorder. Dr. Mahajan shall ensure that psychiatric reports are forwarded by his treating psychiatrist to the Board on a quarterly basis, or as otherwise directed by the Board. The psychiatric reports shall contain information describing Dr. Mahajan's current treatment plan and any changes that have been made to the treatment plan since the prior report; Dr. Mahajan's compliance with his treatment plan; Dr. Mahajan's mental status; Dr. Mahajan's progress in treatment; and results of any laboratory studies that have been conducted since the prior report. Dr. Mahajan shall ensure that his treating psychiatrist immediately notifies the Board of his failure to comply with his psychiatric treatment plan and/or any determination that Dr. Mahajan is unable to practice due to his psychiatric disorder. It is Dr. Mahajan's responsibility to ensure that quarterly reports are received in the Board's offices no later than the due date for Dr. Mahajan's quarterly declaration.

The psychotherapy required as part of Dr. Mahajan's psychiatric treatment pursuant to this paragraph may be delegated by Dr. Mahajan's treating psychiatrist to an

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appropriately licensed mental health professional approved in advance by the Board, so long as Dr. Mahajan's treating psychiatrist oversees/supervises such psychotherapy; includes information concerning Dr. Mahajan's participation and progress in psychotherapy in his or her quarterly reports; and continues to meet personally with Dr. Mahajan at least once every two months. If such delegation is desired, within thirty days of the effective date of this Step II Consent Agreement, Dr. Mahajan shall submit to the Board for its approval the name and qualifications of a mental health care professional of his choice. However, Dr. Mahajan and the Board hereby agree that his current mental health professional shall be permitted to continue to provide his weekly psychotherapy under his current Board approved treating psychiatrist's supervision and direction for a period of no longer than 90 days, without being approved by the Board, so as to allow appropriate treatment pending Board approval of a mental health professional.

Should the psychotherapy required pursuant to this provision be delegated to a licensed mental health professional, Dr. Mahajan shall ensure that psychotherapy reports are forwarded by his treating mental health professional to the Board on a quarterly basis, or as otherwise directed by the Board. The psychotherapy reports shall contain information describing Dr. Mahajan's current treatment plan and any changes that have been made to the treatment plan since the prior report; Dr. Mahajan's compliance with his treatment plan; Dr. Mahajan's mental status; Dr. Mahajan's progress in treatment; and results of any laboratory studies that have been conducted since the prior report. Dr. Mahajan shall ensure that his treating licensed mental health professional immediately notifies the Board of his failure to comply with his psychotherapy treatment plan and/or any determination that Dr. Mahajan is unable to practice due to his psychiatric disorder. These psychotherapy reports shall be in addition to the reports submitted by Dr. Mahajan's treating psychiatrist. It is Dr. Mahajan's responsibility to ensure that all quarterly reports are received in the Board's offices no later than the due date for Dr. Mahajan's quarterly declaration.

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

The Board expressly reserves the right to disapprove any psychiatrist proposed to serve as Dr. Mahajan's designated treating psychiatrist and/or any licensed mental

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health professional proposed to serve as Dr. Mahajan's designated treating licensed mental health professional, or to withdraw approval of any such psychiatrist or licensed mental health professional previously approved to serve as Dr. Mahajan's designated treating psychiatrist or licensed mental health professional, in the event that the Secretary and Supervising Member of the Board determine that any such psychiatrist or licensed mental health professional has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

Work Hour Limitation

19. For a period of no less than three months from the date he returns to practice, Dr. Mahajan shall limit his work hours to no more than twenty hours of work per week (including time spent for the supervision of other counselors or therapists associated with his practice); thereafter, such work hour limitation shall continue until otherwise approved by the Board. Dr. Mahajan shall keep a log reflecting the dates, times, and facilities and/or locations at which he works. Dr. Mahajan shall submit his work log for receipt in the Board's offices no later than the due date for Dr. Mahajan's quarterly declaration.

    Any request by Dr. Mahajan for modification of the limitation on work hours set forth in this paragraph shall be accompanied by documentation from a physician affiliated with a Board approved treatment provider, or other physician approved by the Board for this purpose, who has evaluated Dr. Mahajan, indicating that such physician supports Dr. Mahajan's request for modification.

Releases

20. Dr. Mahajan shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Mahajan's chemical dependency, psychiatric condition, and/or related conditions, or for purposes of complying with this Consent Agreement, whether such treatment or evaluation occurred before or after the effective date of this Consent Agreement. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Mahajan further agrees to provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Consent Agreement.

Required Reporting by Licensee

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21. Within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall provide a copy of this Consent Agreement to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Mahajan shall promptly provide a copy of this Consent Agreement to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Mahajan provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Consent Agreement Dr. Mahajan shall provide a copy of this Consent Agreement to the Ohio Department of Public Safety, Division of Emergency Medical Services. Further, Dr. Mahajan shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

22. Within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall provide a copy of this Consent Agreement to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. Mahajan further agrees to provide a copy of this Consent Agreement at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license. Further, Dr. Mahajan shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent

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Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

23. Dr. Mahajan shall promptly provide a copy of this Consent Agreement to all persons and entities that provide Dr. Mahajan chemical dependency and/or psychiatric treatment or monitoring. Further, Dr. Mahajan shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

24. Dr. Mahajan shall notify the Board in writing of any change of principal practice address or residence address within thirty days of such change.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. Mahajan appears to have violated or breached any term or condition of this Consent Agreement, the Board reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including, but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Consent Agreement.

If the Secretary and Supervising Member of the Board determine that there is clear and convincing evidence that Dr. Mahajan has violated any term, condition or limitation of this Consent Agreement, Dr. Mahajan agrees that the violation, as alleged, also constitutes clear and convincing evidence that his continued practice presents a danger of immediate and serious harm to the public for purposes of initiating a summary suspension pursuant to Section 4731.22(G), Ohio Revised Code.

DURATION/MODIFICATION OF TERMS

Dr. Mahajan shall not request termination of this Consent Agreement for a minimum of five years. In addition, Dr. Mahajan shall not request modification to the probationary terms, limitations, and conditions contained herein for at least one year, except that Dr. Mahajan may make such request with the mutual approval and joint recommendation of the Secretary and Supervising Member. Otherwise, the above-described terms, limitations and conditions may be amended or terminated in writing at any time upon the agreement of both parties.

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In the event that the Board initiates future formal proceedings against Dr. Mahajan, including but not limited to issuance of a Notice of Opportunity for Hearing, this Consent Agreement shall continue in full force and effect until such time that it is superseded by ratification by the Board of a subsequent Consent Agreement or issuance by the Board of a final Board Order.

In the event that any term, limitation, or condition contained in this Consent Agreement is determined to be invalid by a court of competent jurisdiction, Dr. Mahajan and the Board agree that all other terms, limitations, and conditions contained in this Consent Agreement shall be unaffected.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. Mahajan acknowledges that he has had an opportunity to ask questions concerning the terms of this Consent Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

Dr. Mahajan hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data banks and governmental bodies. Dr. Mahajan acknowledges that his social security number will be used if this information is so reported and agrees to provide his social security number to the Board for such purposes.

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

Mahendra K Mahajan

MAHENDRA KUMAR MAHAJAN, M.D.

9/5/12

DATE

J. Craig Strafford MD MPH

J. CRAIG STRAFFORD, M.D., M.P.H.
Secretary

12 Sept 2012

DATE

MEDICAL BOARD
SEP 06 2012

Halli Brownfield Watson

HALLI BROWNFIELD WATSON
Attorney for Dr. Mahajan

9/5/12
DATE

Mark A. Bechtel

MARK A. BECHTEL, M.D.
Supervising Member

12, Sept 2012
DATE

Sheldon Safko

SHELDON SAFKO
Enforcement Attorney

9/6/12
DATE

MEDICAL BOARD
SEP 06 2012

CONSENT AGREEMENT
BETWEEN
MAHENDRA KUMAR MAHAJAN, M.D.,
AND
THE STATE MEDICAL BOARD OF OHIO
CASE NO. 12-CRF-001

This Consent Agreement is entered into by and between Mahendra Kumar Mahajan, M.D., [Dr. Mahajan], and the State Medical Board of Ohio [Board], a state agency charged with enforcing Chapter 4731., Ohio Revised Code.

Dr. Mahajan enters into this Consent Agreement being fully informed of his/her rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

BASIS FOR ACTION

This Consent Agreement is entered into on the basis of the following stipulations, admissions and understandings:

A. The Board is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for violation of Section 4731.22(B)(19), Ohio Revised Code, for "[i]nability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including, but not limited to, physical deterioration that adversely affects cognitive, motor, or perceptive skills," and for violation of Section 4731.22(B)(26), Ohio Revised Code, for "impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice."

B. The Board enters into this Consent Agreement in lieu of formal proceedings based upon the violation of Sections 4731.22(B)(19) and 4731.22(B)(26), Ohio Revised Code, and expressly reserves the right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Agreement.

C. Dr. Mahajan is licensed to practice medicine and surgery in the State of Ohio, License number 35.043538. On May 12, 2010, the Board issued an Order that placed Dr. Mahajan's license on probation for at least three years.

D. Dr. Mahajan states that he is also licensed to practice medicine and surgery in the State of Indiana.

E. Dr. Mahajan's license to practice medicine and surgery in the State of Ohio, License Number 35.043538, was summarily suspended by the Board on January 6, 2012, pursuant to the Notice of Summary Suspension and Opportunity for Hearing attached hereto as Exhibit A.

F. Dr. Mahajan admits to the factual and legal allegations as set forth in the Notice of Opportunity for Hearing issued by the Board on January 6, 2012, attached hereto as Exhibit A, and incorporated herein.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, Dr. Mahajan knowingly and voluntarily agrees with the Board to the following terms, conditions and limitations:

SUSPENSION OF CERTIFICATE

1. The certificate of Dr. Mahajan to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but no less than 180 days from the effective date of this Consent Agreement. Further, the probationary terms set forth in the May 12, 2010 Board Order are hereby terminated and superseded by the following terms, conditions, and limitations.

Obey all Laws

2. Dr. Mahajan shall obey all federal, state, and local laws.

Sobriety

3. Dr. Mahajan shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of Dr. Mahajan's history of chemical dependency. Further, in the event that Dr. Mahajan is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. Mahajan shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. Mahajan received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Mahajan shall provide

the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

4. Dr. Mahajan shall abstain completely from the use of alcohol.

Absences from Ohio

5. Dr. Mahajan shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the monitoring terms set forth in this Consent Agreement for occasional periods of absence of fourteen days or less. In the event that Dr. Mahajan resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Mahajan may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Mahajan is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Consent Agreement.

Psychiatric Treatment

6. Dr. Mahajan admits that he has been diagnosed with depression. Within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall submit to the Board for its prior approval the name and curriculum vitae of a psychiatrist of Dr. Mahajan's choice. Upon approval by the Board, Dr. Mahajan shall undergo and continue psychiatric treatment monthly or as otherwise directed by the Board. Dr. Mahajan shall comply with his psychiatric treatment plan, including taking medications as prescribed and/or ordered for his psychiatric disorder.

   Dr. Mahajan shall continue in psychiatric treatment until such time as the Board determines that no further treatment is necessary. To make this determination, the Board shall require reports from the approved treatment psychiatrist. The psychiatric reports shall contain information describing Dr. Mahajan's current treatment plan and any changes that have been made to the treatment plan since the prior report; Dr. Mahajan's compliance with his treatment plan; Dr. Mahajan's psychiatric status; Dr. Mahajan's progress in treatment; and results of any laboratory studies that have been conducted since the prior report. Dr. Mahajan shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Mahajan's quarterly declaration.

Dr. Mahajan shall ensure that his treating psychiatrist immediately notifies the Board of his failure to comply with his psychiatric treatment plan and/or any determination that Dr. Mahajan is unable to practice due to his psychiatric disorder.

In the event that the designated treating psychiatrist becomes unable or unwilling to serve in this capacity, Dr. Mahajan must immediately so notify the Board in writing and make arrangements acceptable to the Board for another psychiatrist as soon as practicable. Dr. Mahajan shall further ensure that the previously designated treating psychiatrist also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

The Board expressly reserves the right to disapprove any psychiatrist proposed to serve as Dr. Mahajan's designated treating psychiatrist, or to withdraw approval of any such psychiatrist previously approved to serve as Dr. Mahajan's designated treating psychiatrist, in the event that the Secretary and Supervising Member of the Board determine that any such psychiatrist has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

Releases; Quarterly Declarations and Appearances

7. Dr. Mahajan shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Mahajan's chemical dependency, psychiatric condition, or related conditions, or for purposes of complying with this Consent Agreement, whether such treatment or evaluation occurred before or after the effective date of this Consent Agreement. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Mahajan further agrees to provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Consent Agreement.

8. Dr. Mahajan shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Consent Agreement. The first quarterly declaration must be received in the Board's offices on the date his quarterly declaration would have been due pursuant to his May 2010 Order, or as otherwise requested by the Board. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

9. Dr. Mahajan shall appear in person for an interview before the full Board or its designated representative during the third month following the effective date of this Consent Agreement. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

Drug & Alcohol Screens; Drug Testing Facility and Collection Site

10. Dr. Mahajan shall submit to random urine screenings for drugs and alcohol at least four times per month, or as otherwise directed by the Board. Dr. Mahajan shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Mahajan's drug(s) of choice.

    Dr. Mahajan shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Mahajan acknowledges that he understands that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Consent Agreement.

    All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph 11 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

    Dr. Mahajan shall submit, at his/her expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Mahajan shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Consent Agreement. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Consent Agreement.

Further, within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Consent Agreement. Further, Dr. Mahajan shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Mahajan and the Board-approved drug testing facility and/or collection site. Dr. Mahajan's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Consent Agreement.

Dr. Mahajan shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Mahajan and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Mahajan shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Consent Agreement, Dr. Mahajan must immediately notify the Board in writing, and make arrangements acceptable to the Board, pursuant to Paragraph 11 below, as soon as practicable. Dr. Mahajan shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

Dr. Mahajan acknowledges that the Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

11. Dr. Mahajan and the Board agree that it is the intent of this Consent Agreement that Dr. Mahajan shall submit his/her urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Mahajan, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or

collection site, or a supervising physician, to facilitate the urine screening process for Dr. Mahajan:

a. Within thirty days of the date upon which Dr. Mahajan is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Mahajan, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Mahajan shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Mahajan's residence or employment location, or to a physician who practices in the same locale as Dr. Mahajan. Dr. Mahajan shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Mahajan acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

b. Dr. Mahajan shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Mahajan must immediately notify the Board in writing. Dr. Mahajan shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his/her urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Mahajan shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Mahajan.

d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Mahajan's designated alternate drug testing facility and/or collection

site, or any person proposed to serve as his/her supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

12. All screening reports required under this Consent Agreement from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Mahajan's quarterly declaration. It is Dr. Mahajan's responsibility to ensure that reports are timely submitted.

13. The Board retains the right to require, and Dr. Mahajan agrees to submit, blood, urine, breath, saliva and/or hair specimens for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Mahajan, or for any other purpose, at Dr. Mahajan's expense upon the Board's request and without prior notice. Dr. Mahajan's refusal to submit a specimen upon request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary or Supervising Member of the Board.

Rehabilitation Program

14. Within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall undertake and maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than three times per week. Substitution of any other specific program must receive prior Board approval.

    Dr. Mahajan shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Mahajan's quarterly declarations.

15. Immediately upon completion of any required treatment for chemical dependency, Dr. Mahajan shall enter into an aftercare contract with a Board-approved treatment provider and shall maintain continued compliance with the terms of said aftercare contract, provided that, where the terms of the aftercare contract conflict with the terms of this Consent Agreement, the terms of this Consent Agreement shall control.

CONDITIONS FOR REINSTATEMENT

16. The Board shall not consider reinstatement or restoration of Dr. Mahajan's certificate to practice medicine and surgery until all of the following conditions are met:

a. Dr. Mahajan shall submit an application for reinstatement or restoration, as appropriate, accompanied by appropriate fees, if any.

b. Dr. Mahajan shall demonstrate to the satisfaction of the Board that he can resume practice in compliance with acceptable and prevailing standards of care under the provisions of his/her certificate. Such demonstration shall include but shall not be limited to the following:

i. Certification from a treatment provider approved under Section 4731.25 of the Revised Code that Dr. Mahajan has successfully completed any required inpatient treatment, including at least twenty-eight days of inpatient or residential treatment for chemical abuse/dependence, as set forth in Rules 4731-16-02 and 4731-16-08, Ohio Administrative Code, completed consecutively.

ii. Evidence of continuing full compliance with, or successful completion of, a post-discharge aftercare contract with a treatment provider approved under Section 4731.25 of the Revised Code. Such evidence shall include, but not be limited to, a copy of the signed aftercare contract. The aftercare contract must comply with rule 4731-16-10 of the Administrative Code.

iii. Evidence of continuing full compliance with this Consent Agreement.

iv. Four written reports indicating that Dr. Mahajan's ability to practice has been assessed and that he has been found capable of practicing according to acceptable and prevailing standards of care.

Two of the four reports shall be made by physicians knowledgeable in the area of addictionology and who are either affiliated with a current Board-approved treatment provider or otherwise have been approved in advance by the Board to provide an assessment of Dr. Mahajan. Further, the two aforementioned physicians shall not be affiliated with the same treatment provider or medical group practice. Prior to the assessments, Dr. Mahajan shall provide the evaluators with copies of patient records from any evaluations and/or treatment that he has received, and a copy of this Consent Agreement. The reports from the evaluators shall include any recommendations for treatment, monitoring, or supervision of Dr. Mahajan, and any conditions, restrictions, or limitations that should be imposed on Dr. Mahajan's practice. The reports shall also describe the basis for the evaluator's determinations.

Two of the four written reports shall be made by psychiatrists, approved in advance by the Board, who shall conduct a psychiatric examination of Dr. Mahajan. Prior to the examination, Dr. Mahajan shall provide the

psychiatrist with copies of patient records from any prior evaluations and/or treatment that he has received, and a copy of this Consent Agreement. The report from the evaluating psychiatrist shall include the psychiatrist's diagnoses and conclusions; any recommendations for care, counseling, and treatment for the psychiatric diagnoses; any conditions, restrictions, or limitations that should be imposed on Dr. Mahajan's practice; and the basis for the psychiatrist's determinations. The two aforementioned psychiatrists shall not be affiliated with the same treatment provider or medical group practice.

All reports required pursuant to this paragraph shall be based upon examinations occurring within the three months immediately preceding any application for reinstatement. Further, at the discretion of the Secretary and Supervising Member of the Board, the Board may request an updated assessment and report if the Secretary and Supervising Member determine that such updated assessment and report is warranted for any reason.

v. In the event that the Board initiates future formal proceedings against Dr. Mahajan, including but not limited to issuance of a Notice of Opportunity for Hearing, Dr. Mahajan shall be ineligible for reinstatement until such proceedings are fully resolved by ratification by the Board of a subsequent Consent Agreement or issuance by the Board of a final Board Order.

c. Dr. Mahajan shall enter into a written consent agreement, which shall be in effect for a minimum of five years, including probationary terms, conditions and limitations as determined by the Board within 180 days of the date upon which all the above-specified conditions for reinstatement or restoration have been completed or, if the Board and Dr. Mahajan are unable to agree on the terms of a written Consent Agreement, then Dr. Mahajan further agrees to abide by any terms, conditions and limitations imposed by Board Order after a hearing conducted pursuant to Chapter 119. of the Ohio Revised Code. The Board shall provide notice to Dr. Mahajan that said hearing has been scheduled, advising Dr. Mahajan of his/her hearing rights, and stating the date, time, and location of the hearing at which the Board will present its evidence, after which the Board will make a determination of the matter by Board Order.

Further, upon reinstatement of Dr. Mahajan's certificate to practice medicine and surgery in this state, the Board shall require continued monitoring which shall include, but not be limited to, compliance with the written consent agreement entered into before reinstatement or with conditions imposed by Board Order after a hearing conducted pursuant to Chapter 119. of the Revised Code. Moreover, upon termination of the consent agreement or Board Order, Dr. Mahajan shall submit to the Board for at least two years annual progress reports made under

penalty of Board disciplinary action or criminal prosecution stating whether Dr. Mahajan has maintained sobriety.

17. In the event that Dr. Mahajan 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 Dr. Mahajan's fitness to resume practice.

REQUIRED REPORTING BY LICENSEE

18. Within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall provide a copy of this Consent Agreement to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Mahajan shall promptly provide a copy of this Consent Agreement to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Mahajan provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Consent Agreement Dr. Mahajan shall provide a copy of this Consent Agreement to the Ohio Department of Public Safety, Division of Emergency Medical Services. Further, Dr. Mahajan shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

19. Within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall provide a copy of this Consent Agreement to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. Mahajan further agrees to provide a copy of this Consent Agreement at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement of any professional license. Further, Dr. Mahajan shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date

of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

20. Dr. Mahajan shall promptly provide a copy of this Consent Agreement to all persons and entities that provide Dr. Mahajan chemical dependency and/or psychiatric treatment or monitoring. Further, Dr. Mahajan shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

21. Dr. Mahajan shall notify the Board in writing of any change of principal practice address or residence address within thirty days of such change.

DURATION/MODIFICATION OF TERMS

The above-described terms, conditions and limitations may be amended or terminated in writing at any time upon the agreement of both parties. In the event that the Board initiates future formal proceedings against Dr. Mahajan, including but not limited to issuance of a Notice of Opportunity for Hearing, this Consent Agreement shall continue in full force and effect until such time that it is superseded by ratification by the Board of a subsequent Consent Agreement or issuance by the Board of a final Board Order.

In the event that any term, limitation, or condition contained in this Consent Agreement is determined to be invalid by a court of competent jurisdiction, Dr. Mahajan and the Board agree that all other terms, limitations, and conditions contained in this Consent Agreement shall be unaffected.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. Mahajan appears to have violated or breached any term or condition of this Consent Agreement, the Board reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Consent Agreement.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. Mahajan acknowledges that he has had an opportunity to ask questions concerning the terms of this Consent Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

Dr. Mahajan hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data banks and governmental bodies. Dr. Mahajan acknowledges that his/her social security number will be used if this information is so reported and agrees to provide his/her social security number to the Board for such purposes.

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

Mahendra K Mahajan

MAHENDRA KUMAR MAHAJAN, M.D.

3/13/12

DATE

J. Craig Strafford MD MPH

J. CRAIG STRAFFORD, M.D., M.P.H.
Secretary

14 MAR 2012

DATE

HALLI BROWNFIELD WATSON
Attorney for Dr. Mahajan

3/13/12
DATE

JACK C. AMATO, M.D.
Supervising Member

3-14-12
DATE

KATHERINE J. BOCKBRADER
Assistant Attorney General

3-14-12
DATE

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

January 6, 2012

Case number: 12-CRF- 001

Mahendra Kumar Mahajan, M.D.
2614 Lantz Road
Beavercreek, Ohio 45434

Dear Doctor Mahajan:

Enclosed please find certified copies of the Entry of Order, the Notice of Summary Suspension and Opportunity for Hearing, and the Motion by the State Medical Board of Ohio made at a conference call on January 6, 2012, scheduled pursuant to Section 4731.22(G), Ohio Revised Code, adopting the Order of Summary Suspension and issuing the Notice of Summary Suspension and Opportunity for Hearing.

You are advised that continued practice after receipt of this Order shall be considered practicing without a certificate, in violation of Section 4731.41, Ohio Revised Code.

Pursuant to Chapter 119, Ohio Revised Code, you are hereby advised that you are entitled to a hearing on the matters set forth in the Notice of Summary Suspension and Opportunity for Hearing. If you wish to request such hearing, that request must be made in writing and be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice. Further information concerning such hearing is contained within the Notice of Summary Suspension and Opportunity for Hearing.

THE STATE MEDICAL BOARD OF OHIO

J. Craig Strafford, MD, MPH
by authority Rebecca Marshall

J. Craig Strafford, M.D., M.P.H., Secretary

JCS/flb
Enclosures

Mailed 1-6-12

CERTIFICATION

I hereby certify that the attached copies of the Entry of Order of the State Medical Board of Ohio and the Motion by the State Medical Board, in a conference call on January 6, 2012, scheduled pursuant to Section 4731.22(G), Ohio Revised Code, to Adopt the Order of Summary Suspension and to Issue the Notice of Summary Suspension and Opportunity for Hearing, constitute true and complete copies of the Motion and Order in the Matter of Mahendra Kumar Mahajan, M.D., Case number: 12-CRF-001 as they appear in the Journal of the State Medical Board of Ohio.

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

J. Craig Strafford, MD, MPH
by authority Rebecca Marshall
J. Craig Strafford, M.D., M.P.H., Secretary

(SEAL)

January 6, 2012
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	:
	:
MAHENDRA KUMAR MAHAJAN, M.D.	:
	:
CASE NUMBER: 12-CRF- 001	:

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio the 6th day of January 2012.

Pursuant to Section 4731.22(G), Ohio Revised Code, and upon recommendation of J. Craig Strafford, M.D., M.P.H., Secretary, and Jack C. Amato, M.D., Supervising Member; and

Pursuant to their determination, based upon their review of the information supporting the allegations as set forth in the Notice of Summary Suspension and Opportunity for Hearing, that there is clear and convincing evidence that Mahendra Kumar Mahajan, M.D., has violated Sections 4731.22(B)(19) and (B)(26), Ohio Revised Code, as alleged in the Notice of Summary Suspension and Opportunity for Hearing that is enclosed herewith and fully incorporated herein; and,

Pursuant to their further determination, based upon their review of the information supporting the allegations as set forth in the Notice of Summary Suspension and Opportunity for Hearing, that Dr. Mahajan's continued practice presents a danger of immediate and serious harm to the public;

The following Order is hereby entered on the Journal of the State Medical Board of Ohio for the 6th day of January 2012:

> It is hereby ORDERED that the certificate of Mahendra Kumar Mahajan, M.D., to practice medicine and surgery in the State of Ohio be summarily suspended.
>
> It is hereby ORDERED that Mahendra Kumar Mahajan, M.D., shall immediately cease the practice of medicine and surgery in Ohio and immediately refer all active patients to other appropriate physicians.

This Order shall become effective immediately.

J. Craig Strafford, MD, MPH
by authority Rebecca Marshall
J. Craig Strafford, M.D., M.P.H.,
Secretary

(SEAL)

January 6, 2012
Date

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

EXCERPT FROM TELECONFERENCE OF JANUARY 6, 2012

CONFERENCE CALL OF JANUARY 6, 2012 TO CONSIDER THE SUMMARY SUSPENSION OF A CERTIFICATE

MAHENDRA KUMAR MAHAJAN, M.D. – ORDER OF SUMMARY SUSPENSION AND NOTICE OF OPPORTUNITY FOR HEARING

.....

Dr. Steinbergh moved to enter an Order of Summary Suspension in the matter of Mahendra Kumar Mahajan, M.D., in accordance with Section 4731.22(G), Ohio Revised Code, and to issue the Notice of Summary Suspension and Opportunity for Hearing to Dr. Mahendra Mahajan. Mr. Hairston seconded the motion. A vote was taken:

ROLL CALL:	Mr. Hairston	- aye
	Dr. Suppan	- aye
	Dr. Steinbergh	- aye
	Dr. Mahajan	- aye
	Dr. Talmage	- abstain
	Ms. Elsass	- aye
	Dr. Ramprasad	- aye

The motion carried.

Ms. Marshall stated that she has already obtained Dr. Strafford's prior authorization to sign, on his behalf, the Order of Summary Suspension, Notice of Opportunity for Hearing, certification, and cover letter in the matter of Mahendra Kumar Mahajan, M.D., in his absence, in the event that the Board approved the Order.

State Medical Board of Ohio

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NOTICE OF SUMMARY SUSPENSION
AND
OPPORTUNITY FOR HEARING

January 6, 2012

Case number: 12-CRF- 001

Mahendra Kumar Mahajan, M.D.
2614 Lantz Road
Beavercreek, Ohio 45434

Dear Doctor Mahajan:

The Secretary and the Supervising Member of the State Medical Board of Ohio [Board] have determined that there is clear and convincing evidence that you have violated Sections 4731.22(B)(19) and (B)(26), Ohio Revised Code, and have further determined that your continued practice presents a danger of immediate and serious harm to the public, as set forth in paragraphs (1) through (3), below.

Therefore, pursuant to Section 4731.22(G), Ohio Revised Code, and upon recommendation of J. Craig Strafford, M.D., M.P.H., Secretary, and Jack C. Amato, M.D., Supervising Member, you are hereby notified that, as set forth in the attached Entry of Order, your certificate to practice medicine and surgery in the State of Ohio is summarily suspended. Accordingly, at this time, you are no longer authorized to practice medicine and surgery in Ohio.

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

(1) By letter dated December 20, 2011, Tracy Cummings, M.D. and Todd Palumbo, M.D., at Lindner Center of HOPE, [Lindner], a Board-approved treatment provider, in Mason, Ohio, notified the Board that on or about December 6, 2011, you were admitted to Lindner for a diagnostic evaluation. Subsequently, you were determined to be impaired in your ability to practice according to acceptable and prevailing

standards of care due to diagnoses of major depressive disorder and alcohol abuse. It was recommended that you complete residential treatment, and have monitoring and supervision.

(2) By letter dated January 3, 2012, Tracy Cummings, M.D. and Todd Palumbo, M.D. at Lindner, notified the Board that you were unsuccessful in completing 28 days of treatment due to you discharging yourself from Lindner against medical advice, on December 30, 2011, after being denied a therapeutic leave of absence. Subsequently on December 31, 2011, you requested re-admission which was granted. It was recommended that you complete an additional week of treatment at Lindner. Furthermore, Dr. Cummings and Dr. Palumbo opined that to a reasonable degree of medical certainty, you are, at this time, impaired in your ability to practice medicine and surgery due to diagnoses of major depressive disorder, alcohol abuse, and poor impulse control and anger management.

(3) Although you have entered treatment, the Board has not received information that you have completed the recommended/required treatment and entered into an aftercare contract with a Board approved treatment provider. In addition, the Board has not received information that you have been determined to be capable of practicing in accordance with acceptable and prevailing standards of care.

Section 4731.22(B)(26), Ohio Revised Code, provides that if the Board determines that an individual's ability to practice is impaired, the Board shall suspend the individual's certificate and shall require the individual, as a condition for continued, reinstated, or renewed certification to practice, to submit to treatment and, before being eligible to apply for reinstatement, to demonstrate to the Board the ability to resume practice in compliance with acceptable and prevailing standards of care, including completing required treatment, providing evidence of compliance with an aftercare contract or written consent agreement, and providing written reports indicating that the individual's ability to practice has been assessed by individuals or providers approved by the Board and that the individual has been found capable of practicing according to acceptable and prevailing standards of care.

Further, Rule 4731-16-02(B)(1), Ohio Administrative Code, provides that if an examination discloses impairment, or if the Board has other reliable, substantial and probative evidence demonstrating impairment, the Board shall initiate proceedings to suspend the licensee, and may issue an order of summary suspension as provided in Section 4731.22(G), Ohio Revised Code.

Furthermore, Section 4731.22(B)(19), Ohio Revised Code, provides that if the Board finds any individual unable to practice, the Board shall require the individual to submit to care, counseling, or treatment by physicians approved or designated by the Board, as a condition for initial, continued, reinstated, or renewed authority to practice.

Further, Rule 4731-28-01, Ohio Administrative Code, provides that "[f]or the purposes of ... division (B)(19) of section 4731.22 of the Revised Code...the following definitions apply: (A) 'Mental illness' includes, but is not limited to, mental disorder; and (B) 'Inability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including, but not limited to, physical deterioration that adversely affects cognitive, motor, or perceptive skills', includes inability to practice in accordance with such standards without appropriate treatment, monitoring, or supervision."

Your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) above individually and/or collectively, constitute "[i]mpairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice," as that clause is used in Section 4731.22(B)(26), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) above, individually and/or collectively constitute "[i]nability to practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness, including, but not limited to, physical deterioration that adversely affects cognitive, motor, or perceptive skills," as that clause is used in Section 4731.22(B)(19), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, and Chapter 4731., Ohio Revised Code, you are hereby advised that you are entitled to a hearing concerning these matters. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

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

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

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

Copies of the applicable sections are enclosed for your information.

Very truly yours,

J. Craig Strafford, MD, MPH
by authority Rebecca Marshall

J. Craig Strafford, M.D., M.P.H.
Secretary

JCS/SRS/flb
Enclosures

CERTIFIED MAIL #91 7199 9991 7030 3376 6089
RETURN RECEIPT REQUESTED

cc: Hand Delivery

cc: Nicholas E. Subashi, Esq.
Subashi & Wildermuth
50 Chestnut Street, Suite 230
Dayton, Ohio 45440

CERTIFIED MAIL #91 7199 9991 7030 3376 6072
RETURN RECEIPT REQUESTED

20822 - U60

FILED
COURT OF APPEALS
FRANKLIN CO OHIO
2011 DEC 27 PM 12: 35
CLERK OF COURTS

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Mahendra Kumar Mahajan, M.D.,	:	
Appellant-Appellant,	:	No. 11AP-421 (C.P.C. No. 10CVF-06-9077)
v.	:	No. 11AP-422 (C P.C. No. 10CVF-07-9949)
State Medical Board of Ohio,	:	(REGULAR CALENDAR)
Appellee-Appellee.	:	

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on December 27, 2011, appellant's first, second, third, fourth, fifth, sixth, and eighth assignments of error are overruled, his seventh assignment of error is moot, and it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs shall be assessed against appellant.

FRENCH, J., BRYANT, P.J., and CONNOR, J.

By Judith French
Judge Judith L. French

20822 - T92

(Lynch)

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FILED
COURT OF APPEALS
FRANKLIN CO. OHIO
2011 DEC 27 PM 12:31
CLERK OF COURTS

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Mahendra Kumar Mahajan, M.D.,	:	
Appellant-Appellant,	:	No. 11AP-421 (C.P.C. No 10CVF-06-9077)
v.	:	No. 11AP-422 (C.P.C. No. 10CVF-07-9949)
State Medical Board of Ohio,	:	(REGULAR CALENDAR)
Appellee-Appellee.	:	

D E C I S I O N

Rendered on December 27, 2011

Subashi & Wildermuth, *Nicholas E. Subashi*, and *Halli Brownfield Watson*, for appellant.

Michael DeWine, Attorney General, and *Katherine J. Bockbrader*, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

FRENCH, J.

{¶1} Appellant, Mahendra Kumar Mahajan, M.D. ("Dr. Mahajan"), appeals the judgment of the Franklin County Court of Common Pleas, which affirmed the decision of appellee, the State Medical Board of Ohio ("board"), to impose probation upon Dr. Mahajan's certificate to practice medicine and surgery in Ohio and order him to meet

certain conditions before probation would terminate. Having concluded that the trial court did not abuse its discretion by affirming the board's order, we affirm.

I. BACKGROUND

{¶2} By letter dated November 14, 2007, the board notified Dr. Mahajan that it intended to determine whether to impose discipline against his certificate to practice medicine and surgery in Ohio. The board based its proposed action on allegations concerning "Patients 1 – 10," as identified in a confidential patient key, in the course of his psychiatric practice from about 2000 to 2006. (The specific allegations are detailed and discussed below.) The board alleged that the acts, conduct or omissions constitute the following:

> 1) "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," as those clauses are used in R.C. 4731.22(B)(2); and/or
>
> 2) "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 R.C. 4731.22(B)(6).

{¶3} Upon Dr. Mahajan's request, a hearing examiner of the board held a three-day hearing on January 21, 22, and 23, 2009. During the hearing, the following witnesses testified: Dr. Mahajan, on his own behalf; Robert A. Karp, M.D., an expert testifying on behalf of the board; Thomas Gutheil, M.D., an expert testifying on behalf of Dr. Mahajan; and Daniel S. Polster, M.D., an expert testifying on behalf of Dr. Mahajan. Evidence before the hearing examiner included documentary evidence and the following: a letter from James R. Hawkins, M.D.; a letter from Amita R. Patel; a 2005

consent agreement, by which Dr. Mahajan agreed to probationary terms and conditions concerning a violation of R.C. 4731.22(B)(12); and letters of support for Dr. Mahajan from patients and colleagues.

{¶4} On April 5, 2010, the hearing examiner issued a 110-page report and recommendation. In summary, the hearing examiner made the following findings of fact:

> 1) Adequate medical documentation is an important element in the care of patients, it is necessary for both "medico-legal purposes" and patient safety, and "it minimizes the risk of relying on the fallible memory of a treating physician. * * * [T]he evidence supports a finding that Dr. Mahajan failed to perform and/or document a psychiatric evaluation of Patients 1, 3, 4, 5, 6, 7, 9 and 10." Report and Recommendation 99 (hereinafter, RR __).
>
> 2) There is a lack of evidence that Dr. Mahajan failed to order, review or document baseline or follow-up laboratory evaluations of Patients 1, 3, 4, 5, 6, 7, and 9, or failed to maintain laboratory results for Patients 2 and 8.
>
> 3) The evidence supports a finding that Dr. Mahajan failed to order and/or document therapeutic levels of Depakote for Patients 2 and 8 and failed to order and/or document therapeutic levels of Tegretol for Patient 8.
>
> 4) The evidence supports a finding that, for Patients 1 through 10, Dr. Mahajan failed to document that the relevant diagnostic-manual criteria had been met for any psychiatric diagnosis for which he provided a Diagnostic and Statistical Manual code.
>
> 5) The evidence supports a finding that Dr. Mahajan did not properly document the performance of an initial or ongoing discussion of informed consent regarding diagnoses and medications for Patients 1 through 10.
>
> 6) The evidence is insufficient to support a finding that Dr. Mahajan failed to consistently follow up on medication changes, additions, and deletions for the ten patients. Also, there is insufficient evidence to support a finding that Dr.

> Mahajan inappropriately prescribed medications to the ten patients on an ad hoc basis.
>
> 7) The evidence is insufficient to support a finding that Dr. Mahajan failed to document the absence or presence of adverse effects from medication prescribed to Patients 1, 2, 3, 4, 5, 7, and 8. However, the evidence supports a finding that Dr. Mahajan failed to document the absence or presence of adverse effects from medication prescribed to Patients 6 and 9.
>
> 8) The "evidence overwhelming supports a finding that Dr. Mahajan failed to discuss and/or document" his discussion of tardive dyskinesia for Patients 2, 5, 7, 8, 9, and 10, to whom he had prescribed antipsychotic medication. (RR 103.) Dr. Mahajan also failed to perform or document Abnormal Involuntary Movement examinations for these same patients.

{¶5} The hearing examiner concluded that the findings of fact did not support a conclusion that Dr. Mahajan committed a violation of R.C. 4731.22(B)(2), and certain of the findings failed to support a conclusion that Dr. Mahajan committed a violation of R.C. 4731.22(B)(6). Nevertheless, seven of the findings supported the conclusion that the acts, conduct, and/or omissions reflected in those findings "constitute '[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,' as that clause is used" in R.C. 4731.22(B)(6).

{¶6} The hearing examiner recommended that Dr. Mahajan's certificate to practice medicine and surgery be suspended for an indefinite period of time and not be restored until certain conditions were met. The hearing examiner also recommended that, upon restoration, Dr. Mahajan's certificate be subject to probationary terms and conditions for a period of at least three years.

{¶7} On May 12, 2010, the board held a hearing at which it considered the hearing examiner's report and recommendation. The board issued a final order, which provided that Dr. Mahajan's certificate to practice medicine and surgery in Ohio shall be subject to specified probationary terms and conditions for a period of at least three years. The probationary terms included documentation of Dr. Mahajan's completion of a course or courses on maintaining adequate and appropriate medical records, completion of a report about what he learned from the course(s), the appointment of a monitoring physician, and notification to employers and others concerning the order.

{¶8} Dr. Mahajan appealed the board's order to the trial court. The court issued an 18-page decision in which it affirmed the board's order, with the exception of one probationary term that imposed restrictions upon Dr. Mahajan's travel. Specifically, the trial court concluded that the order, with the exception of the travel-related provision, was supported by reliable, probative, and substantial evidence and was in accordance with law.

II. ASSIGNMENTS OF ERROR

{¶9} Dr. Mahajan filed a notice of appeal to this court. He raises the following assignments of error:

> [1.] The common pleas court committed an error of law and abused its discretion in finding that alleged deficiencies in patient charting may be the basis for a finding that a physician failed to comply with minimal standards of care in violation of R.C. 4731.22(B)(6).
>
> [2.] Even if documentation deficiencies may serve as proof that a physician fell below the standard of care, the conclusion that Dr. Mahajan's care and treatment of these ten patients fell below the standard of care is not supported by reliable, probative, and substantial evidence, and the

> common pleas court abused its discretion in finding that it was.
>
> [3.] The common pleas court erred in affirming numerous erroneous evidentiary rulings made by the Hearing Examiner and by not considering items improperly excluded, redacted, and/or stricken from the administrative record by the Board.
>
> [4.] The common pleas court erred in overruling Appellant's Motion to Dismiss and finding that Appellant has not been deprived of a full and fair record in this matter resulting in prejudice to Appellant, the violation of his due process rights, and the Board's inability to comply with R.C. 119.09.
>
> [5.] The common pleas court erred by not invalidating the Board's Order based upon the Board's failure to comply with Ohio's Open Meetings Act in adopting said Order.
>
> [6.] The Hearing Examiner who presided over the proceedings before the Board was biased, partial, and prejudiced to such a degree that his presence adversely affected the Board's decision.
>
> [7.] Although the common pleas court was correct in finding that the travel restriction contained in the Board's Order is not in accordance with law, it erred in failing to strike this provision and remanding the Order to the Board to revise this term of Appellant's probation.
>
> [8.] The common pleas court erred by failing to award Appellant attorneys' fees pursuant to R.C. 2335.59 and/or other provisions of law, as the Board was not substantially justified in initiating this disciplinary action against him.

III. DISCUSSION

{¶10} In an administrative appeal, pursuant to R.C. 119.12, the trial court reviews an order to determine whether it is supported by reliable, probative, and substantial evidence and is in accordance with the law. In applying this standard, the court must "give due deference to the administrative resolution of evidentiary conflicts." *Univ. of Cincinnati v. Conrad* (1980), 63 Ohio St.2d 108, 111.

{¶11} The Ohio Supreme Court has defined reliable, probative, and substantial evidence as follows:

> * * * (1) "Reliable" evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) "Probative" evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) "Substantial" evidence is evidence with some weight; it must have importance and value.

Our Place, Inc. v. Ohio Liquor Control Comm. (1992), 63 Ohio St.3d 570, 571. (Footnotes omitted.)

{¶12} On appeal to this court, the standard of review is more limited. Unlike the court of common pleas, a court of appeals does not determine the weight of the evidence. *Rossford Exempted Village School Dist. Bd. of Edn. v. State Bd. of Edn.* (1992), 63 Ohio St.3d 705, 707. In reviewing the court of common pleas' determination that the board's order was supported by reliable, probative, and substantial evidence, this court's role is limited to determining whether the court of common pleas abused its discretion. *Roy v. Ohio State Med. Bd.* (1992), 80 Ohio App.3d 675, 680. The term "abuse of discretion" connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary or unconscionable. *Blakemore v. Blakemore* (1983), 5 Ohio St.3d 217, 219. However, on the question whether the board's order was in accordance with the law, this court's review is plenary. *Univ. Hosp., Univ. of Cincinnati College of Medicine v. State Emp. Relations Bd.* (1992), 63 Ohio St.3d 339, 343.

{¶13} We will address Dr. Mahajan's assignments of error out of order. We begin with the assignments that concern evidentiary and procedural issues.

A. Assignment of Error No. 3

{¶14} In this assignment, Dr. Mahajan contends that the trial court erred by affirming evidentiary rulings made by the hearing examiner. We disagree.

1. Disclosure of the Investigative Report

{¶15} First, Dr. Mahajan contends that the hearing examiner erred by not requiring the board's expert witness, Dr. Karp, to disclose all of his related files. The board's counsel agreed to the disclosure of two of the files Dr. Karp brought with him, but objected to the disclosure of "a handful of documents" in a third file because they included confidential investigation materials under R.C. 4731.22(F)(5). (Tr. 150.) R.C. 4731.22(F)(5) provides that:

> Information received by the board pursuant to an investigation is confidential and not subject to discovery in any civil action.
>
> The board shall conduct all investigations and proceedings in a manner that protects the confidentiality of patients and persons who file complaints with the board. * * *

{¶16} The Supreme Court of Ohio has recognized that several groups and individuals have a privilege of confidentiality in the board's investigative files, including patients, the physician under investigation, and witnesses. *State ex rel. Wallace v. State Med. Bd. of Ohio*, 89 Ohio St.3d 431, 435, 2000-Ohio-213. The court also has recognized that the board itself holds "its own confidentiality privilege." Id. at 436. However, the board may not "unilaterally waive others' privileges to confidentiality, because the [board] is not the holder of those privileges." Id. Thus, even if Dr. Mahajan were to waive his privilege of confidentiality regarding the investigative files, the board would not be permitted to disclose the files unless other protected persons, including

patients, witnesses, and the board itself, waived the privilege. Dr. Mahajan points to no such evidence of waiver in this record. Therefore, the hearing examiner did not err by precluding the disclosure of materials within Dr. Karp's file that included confidential investigative materials, and the trial court did not err by affirming the hearing examiner's action.

{¶17} The Supreme Court's decision in *State ex rel. Mahajan v. State Med. Bd. of Ohio*, 127 Ohio St.3d 497, 2010-Ohio-5995, does not compel a different result. That decision stems from Dr. Mahajan's request for public records held by the board, including communications relating to the board's investigation of him. On mandamus, the Supreme Court held that the board incorrectly redacted from certain documents (1) Dr. Mahajan's name and (2) quotations from a deposition, because he, alone, held and waived the privilege of confidentiality regarding that information. The court did not, however, change its prior recognition that multiple entities hold privileges of confidentiality relating to the board investigation, including witnesses like Dr. Karp and the board itself, and no one entity may waive the privilege for all.

2. Cross-Examination of Dr. Karp

{¶18} Dr. Mahajan also contends that the hearing examiner precluded his counsel from cross-examining Dr. Karp about his communications with board staff, including Mr. David Katko, the investigator, and about any potential influence by board staff. Our review of the hearing transcript, however, indicates that Dr. Mahajan's counsel cross-examined Dr. Karp extensively. While the hearing examiner precluded Dr. Mahajan's counsel from asking for privileged information, the hearing examiner asked Dr. Karp whether he based his "report on anything anyone told you to decide?

Did anyone tell you what your determination should be in your report?" (Tr. 192.) Dr. Karp responded in the negative and said that he is "hired solely for my time and not my opinion." (Tr. 192.) Speaking broadly, he said that on no case had Mr. Katko or anyone else "shaped the substantive conclusions of the report. They are my own." (Tr. 193.)

{¶19} For the reasons we explained above, we agree with the trial court that the hearing examiner properly excluded testimony concerning the contents of the investigation itself, including Dr. Karp's communications as part of that investigation with board staff and counsel. The decisions cited by Dr. Mahajan do not require a different result. See *In re Kralik* (1995), 101 Ohio App.3d 232 (holding that the hearing examiner improperly precluded cross-examination where expert witness had received confidential material improperly from the board and then relied on that material to form opinion); *Dahlquist v. Ohio State Med. Bd.*, 10th Dist. No. 04AP-811, 2005-Ohio-2298 (concluding that appellant had not demonstrated prejudice from hearing examiner's rulings on cross-examination of expert and expressly declining to decide whether rulings were proper).

3. Other Evidentiary Rulings

{¶20} Dr. Mahajan contends that the hearing examiner made several other erroneous evidentiary rulings. First, Dr. Mahajan argues that the hearing examiner improperly precluded Dr. Karp from expressing his opinion about whether Dr. Mahajan had departed from the standard of care and whether Dr. Mahajan's certificate to practice medicine should be suspended or revoked. Even if the hearing examiner erred by doing so, given the board's expertise on these very issues, and Dr. Mahajan's

contention that Dr. Karp's testimony lacked credibility, it is difficult to discern how the lack of testimony by Dr. Karp in this regard caused him prejudice.

{¶21} Dr. Mahajan argues that the hearing examiner erred by not allowing the admission of Exhibit PP, which related to Dr. Mahajan's prior disciplinary action before the board. Dr. Mahajan does not explain why this document could not have been produced at the hearing, how it was relevant to this action or how exclusion of this exhibit caused him prejudice. See also Ohio Adm.Code 4731-13-15(F) (regarding motions to reopen the hearing record).

{¶22} Dr. Mahajan argues that the hearing examiner erred by striking attachments to his brief and motions, including the affidavit of a statistics professor. He attempted to add this new information to the record, however, after the deadlines for exchanging information had long passed, after the hearing was concluded, and after the record had closed. The hearing examiner did not err by excluding it. See Ohio Adm.Code 4731-13-15(F) and 4731-13-18(D)(1) (regarding deadlines for exchange of exhibits and witness lists).

{¶23} Finally, Dr. Mahajan argues that the hearing examiner erred by striking documents relating to alleged misconduct by Mr. Katko. Again, Dr. Mahajan attempted to introduce these documents after the hearing had ended and the record was closed. While Dr. Mahajan argues that the documents were necessary to remedy the hearing examiner's mistaken rulings concerning investigative materials, we have already determined that the hearing examiner did not err by precluding the disclosure of confidential information.

{¶24} For all these reasons, we overrule Dr. Mahajan's third assignment of error.

B. Assignment of Error Nos. 4 and 5

{¶25} In his fourth assignment of error, Dr. Mahajan contends that the trial court erred by not granting his motion to dismiss on the grounds that the board deprived him a full and fair record of the hearing. In his fifth assignment of error, Dr. Mahajan contends that the trial court erred by not invalidating the board's order because the board failed to comply with Ohio's open meetings law, R.C. 121.22. We will address these assignments together.

{¶26} R.C. 121.22(A) requires "public officials to take official action and to conduct all deliberations upon official business only in open meetings." Important for our purposes here, R.C. 121.22(C) provides that the "minutes" of a meeting of a public body, like the board, "shall be promptly prepared, filed, and maintained and shall be open to public inspection." In construing these provisions, the Supreme Court of Ohio defined the word " 'minutes' " in this context to mean " 'a series of brief notes taken to provide a record of proceedings * * *: an official record composed of such notes.' " *White v. Clinton Cty. Bd. of Commrs.*, 76 Ohio St.3d 416, 1996-Ohio-380, fn. 3, quoting Webster's Third New International Dictionary (1986) 1440. In *White*, the court was construing R.C. 121.22(C) and R.C. 305.10, which requires the clerk of the board of county commissioners to keep a record of that board's proceedings. The court "refrain[ed] from laying down specific guidelines, other than the dictate that for public records maintained under R.C. 121.22 and 305.10, full and accurate minutes must contain sufficient facts and information to permit the public to understand and appreciate the rationale behind the relevant public body's decision." *White* at 424.

{¶27} Applying these principles here, we conclude that the board's minutes contain sufficient facts and information to permit the public to understand and appreciate the rationale behind its decision to impose probation upon Dr. Mahajan's certificate to practice medicine and surgery in Ohio. The minutes are seven, single-spaced pages in length. They include detailed notes of each speaker's statements, identification of each motion, and the official votes of the board members on each motion. While Dr. Mahajan contends that the minutes do not contain every statement made by board members, having reviewed the minutes and the transcript, we conclude that the minutes are full and accurate. They reflect substantial reasoning and explanation by the board members and certainly reflect enough for us to understand and appreciate their rationale. In particular, given the lengthy summary of statements by board members Dr. Darshan Mahajan and Dr. Steinbergh, we are able to understand fully why the board decided to modify the recommendation of the hearing examiner and impose probation, rather than suspension. See R.C. 119.09 (requiring that, when an administrative agency modifies or disapproves the recommendations of the hearing examiner, it must include in the record the reasons for that modification or disapproval).

{¶28} Although R.C. 121.22(C) only requires the board to prepare and publish minutes of its meetings, Ohio Adm.Code 4731-9-01 allows a party to record, film or photograph a board meeting. That rule provides that the presiding officer of the board, or a designee, shall designate a reasonable location within the meeting room from which the recording may occur. Ohio Adm.Code 4731-9-01(C)(1). The recording equipment may not interfere with any individual's ability to hear, see, and participate in

the meeting or with the board's orderly transaction of business. Ohio Adm.Code 4731-9-01(C)(2).

{¶29} Here, Dr. Mahajan's counsel hired a court reporter to transcribe the board's proceedings, as permitted by Ohio Adm.Code 4731-9-01. Dr. Mahajan contends, however, that the board's general counsel required the court reporter to move from the front of the meeting room to a location in the back of the room where she was unable to hear the entire proceedings. Ohio Adm.Code 4731-9-01 grants to the presiding officer of the board, or a designee, the ability to designate a reasonable location for recording the meeting. The trial court did not abuse its discretion in determining that the board's request to the court reporter was reasonable, given the need to transact board business.

{¶30} Finally, in reaching our conclusion, we take particular issue with Dr. Mahajan's statement that the general counsel's "conduct also violates Dr. Mahajan's due-process rights by destroying, in bad faith, portions of the record essential to appellate review and has impaired his fundamental right of access to the courts." (Appellant's brief, 47.) Dr. Mahajan follows this statement with nothing more than boilerplate law and citations concerning an individual's right of access to the courts. The allegation that any individual, let alone an officer of the court, destroyed public records in bad faith is a serious charge, and one that should not be made off-handedly and without support. There is nothing in the record to indicate that the general counsel destroyed public records. Rather, Dr. Mahajan has merely overstated his argument that the record is incomplete, an argument we have rejected.

{¶31} In summary, the trial court did not abuse its discretion by determining that the board's meeting and minutes complied with R.C. 121.22 and by denying Dr. Mahajan's motion to dismiss. Accordingly, we overrule the fourth and fifth assignments of error.

C. Assignment of Error No. 1

{¶32} In his first assignment of error, Dr. Mahajan contends that charting deficiencies cannot serve as a basis for violations of the standard of care for purposes of R.C. 4731.22(B)(6), and he cites a number of cases he says support that proposition. In doing so, Dr. Mahajan repeatedly characterizes these deficiencies as the sole basis for the board's action, a characterization that is simply untrue. As we discuss below, the board also found, in several instances, that Dr. Mahajan's *treatment* of patients fell below the standard of care.

{¶33} Dr. Mahajan also contends that the hearing examiner assumed that, if Dr. Mahajan did not document an action, then it was not done. Again, Dr. Mahajan's characterization is inaccurate and blurs the distinction between allegations concerning Dr. Mahajan's treatment of his patients and allegations concerning his documentation of that treatment and the reasons for it.

{¶34} Dr. Karp testified at length about what he expects to see in a psychiatric patient medical record, as detailed in the hearing examiner's report and recommendation at pages 8-9. Dr. Karp said: "From a legal, from an ethical, and from a medical view, all we have to base our assessment on a doctor's practice is what is contained in the record." (Tr. 64.) The record, Dr. Karp said, "is for everybody, including the patient. This is so because if a patient has complex medical issues or

psychiatric issues and an emergency arises or they change clinicians, it is critical for their well-being and their care that the interventions that were made are understood in a rational and clear way so that they could either be continued or changed." (Tr. 64-65.)

{¶35} At the hearing, board member Dr. Steinbergh explained that "[t]he medical record is one of the most important things that a physician does beyond the assessment of the patient." (Board Hearing Tr. 13.) Because the record demonstrates "how the physician is thinking" and "what the physician is doing," it is "recognized as a really critical piece of medical care. So you cannot just be providing medical care without an appropriate record." (Board Hearing Tr. 13.) He noted the importance of a good medical record where, for example, a primary care physician and a psychiatrist coordinate care or where one physician takes over for another. "It's acceptable and absolutely demands of a physician to provide and produce an appropriate medical record. And if there isn't one, we don't know what happened." (Board Hearing Tr. 14.)

{¶36} Far from simply assuming that Dr. Mahajan did not perform anything that was undocumented, the board considered the entirety of the medical records, testimony from Dr. Mahajan, and testimony from three experts to determine whether Dr. Mahajan was documenting the treatment of his patients appropriately. Upon determining that, in some respects, there were charting deficiencies, the board conformed its discipline to those deficiencies. Rather than suspend Dr. Mahajan from practice, Dr. Steinbergh proposed, and the board agreed, to impose probation with specific conditions designed to improve Dr. Mahajan's record-keeping. As Dr. Steinbergh explained, Dr. Mahajan "needs to undergo a good medical record course or courses to improve his ability to

produce the record that is recognizable by the medical community." (Board Hearing Tr. 16.)

{¶37} The Supreme Court of Ohio has stated that, "when reviewing a medical board's order, courts must accord due deference to the board's interpretation of the technical and ethical requirements of its profession." *Pons v. Ohio State Med. Bd.*, 66 Ohio St.3d 619, 621, 1993-Ohio-122. The reason the General Assembly provided " 'for administrative hearings in particular fields was to facilitate such matters by placing the decision on facts with boards or commissions composed of [individuals] equipped with the necessary knowledge and experience pertaining to a particular field.' " *Arlen v. State* (1980), 61 Ohio St.2d 168, 173, quoting *Farrand v. State Med. Bd.* (1949), 151 Ohio St. 222, 224.

{¶38} The board has authority to adopt rules to carry out the purposes of R.C. Chapter 4731. See R.C. 4731.05(A). The board need not, however, adopt rules concerning "every conceivable act of practice that falls below minimal standards." *Johnson v. State Med. Bd. of Ohio* (Sept. 28, 1999), 10th Dist. No. 98AP-1324. The absence of a specific rule does not, as Dr. Mahajan contends, render board interpretation of the standard of care ad hoc or otherwise invalid.

{¶39} Here, Dr. Karp testified, and the hearing examiner found, that the standard of care applicable to a physician providing psychiatric care to juveniles includes documentation of certain discussions, treatments, and medication regimens, including the following: psychiatric evaluations, therapeutic levels of mood-stabilizing drugs, diagnostic criteria in support of diagnostic-manual diagnoses, informed consent, and for juvenile patients prescribed antipsychotic medication, certain testing and discussions

about tardive dyskinesia. The board agreed and conformed its discipline to its findings. According deference to the board's interpretation of the technical requirements of the practice of medicine, we conclude that the board did not err by doing so.

{¶40} In arguing otherwise, Dr. Mahajan relies on our decision in *Mathew v. State Med. Bd. of Ohio* (Nov. 5, 1992), 10th Dist. No. 92AP-199. In *Mathew*, we reversed a trial court's modification of the penalty imposed by the board against Varughese Mathew, D.O., but affirmed the trial court's conclusion that the board's order was supported by reliable, probative, and substantial evidence. In doing so, we examined two findings of fact by the hearing examiner—one that found Dr. Mathew violated the standard of care by failing to document his reasons for not providing standard post-operative treatment for breast cancer, and another that found he violated the standard of care by failing to discuss treatment options with the patient (identified as patient 4). The hearing examiner based his findings on the opinion of an expert who testified that his opinion might be different if Dr. Mathew had discussed the options with patient 4 and had consulted with other physicians before concluding that she had no treatment options. Because the hearing examiner also found that Dr. Mathew, in fact, had these other conversations, we limited the finding that Dr. Mathew violated the standard of care by failing to involve patient 4 in discussions about treatment options and noted the inconsistency in the findings for the board's evaluation on remand. Nevertheless, we concluded that "the overall board's decision with respect to Dr. Mathew's treatment falling below the minimum standard of care with patients 1, 2 and 4 is supported by reliable, probative and substantial evidence, and is in accordance with law."

{¶41} Although the *Mathew* opinion provides little guidance applicable to this case, it appears generally to support the principle that a physician may violate the standard of care by failing to document certain discussions and evaluations, where the evidence supports that failure. As we discuss below, the board found that Dr. Mahajan failed to have and/or document certain necessary discussions with patients and their families, including discussions about medication regimens and possible side effects.

{¶42} In short, we defer to the board's interpretation of the technical requirements for the practice of medicine and conclude that the board did not err by determining that the standard of care applicable to Dr. Mahajan includes documentation of certain discussions, treatments, and medication regimens. Therefore, we overrule his first assignment of error.

D. Assignment of Error No. 2

{¶43} In his second assignment, Dr. Mahajan contends that, even if charting deficiencies can serve as proof that a physician violated the standard of care, the conclusion that he violated the standard of care is not supported by reliable, probative, and substantial evidence. Within this assignment, Dr. Mahajan raises a number of issues, which we address before turning to the merits.

1. Consideration of Dr. Mahajan's Testimony

{¶44} Dr. Mahajan contends that the hearing examiner erred by disregarding his testimony about his care of patients. Dr. Mahajan cites, in particular, the hearing examiner's conclusion that Dr. Mahajan, who had a busy practice, could not "accurately recall details of visits from years before." (RR 97.) While the hearing examiner did not

disregard Dr. Mahajan's recollections of undocumented events entirely, he afforded them "little weight." (RR 97.)

{¶45} As the trial court stated, a fact-finder is free to believe all, some or none of a witness's testimony. *D'Souza v. State Med. Bd. of Ohio*, 10th Dist. No. 09AP-97, 2009-Ohio-6901, ¶17. Given the number of patients Dr. Mahajan saw in a six-year span and the passage of time, the hearing examiner questioned the accuracy of Dr. Mahajan's recollection about actions taken with respect to specific patients. The board accepted the hearing examiner's findings of fact in this respect, and, as the fact-finder, the board was free to do so.

2. Reliability of Dr. Karp's Testimony

{¶46} Dr. Mahajan also questions the hearing examiner's reliance on Dr. Karp's testimony. In his brief, Dr. Mahajan contends that Dr. Karp's expert testimony was unreliable, in part because he lacked the experience to understand Dr. Mahajan's busy, urban practice. He also contends that Dr. Karp made a number of errors in his opinion, and, therefore, his opinions and testimony are not reliable, probative, and substantial evidence on which the board could rely.

{¶47} Just as with the testimony of Dr. Mahajan and the other witnesses, however, the board was free to judge the credibility of Dr. Karp's testimony and afford it weight accordingly. See *Mathew* ("The medical opinions come from the medical experts, and the trier of fact (the board) was entitled to determine the credibility of the witnesses and the weight to be given to their testimony."). The hearing examiner recognized that Dr. Karp's testimony contained mistakes, and the report and recommendation identifies several examples. Taking these mistakes into account, the

hearing examiner found that, "because of inaccuracies in Dr. Karp's reading of some of Dr. Mahajan's medical records, his opinions must be closely examined in conjunction with the medical records." (RR 96.) Overall, however, the hearing examiner found Dr. Karp to be a reliable and objective expert who not only had experience in psychiatry, but also had experience treating both adults and children. Given the hearing examiner's careful consideration of Dr. Karp's credentials, experience, and testimony, as well as the hearing examiner's comparison of Dr. Karp's testimony against the medical records, the trial court did not err in concluding that Dr. Karp's opinions and testimony were reliable, probative, and substantial evidence on which the board could rely.

{¶48} We turn, then, to the specific findings and conclusions at issue.

3. Failure to Complete and/or Document Psychiatric Evaluations

{¶49} The board adopted the hearing examiner's finding that Dr. Mahajan failed to complete and/or document psychiatric evaluations for Patients 1, 3, 4, 5, 6, 7, 9, and 10. In his report and recommendation, the hearing examiner based this finding on Dr. Karp's report and testimony, as well as the medical records, which confirmed the absence of adequate documentation.

{¶50} Dr. Mahajan contends that, while Dr. Karp testified as to the necessary elements of a psychiatric evaluation, he did not testify that each element is always required. We agree. Dr. Karp stated: "I certainly do not expect to see an initial evaluation including all elements as recommended in the practice parameters or guidelines. But I do expect to see some semblance of understanding of the patient's presenting problem, its development over time, sufficient to formulate a reasonable psychiatric diagnosis which then should be associated with an initial and reasonable

treatment plan." (Tr. 42.) Using these parameters, Dr. Karp analyzed the record for each of the ten patients and concluded that, for eight of them, Dr. Mahajan's documentation of a psychiatric evaluation was either absent or deficient. In combination, Dr. Karp's report, his testimony, and the medical records, are reliable, probative, and substantial evidence on which the board could rely to make its findings.

4. Failure to Order and/or Document Therapeutic Levels of Depakote and Tegretol

{¶51} As to Patients 2 and 8, the board adopted the hearing examiner's finding that Dr. Mahajan failed to do the following: (1) order and/or document therapeutic levels of Depakote for Patient 2; (2) order and/or document follow-up therapeutic levels of Depakote for Patient 8; and (3) order and/or document therapeutic levels of Tegretol for Patient 8. Dr. Mahajan disagrees with these findings.

{¶52} As a general matter, Dr. Karp explained that lab work establishing the blood concentration of medication in a patient prescribed mood-stabilizing drugs, like lithium, Depakote, and Tegretol, is important for the following reasons: (1) to establish that effective levels are present; (2) to ensure that harmful levels are not present; and (3) to ensure the patient is taking the medication. (Tr. 103-04.) He said that initial testing would be done to establish blood levels once a patient is stabilized on the medication, typically within a week, and then again, "in the initial year, outpatient, somewhere between once every month to once every three, possibly even four months." (Tr. 106.)

{¶53} Dr. Polster similarly testified that the purpose of testing to establish blood levels for Depakote includes the following: (1) to document the presence of a

therapeutic range of the medication; (2) to ensure the patient is complying with the dosage instructions; and (3) to see if the medication is "affecting the body in any way." (Tr. 896.) When asked how frequently he would send a patient on Depakote for lab tests, he responded: "Once I have a patient on Depakote, on a dosage that I consider stable, I'll send them about every six months to get those things checked." (Tr. 897.)

{¶54} Dr. Mahajan prescribed Depakote to Patient 2 from December 2003 to March 2004. There is no dispute that he did not order lab work to establish blood levels of Depakote for this patient.

{¶55} As noted, Dr. Karp testified generally that testing would normally be done for a patient prescribed Depakote. As for Dr. Mahajan's treatment, Dr. Karp said that "bloodwork" relating to mood stabilizers, including Depakote, was "absent basically" for the patients prescribed these drugs, including Patient 2. (Tr. 104.)

{¶56} Dr. Mahajan testified that lab work was unnecessary for Patient 2. ("Absolutely not, sir. It was not essential." Tr. 431.) He also said that the decision whether or when to do bloodwork is subject to a physician's clinical judgment, and it becomes more important with lithium, Tegretol, and Digoxin hard medicines. (Tr. 432.) Dr. Gutheil testified that Patient 2 stopped taking Depakote before or about the time blood levels would be needed. (Tr. 717-18.)

{¶57} Based on the testimony of Drs. Mahajan, Gutheil, and Polster, the hearing examiner could have concluded that Dr. Mahajan did not violate the standard of care by failing to order lab work for Patient 2, who was on Depakote for about four months. However, Dr. Karp's testimony, as supported by the medical records, was reliable,

probative, and substantial evidence on which the hearing examiner could rely to conclude that Dr. Mahajan's treatment of Patient 2 did violate the standard of care.

{¶58} Dr. Mahajan first prescribed Depakote to Patient 8 during a hospital stay in March 2002, when lab work established blood levels for the drug. He discontinued Depakote during a hospital stay in June 2003, when he prescribed Tegretol. He discontinued Tegretol at an office visit on July 28, 2003. Other than the lab work performed during the hospital stay in March 2002, there was no record of testing to establish or monitor blood levels for Depakote or Tegretol for this patient.

{¶59} As we discussed above, Dr. Karp testified generally about the testing that would normally be done on patients taking Depakote and Tegretol. Again, as to Dr. Mahajan's treatment, he said that "bloodwork" relating to mood stabilizers, including Depakote and Tegretol, was "absent basically" for the patients prescribed these drugs, including Patient 8. (Tr. 104.)

{¶60} Also, as noted, Dr. Polster testified generally about testing relating to Depakote. When asked about Patient 8, for whom Depakote had been prescribed for more than a year, Dr. Polster stated: "I would say that I would at least like to monitor those parameters once a year, and I know practitioners that will monitor them once a year. So I would want those things checked at least yearly." (Tr. 898.)

{¶61} Dr. Gutheil testified that he "had some mild reservations about" Dr. Mahajan's treatment of Patient 8. (Tr. 721.) He noted that Patient 8 was on Depakote "for a significantly long period of time" and on Tegretol "for a moderately short" period of time. (Tr. 721.) "And in both those cases, lab testing would be indicated. Tegretol has a blood risk factor and Depakote has a liver risk factor." (Tr. 721.) He also said that

"the standard of care would require those to be done." (Tr. 721.) He acknowledged some difficulty with Patient 8's compliance with requests for testing, but stated that "[t]he appropriate response would have been to further emphasize the importance and/or discontinue the medication, which of course is risky because then the patient has the untreated symptoms." (Tr. 721.)

{¶62} In his brief, Dr. Mahajan contends that Dr. Gutheil did not testify that Dr. Mahajan's treatment of Patient 8 fell below the standard of care. We agree that Dr. Gutheil was somewhat equivocal on that point. He stated that Dr. Mahajan's failure to order testing fell below the standard of care, then stated that it might not have fallen below the minimum standard, and then concluded by stating that Dr. Mahajan's treatment of Patient 8 deviated from the standard of care. (Tr. 721-23.)

{¶63} The testimony of Dr. Karp was not equivocal, however. He testified generally that testing should be ordered once a patient prescribed Depakote or Tegretol is stabilized and then monitored periodically thereafter, every one to four months. Even Dr. Mahajan, when discussing Patient 2, said that testing becomes more important when Tegretol is prescribed. (See Tr. 432.) Dr. Polster testified that, as to Depakote, he would send a patient for testing every six months. Patient 8 was on Depakote for well over a year.

{¶64} Even if we were to disregard Dr. Gutheil's testimony as to Patient 8 entirely, Dr. Karp's testimony would support the hearing examiner's conclusion that Dr. Mahajan violated the standard of care with respect to his treatment of Patient 8 by failing to order follow-up testing for Depakote and by failing to order testing for Tegretol. Although Dr. Polster does not appear to have reached a conclusion regarding the use of

Tegretol for Patient 8, Dr. Polster's testimony supports the conclusion regarding the use of Depakote for this patient. Accordingly, we conclude that reliable, probative, and substantial evidence supports the hearing examiner's conclusions regarding Patient 8.

5. Failure to Document Diagnostic Criteria

{¶65} The Diagnostic and Statistical Manual ("DSM") was introduced in the 1950's as a way to standardize psychiatric diagnoses. The current version is the Diagnostic and Statistical Manual IV, Text Revised. In general terms, the manual identifies mental disorders, provides corresponding codes for purposes of diagnosis and shorthand communication, and identifies relevant criteria that may support a diagnosis.

{¶66} Dr. Karp testified that, although professional associations recommend that psychiatrists conform to DSM standards in making a diagnosis and identifying the criteria necessary for reaching that diagnosis, "[f]ew psychiatrists outside of academia conform to that recommendation." (Tr. 79.) "But what is commonly done is that we document sufficient criteria, usually not just one, but multiple criteria that the average practitioner would think * * * reasonably reflects the diagnosis that the doctor made." (Tr. 79.)

{¶67} As for diagnoses contained within Dr. Mahajan's records, Dr. Karp's report stated: "The majority of diagnoses are specified as numbers, presumably from the [DSM]. In no case are criteria described matching the designated code and fulfilling [the] criteria for the disorder." (State's Exhibit 12 at 2.)

{¶68} Dr. Mahajan testified that the manual is flexible, its use is controversial, and it does not have the force of law. Dr. Gutheil testified that there was a consistency

between Dr. Mahajan's diagnoses and the other information contained within his treatment records for Patients 1 through 10.

{¶69} The hearing examiner concluded that, while a practitioner is not required to use the DSM as a diagnostic tool, Dr. Mahajan chose to use DSM diagnosis codes. Dr. Mahajan did not, however, consistently identify the relevant criteria necessary for reaching a diagnosis. Dr. Karp's testimony and report, as supported by the medical records, constitute reliable, probative, and substantial evidence and support the board's adoption of the hearing examiner's findings.

6. Failure to Document Informed-Consent Discussions

{¶70} Dr. Karp testified about the importance of having an informed-consent discussion with a patient to make that patient "aware of the treatment that is recommended, the benefits, common, serious, expected side effects of the treatment that is recommended, the alternatives, including no treatment, and the rationale for the specific treatment that is identified." (Tr. 98.) In his report, Dr. Karp stated that there are no indications that "Dr. Mahajan documented an initial, or ongoing, informed consent discussion" concerning his diagnoses or recommended medications for Patients 1 through 10. (State's Exhibit 12 at 3.) Dr. Mahajan testified, however, that he always discusses with each patient or guardian his diagnoses and the medication he prescribes.

{¶71} The hearing examiner found that Dr. Mahajan did not adequately document initial or ongoing informed-consent discussions, and the board adopted this finding. Dr. Karp's report is reliable, probative, and substantial evidence, and it supports this finding.

{¶72} In arguing to the contrary, Dr. Mahajan relies on *Bedel v. Univ. OB/GYN Assoc., Inc.* (1991), 76 Ohio App.3d 742. In *Bedel*, the spouse of a deceased patient brought a medical malpractice suit that alleged the patient had not been adequately informed about the dangers associated with an amniocentesis. The trial court granted summary judgment in favor of the defendants. On appeal, the plaintiff argued that the consent forms did not identify the doctor who performed the procedure and, therefore, failed as informed consents under R.C. 2317.54. The First District Court of Appeals rejected that argument. The court went on to say that, even if the absence of a doctor's identity on the form were relevant to determining liability for the tort of lack of informed consent, the affidavit of one of the defendant doctors said that he informed the patient that a certain doctor would be performing the amniocentesis. The court then said that, because the plaintiff had not offered contrary evidence to dispute the doctor's affidavit and because informed consent can be given orally, "we conclude that the decedent, as a matter of law, was informed of and consented to" the specified doctor's performance of the procedure. Id. at 745. Nevertheless, the court went on to reverse the grant of summary judgment because issues of fact remained as to whether the informing doctor informed the patient of a material risk.

{¶73} *Bedel* has nothing to do with the issues before us in this case, which considers whether Dr. Mahajan should have and did document informed-consent discussions for purposes of determining whether he violated the standard of care under R.C. 4731.22(B)(6). Dr. Mahajan's reliance on *Bedel* in this context is misplaced and does not refute the evidence supporting the finding that he did not adequately document informed-consent discussions.

7. Failure to Document Adverse Effects of Medication

{¶74} The board originally alleged that Dr. Mahajan failed to adequately document the presence or absence of adverse effects for medications prescribed to Patients 1 through 9. Upon review of the medical records, however, the hearing examiner found, and the board adopted the finding, that Dr. Mahajan had failed to adequately document the adverse effects of medication only with respect to Patients 6 and 9. The medical records serve as reliable, probative, and substantial evidence to support the hearing examiner's finding.

8. Failure to Discuss and/or Document a Discussion About Tardive Dyskinesia

{¶75} Dr. Mahajan prescribed antipsychotic medication to Patients 2, 5, 7, 8, 9, and 10. Dr. Karp testified that these medications can cause tardive dyskinesia, or involuntary twitches or jerks, as a side effect. He said that, for patients prescribed these medications, particularly children who take them for a long period of time, it is important to discuss this side effect with the patient or parents "so that they know what to look for, they know what to report and when to report it." (Tr. 113.) Upon reviewing Dr. Mahajan's records, Dr. Karp concluded that Dr. Mahajan did not document an initial or follow-up discussion about tardive dyskinesia for Patients 2, 5, 7, 8, 9, and 10, all of whom were prescribed antipsychotic medications, beyond a generic consent form.

{¶76} Dr. Karp also testified that, for patients prescribed antipsychotic medications, it is important to perform and document, at least annually, an examination known as the abnormal involuntary movement scale, or AIMS, test. Upon reviewing Dr. Mahajan's records, Dr. Karp found no documentation of a base exam for Patients 2, 5,

7, 8, 9, and 10, all of whom were prescribed antipsychotic medications. He found no documentation of an annual exam for Patients 2, 5, 7, 8, and 10.

{¶77} Dr. Gutheil testified that tardive dyskinesia was a significant problem with patients prescribed antipsychotic medications in the 1950's and 60's, but that it was very rarely associated with newer medications. He said that AIMS testing would only be required if a patient developed certain symptoms.

{¶78} With respect to Patient 2, Dr. Polster stated that, in his view, it is important for any patient prescribed an antipsychotic drug to "be monitored for the presence of any abnormal movements that might be consistent with what's called tardive dyskinesia." (Tr. 885.) When asked whether Dr. Mahajan should have conducted a formal AIMS test, Dr. Polster stated: "I think either a formal AIMS test or documentation of a visual monitoring of abnormal movements." (Tr. 886.)

{¶79} The hearing examiner found that "the evidence overwhelmingly supports a finding that Dr. Mahajan failed to discuss and/or document the discussion, either initially or in follow-up, of tardive dyskinesia for Patients 2, 5, and 7 through 10. Further, Dr. Mahajan failed to perform and/or document [AIMS] examinations at baseline or during treatment for Patients 2, 5, and 7 through 10." (RR 103.) Dr. Karp's testimony and report, Dr. Polster's testimony as to Patient 2, and the medical records, together constitute reliable, probative, and substantial evidence to support the hearing examiner's findings, which the board adopted.

9. Conclusion

{¶80} Having concluded that reliable, probative, and substantial evidence supports the hearing examiner's findings and conclusions, and the board's adoption of

those findings and conclusions, we further conclude that the trial court did not abuse its discretion by affirming the board's conclusion that Dr. Mahajan violated the standard of care. Accordingly, we overrule Dr. Mahajan's second assignment of error.

E. Assignment of Error No. 6

{¶81} Dr. Mahajan contends that the hearing examiner was biased, partial, and prejudiced against him. In support, Dr. Mahajan relies on his prior arguments. Having rejected those arguments, we reject his contention that the hearing examiner was biased, partial or prejudiced against him. Therefore, we overrule his sixth assignment of error.

F. Assignment of Error No. 7

{¶82} In his seventh assignment of error, Dr. Mahajan contends that the trial court erred by not striking the travel restriction contained in the board's order after it found that the restriction was not in accordance with law. At oral argument, the parties agreed that this issue is now moot.

G. Assignment of Error No. 8

{¶83} In his eighth assignment of error, Dr. Mahajan contends that the board was not substantially justified in bringing the action against him, and he should be awarded his attorney fees and costs pursuant to R.C. 2335.59. Having overruled Dr. Mahajan's assignments of error, we conclude that the board was substantially justified in bringing the action, and Dr. Mahajan has no grounds to support an award of fees and costs under R.C. 2335.59. Therefore, we overrule this assignment.

IV. CONCLUSION

{¶84} In summary, we conclude that the trial court did not abuse its discretion in concluding that the board's order was supported by reliable, probative, and substantial evidence and was in accordance with law. Accordingly, we overrule Dr. Mahajan's first, second, third, fourth, fifth, sixth, and eighth assignments of error and conclude that his seventh assignment of error is moot. We affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

BRYANT, P.J., and CONNOR, J., concur.

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IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

MAHENDRA KUMAR MAHAJAN, M.D.	:	
	:	**CASE NO. 10-CVF-06-9077**
Appellant,	:	**(consolidated with Case No.**
	:	**10-CVF-07-9949)**
v.	:	
	:	**JUDGE JULIE LYNCH**
STATE MEDICAL BOARD OF OHIO	:	
	:	
Appellee.	:	

NOTICE OF APPEAL OF APPELLANT MAHENDRA KUMAR MAHAJAN, M.D.

Appellant Mahendra Kumar Mahajan, M.D., by and through the undersigned counsel, hereby gives this Notice of Appeal of this matter to the Court of Appeals of Franklin County, Ohio, Tenth Appellate District from the final judgment of the Court of Common Pleas, Franklin County, Ohio, filed in this action on April 12, 2011, which affirmed in part the Ohio State Medical Board's Order. The judgment entry was issued as final and appealable on April 12, 2011, and a copy of said order is attached hereto as Exhibit A. Appellant also appeals from the Decisions on Pending Motions of the Franklin County Court of Common Pleas, attached hereto as Exhibit B, also entered on April 12, 2011, which also became final and appealable on that date. This appeal involves questions of law and fact.

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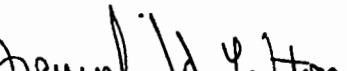
S&W
Subashi
& Wildermuth

The Greene Town Center
50 Chestnut Street
Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
fax: 937-427-8816

Respectfully submitted,

SUBASHI & WILDERMUTH



nsubashi@swohiolaw.com
Halli Brownfield Watson (0082466)
hwatson@swohiolaw.com
The Greene Town Center
50 Chestnut Street, Suite 230
Dayton, OH 45440
(937) 427-8800
(937) 427-8816 (fax)
Attorneys for Appellant
Mahendra Kumar Mahajan, M.D.

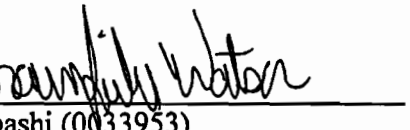
CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing was served via regular U.S. mail upon the following on this 9th day of May, 2011:

Karen A. Unver, Esq. (0055623)
KUnver@ag.state.oh.us
Assistant Attorney General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, OH 43215-3400

Katherine J. Bockbrader, Esq. (0066472)
Katherine.bockrader@ohioattorneygeneral.gov
Assistant Attorney General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, OH 43215-3400

Attorneys for Appellee State Medical Board of Ohio



Nicholas E. Subashi (0033953)
Halli Brownfield Watson (0082466)

S&W

Subashi
& Wildermuth

The Greene Town Center
50 Chestnut Street
Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
fax: 937-427-8816

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TERMINATION NO. 10
BY: 4/12/11

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

FINAL APPEALABLE ORDER

MAHENDRA K. MAHAJAN, M.D.,	][	CASE NUMBERS 10CVF-9077
	[]	10CVF-9949
	][	
APPELLANT,	[]	JUDGE LYNCH
	][	
vs.	[]	MAGISTRATE MCCARTHY
	][	
STATE MEDICAL BOARD OF OHIO	[]	
	][	
	[]	
	][	
APPELLEE	[]	

FILED
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CLERK OF COURTS

DECISION AND JUDGMENT TO AFFIRM IN PART
AND
ORDER OF REMAND

LYNCH, J.

This matter is now before the court on the merits of this administrative appeal. By way of factual background, appellant, Mahendra Kumar Mahajan, M.D., is a physician licensed by the State Medical Board of Ohio to practice medicine in Ohio. Dr. Mahajan is a psychiatrist who has practiced in Dayton since 1982. In connection with his practice, he was suspected of violating certain minimal standards concerning administration of patient care and medical records creation. He was given an opportunity to respond to the concerns of appellee and in January 2009 a three day hearing was held before the board. Following the hearing, the hearing examiner found that appellant did violate certain identified standards. The hearing examiner recommended to appellee that, inter alia, appellant's license to practice medicine be suspended until certain conditions were met. Appellee rejected the hearing examiner's suspension and sanction

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recommendations and in their stead, the board issued a sanction of probation with the condition that appellant improve his skills at medical chart creation.

This appeal is governed by R.C. 119.12 which in pertinent part provides:

> The court may affirm the order of the agency complained of in the appeal if it finds, upon consideration of the entire record and such additional evidence as the court has admitted, that the order is supported by reliable, probative, and substantial evidence and is in accordance with law. In the absence of such a finding, it may reverse, vacate, or modify the order or make such other ruling as is supported by reliable, probative, and substantial evidence and is in accordance with law.

In considering this matter on appeal, this court is limited to determining whether appellee's adjudication order is supported by sufficient evidence in the record and whether it is lawful. 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, 614 N.E.2d 748; *Hayes v. State Med. Bd. of Ohio* (2000), 138 Ohio App. 3d 762, 767, 742 N.E.2d 238. 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 App. 3d 470, 482, 693 N.E.2d 317. 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.

Appellee's construction and application of its regulations and requirements must be accomplished on a case-by-case basis. Due deference must be accorded

to the decisions of an administrative agency. *VFW Post 8586 v. Ohio Liquor Control Comm.* (1998), 83 Ohio St. 3d 79. It has been noted that "an administrative agency's construction of a statute that the agency is empowered to enforce must be accorded due deference." *Ciriello v. Bd. of Embalmers and Funeral Directors of Ohio*, 105 Ohio App. 3d 213, 218, citing *Leon v. Bd. of Psychology* (1992), 63 Ohio St. 3d 683 and *Chaney v. Clark Cty. Agr. Soc., Inc.* (1993), 90 Ohio App. 3d 421. However, the findings of the agency are not conclusive. *Univ. of Cincinnati v. Conrad* (1980), 63 Ohio St.2d 108, 110-111.

In support of his appeal, appellant raises numerous arguments. They will be addressed here, but as a prefatorial note, and from an overview perspective, many of appellant's arguments are not seen as robust because it seems to be the case that appellant elects to wholly ignore the existence of evidence that is contrary to his position. This court is not free to ignore the evidence, but must consider all of the evidence.

Appellant initially contends "[t]he finding that [appellant] fell below the standard of care is based entirely upon alleged documentation deficiencies." It is true that to a large extend, the findings made against appellant dealt with his failure to properly document his care and treatment of his patients. It is also true that the testimony presented made clear that minimal *standards of patient care* require good documentation of treatment and interventions provided by the physician. This is for obvious reasons which were made the subject of testimony of experts who testified on the issue. In other words, proper medical documentation is a necessary prerequisite to the offering of care that is not substandard.

According to unchallenged testimony, proper documentation is an essential component of proper *client care*.

Next, appellant points to the comments offered by members of the board during their deliberative discussions. While these statements of opinion offered by various board members had value to other members of the board in terms of their considerations of the issues involved, they cannot be used to negate the ultimate conclusions reached by the board as found by the necessary quantum of its membership.[1]

Moving forward, appellant claims the board's decision "makes no sense." He reasons with respect to a board member's statement: "Dr. Darshan Mahajan's (no relation) statement that [appellant] was not negligent in any of the cases involved in this action means that [appellant] did not fall below the standard of *care." Appellant's position is unable to be supported by even the slightest* application of logic. It is a logical absurdity to contend that "A thinks B is not X, therefore, B is not X. Appellant's argument on this point is not well taken.

Next, appellant assigns as error the finding that appellant fell below minimal acceptable practice standards because the contrary was suggested by "four well-qualified, well-credential experienced psychiatrists" who provided opinion evidence at the hearing. Upon review, those who were permitted to offer opinion testimony were indeed qualified to offer it, but even one of *them* offered his criticism of appellant on occasion. Clearly, there was a notable difference of opinions among

[1] R.C. 4731.22(B) provides:" 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:. . ." In this case seven of the eight board members agreed on the result obtained.

those who testified on the salient issues. However, in an adversarial proceeding it is not the number of witnesses on the side of an issue that is controlling. That artificial numbers game is easily manipulated and offers little in terms of furthering considered independent analysis and judgmental determination of the issues.

Rather, it is the duty of the hearing examiner to consider the credibility or believability of the witnesses who testify and to determine the weight to be given to the evidence that is presented by the parties. It has been noted that persons such as hearing examiners, jury members and other finders of fact are best able to view the witnesses and observe their demeanor, gestures and voice inflections, and use these observations in weighing the credibility of the proffered testimony. See, e.g. *Seasons Coal Co. v. Cleveland* (1984), 10 Ohio St. 3d 77, 10 Ohio B. 408, 461 N.E.2d 1273, 1984 Ohio LEXIS 1068. It is worth noting that in his decision, the hearing officer in this case repeatedly offers his qualitative assessments of particular testimony as "convincing," "persuasive" and "reliable," among others. [2]

Next, appellant maintains that the opinions offered by Dr. Karp, appellee's main witness, are "inherently biased." Here, appellant delves into the matter of Dr. Karp's suggested susceptibility to being influenced by appellee's investigator, Mr. Katko. Here, it is offered that Katko retained Dr. Karp "not to perform a neutral evaluation of [appellant's] work, but to justify the apparent bias and rancor that Mr.

[2] In *State v. Samatar*, 152 Ohio App. 3d 311, 2003 Ohio 1639, 787 N.E.2d 691, 2003 Ohio App. LEXIS 1566 (Ohio Ct. App., Franklin County, 2003) it was noted: "Conflicting testimony, including differing opinions offered by expert witnesses, merely places the credibility of the witnesses in issue. See *State v. Mattison* (1985), 23 Ohio App.3d 10, 15, 23 Ohio B. 43, 490 N.E.2d 926. As the trial court noted, when the opinions of expert witnesses differ on methodology, analysis employed, or ultimate opinion, the trier of fact must determine which expert to believe. The determination of witness credibility and the weight to be accorded to that testimony is solely within the province of the trier of fact. *State v. DeHass* (1967), 10 Ohio St.2d 230, 227 N.E.2d 212, paragraph one of the syllabus.

Katko has expressed toward [appellant]." All of this ostensibly relates to Katko's alleged "unprofessional and intimidating" conduct at the time Katko took the investigative deposition of appellant in May 2007. A review of the record fails to uncover any evidence presented at the hearing concerning this aspect of the claim of bias on the part of Dr. Karp due to Katko's alleged unprofessional conduct at the deposition of appellant. This court is not permitted to consider matters that are outside of the record.

Appellant additionally claims that the contract Katko had with appellee concerning his employment as an attorney investigator "shows his bias." Verbiage in the contract requiring that Katko must perform to the satisfaction of appellee and that Katko is an agent of appellee are claimed to be a sufficient basis to support a "justifiable inference that Mr. Katko required Dr. Karp to perform to his [Katko's] expectations." An inference that is unsupported by facts is not justifiable and exists as mere speculation upon which a claim of bias cannot be based. Upon consideration, appellant's argument on this issue is found not to be well taken.

Next, appellant offers that the record shows Dr. Karp has never testified on behalf of a physician and that he has testified previously at the request of Katko. These were matters brought to the attention of the hearing officer whose obligation was to factor this evidence into his adjudicatory calculations in terms of what weight to give to the testimony of Dr. Karp.

Additionally relating to the testimony of Dr. Karp, appellant challenges the hearing examiner's ruling on a question appellant's counsel asked on cross examination of Dr. Karp. The question at issue was: "What did Mr. Katko - - when

he first called you about Dr. Mahajan, what did Mr. Katko tell you?" Appellee's counsel interposed an objection to the question and cited as a basis for the objection that "the answer would constitute confidential investigatory information." The hearing officer sustained the objection and appellant now claims that this ruing constituted "one of the most important errors in the hearing."

Counsel knew that Katko was appellee's investigator whose job it was to perform an investigation into matters relating to appellant's practice of medicine. Katko had performed an investigation and he was thus possessed with certain information gleaned from his investigation. Counsel's expansive question "what did Mr. Katko tell you?" clearly elicits a response touching on of information Katko knew as a result of his investigation. Rather that refocus or reword the question sufficient to limit a response to nonconfidential information; counsel moved on with other questioning. The court finds no error in the hearing officer's ruling on the testimonial objection inasmuch as it clearly calls for confidential information. [3]

Further concerning Dr. Karp's involvement, appellant characterizes the hearing examiner as "supposedly neutral" and calls into question the hearing examiner's integrity and goes on to claim that the hearing officer was biased and prejudiced against him. As grounds for his untoward accusations, appellant seems to suggest that positing more credibility on Dr. Karp's opinions (which were conceded by the hearing examiner to contain some flaws) than on the opinions of

[3] It must be noted that the question at issue appears in the record as quoted above. In urging that the hearing officer's evidentiary ruling was error, counsel incorrectly suggests the question was concerning "what Mr. Katko told him <u>to do</u>." (Emphasis added.) That, however, was not the question asked. If the question appeared in the record as counsel mischaracterized it, this court likely would agree with counsel that the ruling made likely was not the correct one.

other expert witnesses, the hearing officer acted improperly. As pointed out above, it is the role of the fact finder to weigh the evidence and find accordingly.

It is also worth noting that the hearing examiner prepared his report and recommendations. The hearing examiner had no power to impose sanctions on appellant or otherwise effectuate his findings – that was the duty of appellee, which, it will be recalled, rejected some of the hearing examiner's recommendations and went on to substantially accept the hearing examiner's findings by an overwhelming vote of seven out of eight voting members. Accordingly, appellant's suggestion that the result obtained was the product of malevolence directed at him is seen as ill conceived and unfounded.

Next, appellant takes issue with recordkeeping standards used by the hearing examiner in making his determination that certain of the psychiatric evaluations were not properly recorded by appellant. Much of the testimony on that issue came from Dr. Karp, a physiatrist with a broad background of experience. The standards used by Dr. Karp were identified by him as "minimal standard[s] of acceptance." The matrix used by him was described as having a purpose for peer review. He described it as supportive of his attempt to be as objective as he could be. In other words, the matrix was helpful to him in objectively evaluating the practices of appellant. Similarly, it appears to have been useful to the hearing examiner, although he was free to use it or not. It served as an adequate framework for objectively examining appellant's practices and performance.

Appellant additionally takes issue with appellant's record keeping with respect to Tegretol and Depakote. He claims "The Hearing Examiner completely ignored evidence contrary to this finding [that appellant's ministrations of Patient 2 with respect to Depakote and Patient 8 with Depakote fell below the acceptable standard of care]." Once again, it seems to be the case that it is appellant who selectively identifies evidence that may go to support his position, but refuses to acknowledge the evidence opposed to it. The testimony of Dr. Karp, if believed, is sufficient to support the hearing officer's findings made in connection with these drugs. Further, Dr. Gutheil concurred with some of Dr. Karp's positions in this regard. This court is not to weigh the evidence, but to determine if the requisite evidence exists to support the order below. It is worth noting, however, that even appellant's expert, Dr. Gutheil expressed a measure of uncertainty as to the propriety of some of appellant's treatment.

Next, appellant claims the adjudication order under review is contrary to Ohio law. He characterizes as error the hearing examiner's claimed over-reliance on the notion that if an event or a finding is not placed in a medical chart, the event did not occur or the finding was not made. Clearly that notion is not supportable as a matter of reason or common sense.

A review of the record discloses the hearing examiner did not use this shorthand expression as one bearing conclusive effect. Rather, he pointedly observed that there was a lack of credible evidence that undocumented events actually occurred. His decision made clear that as to certain events appellant

claims to have occurred many years ago, the testimony offered by appellant "was not persuasive."

When presented with a situation of, on one hand, the lack of testimony of a reliable, probative nature and, on the other hand, the absence of evidence that should, by proper standards, actually exist, a circumstance is extant wherein the critical need for contemporaneous documentation is clearly demonstrated. In such a situation, and recognizing that the doctors who testified acknowledged the importance of skilled chart documentation, a legitimate inference could be drawn that if the treatment had been given or the clinical observation made, it would have been the subject of a proper chart entry. Once again, it is not a matter of a conclusive inference being drawn, but one of legitimacy.

On this point, appellant calls the court's attention to *Mathew v. State Medical Bd.*, 1992 Ohio App. LEXIS 5607 (Ohio Ct. App., Franklin County, Nov. 5, 1992) and quotes a portion of the following excerpt:

> Dr. Mathew apparently contends that each medical expert witness' testimony must be independently supported by "medical evidence." However, it is only necessary that the medical expert's opinion be based upon **factual evidence**, not medical evidence, that is, factual evidence as to what actually occurred in the treatment, the condition of the patient, and that which Dr. Mathew **did or did not do** with respect to such treatment. (Emphasis added.)

The *Mathew* case is fully supportive of placing judgmental reliance on flawed omissions in care giving, as well as substandard commissions in treatment.

Appellant additionally calls the court's attention to *Reed v. State Med. Bd.*, 162 Ohio App. 3d 429, 2005 Ohio 4071, 833 N.E.2d 814, 2005 Ohio App. LEXIS 3708 (Ohio Ct. App., Franklin County, 2005). Although purportedly offered to

support the proposition that a physician has the right to offer "medically sound, theoretical basis" for omissions in her medical chart, this is not an issue in the case before the court. There can be no question that a physician may be permitted to explain his actions and his inactions.

The case goes on to note that the nonexistence of information in a physician's medical chart may be actionable. It was noted:

> . . . in a number of instances, appellant's medical records were, to say the least, sparse, and it is reasonable to argue that those limited records contained insufficient information to meet the minimum standards required of medical practitioners.

Also cited by appellant is *Lawrence v. State Medical Bd.*, 1993 Ohio App. LEXIS 1437 (Ohio Ct. App., Franklin County, Mar. 11, 1993). Appellant claims this case is "remarkably similar to these [facts of this case]." Appellant's reliance on *Lawrence* is misplaced. The issue in *Lawrence* that is relevant to this action is related to the maintenance of chart notes. The *Lawrence* court found it to be error to sanction a physician for the reason that a lay third party was unable to read the chart notes. This is not an issue in the present action.

Next appellant offers for the court's consideration *Brokamp v. Mercy Hosp.*, 132 Ohio App. 3d 850, 726 N.E.2d 594, 1999 Ohio App. LEXIS 1666 (Ohio Ct. App., Hamilton County, 1999). Appellant claims this medical malpractice case held that "the failure to document aspects of the care provided to a patient does not create a negative inference regarding that undocumented component of care." The relevant issue in *Brokamp* involves whether sufficient evidence was produced in order to warrant giving a rarely given jury instruction concerning the availability to the jury the opportunity to draw a negative inference disfavoring the party who has

control of certain evidence in question and fails, without satisfactory explanation, to provide the evidence to the jury. Here, appellant did not suffer a disadvantage because he withheld or intentionally failed produce evidence. It seems to be the case he produced everything he wanted to. Appellant's argument to the contrary is rejected.

Moving on, appellant next asserts the hearing examiner was not at liberty to disregard appellant's sworn testimony that certain events in his care and treatment of the ten selected patients actually happened. In his role as finder of fact, and with respect the testimony of the witnesses, including appellant, the hearing examiner was duty bound to evaluate the weight and credibility of each witness. A finder of fact is free to believe all, some, or none of a particular witness's testimony. *State v. Caldwell* (1992), 79 Ohio App.3d 667, 679, 607 N.E.2d 1096, citing *State v. Harriston* (1989), 63 Ohio App.3d 58, 63, 577 N.E.2d 1144, 1147.

Here it is not the case that the fact finder mechanically elected to disbelieve all of appellant's testimony and find against him on all counts. It must be recalled the fact finder found in favor of appellant on a number of charges – including some on the matter of lack of documentation. This court is not permitted to attempt to gauge the credibility of each witness and ascribe weight to the testimony of any witness.

Over and above judging credibility and assigning weight, there is no evidence that the hearing examiner acted arbitrarily. It is common knowledge that a person's recollection of events that occurred long ago is very often flawed due to the passage of time and circumstances. To conclude that a person's memory of

past events may be flawed is not an unreasonable one.[4] Appellant's argument on this issue is found not to be well taken.

Next, appellant claims the board's staff (sic) has not presented the requisite evidence. Under this rubric appellant contends a number of things. First, that the expert testimony offered by witnesses called by appellee was insufficient. Upon review, it is found those who offered expert testimony in this case were qualified to do so. Obviously, the qualifications and backgrounds of each witness differ among the individuals involved. It is the decision, in the first instance, for the hearing examiner to weigh the evidence presented by each witness. Secondly, appellee may consider this factor as it determines the ultimate outcomes on the case. Third, it is for this court to determine if the adjudication order containing the decision of appellee is supported by reliable, probative and substantial evidence.

Appellant also offers that "Dr. Karp's inadequate credentials stand in stark contrast to Dr. Gutheil's overwhelming credentials" and, thus, Dr. Gutheil's opinions ought to be accepted and those of Dr. Karp should be rejected. Once again, this issue goes to the weight to be given to the evidence presented. This court finds that the testimony of both doctors should be afforded some weight. It is up to the finders of fact to make additional determinations. It has been explained:

> Appellant ignores the fact that the jury was presented with Crosby's testimony on behalf of appellant, and Dubois' testimony on behalf of appellee. The two experts differed on whether the FM22 had a quench crack when it left appellant's hands, and whether this caused the claw to snap off while appellee was using it. 'Where conflicting expert testimony exists, the trier of fact is responsible for determining which expert is more credible.' *Parsons v. Washington State Community College*, Franklin App. No. 05AP-1138, 2006

[4] Appellant related that he saw approximately 3,400 patients during the period of examination in question, from 2000 through 2006.

> Ohio 2196, P22. This is because, '[t]he weight of conflicting expert evidence and the credibility of the experts are matters peculiarly for the trier of fact.' *Bedel v. Univ. of Cincinnati Hosp.* (1995), 107 Ohio App.3d 420, 428, 669 N.E.2d 9, citing *Hubach v. Cole* (1938), 133 Ohio St. 137, 10 O.O. 187, 12 N.E.2d 283.
>
> *Eastman v. Stanley Works,* 180 Ohio App. 3d 844, 2009 Ohio 634, 907 N.E.2d 768, 2009 Ohio App. LEXIS 530 (Ohio Ct. App., Franklin County, 2009)

Moving on, appellant next argues that he complied with Ohio law regarding informed consent. Here, appellant cites the case of *Bedel v. University OB/GYN Assocs.,* 76 Ohio App. 3d 742, 603 N.E.2d 342, 1991 Ohio App. LEXIS 5899 (Ohio Ct. App., Hamilton County, 1991) for the proposition that unchallenged testimony from a physician that he orally provided the necessary information to his patient so that she could and did give her informed consent to a procedure, then, in that circumstance, a court may find that the consent given was sufficiently informed as a matter of law. Here, appellant's proposition that "[t]he Hearing Examiner's conclusion that [appellant] did not obtain informed consent must be rejected" lacks proper focus.

Concerning the matter of informed consent, the hearing officer did not conclude appellant failed to give the necessary information to evince informed consent. He seemed to make it plain that (1) appellant said he provided the necessary information to his patients, (2) Dr. Gutheil suggested that such testimony be taken seriously and (3) Dr. Karp concurred. What the hearing officer ultimately found was that appellant "**did not properly document** the performance of an initial or ongoing discussion of informed consent regarding . . .", and that merely checking a preprinted box on a form was insufficient documentation.

(Emphasis added.) Thus appellant's argument supported by the *Bedel* case is without relevance.

Appellant next contends appellee cannot enforce ad hoc, invalid rules concerning patient charting that have not been properly promulgated. He notes that appellee has issued a formal rule prohibiting what it was that appellant fell below. It has been observed, however, that "not every conceivable act or practice that falls below minimal standards can be made the subject of a specific rule." *Johnson v. State Med. Bd.*, 1999 Ohio App. LEXIS 4487 (Ohio Ct. App., Franklin County, Sept. 28, 1999). The reasoning offered to support such a notion is based on the fact that the board members are, to a large extent, sufficiently knowledgeable about prevailing standards of care to apply them to other members of the profession. Such specialized knowledge renders the board capable of both interpreting the technical requirements of the medical profession and determining whether a physician's conduct falls below the minimal standard of care. *Walker v. State Med. Bd. of Ohio*, 2002 Ohio 682, 2002 Ohio App. LEXIS 726 (Ohio Ct. App., Franklin County, Feb. 21, 2002). Accordingly, appellant's position on this issue is not supported at law.

Appellant next raises the issues of utilizing a "tiny sample" of patient records and how they were selected and utilized in evaluating the overall quality of his recordkeeping and medical practice. He claims a due process violation in the placement of evidentiary value in the records when judging the overall quality of his practice. At the hearing evidence was offered by a statistics professor who testified that absent a random selection process and a more sizable examination base,

conclusions drawn from the records and applied to the whole of appellant's practice would be invalid.

The suggestion that the intentional selection of ten particular records from a group of thousands and postulate that conclusions drawn therefrom can be considered valid as to the group is, of course, absurd. Here, though, that was not the stated intent of appellee. The purpose of the records selection in this case related to complaints or concerns voiced in those particular individual cases. Whatever results may be obtained from a review of those records must be confined to that select group. Appellee found that as to the ten charts reviewed, appellant did not meet certain identified standards and, it must be remembered, that as to other standards, he was found not to have violated them. The court finds appellant's due process rights were not violated in this instance.

The next contention offered in challenge to appellee's adjudication order relates to his terms of probation. Appellant claims they are unreasonable with respect to the prohibition on appellant's right to travel. The right to interstate travel has been identified as a fundamental right. *Johnson v. City of Cincinnati*, 310 F.3d 484, 2002 U.S. App. LEXIS 20418, (6th Cir. Ohio 2002). Typically, where a fundamental liberty interest protected by the substantive due process component of the Fourteenth Amendment is involved, the government cannot infringe on that right "unless the infringement is narrowly tailored to serve a compelling state interest." *Washington v. Glucksberg*, 521 U.S. 702, 720-21, 138 L. Ed. 2d 772, 117 S. Ct. 2258 (1997) at 721; *Lakewood, Ohio Congregation of Jehovah's Witnesses, Inc. v. City of Lakewood*, 699 F.2d 303, 309 (6th Cir. 1983).

Here, appellee claims that the restriction against travel is a "standard provision" aimed at preventing appellant from leaving Ohio to practice in another state while his probationary term "ticks away" without monitoring. This rational does not either identify a compelling state interest in keeping appellant in Ohio and it is not narrowly tailored to meet what appellee describes as the regulation of medical licenses. Upon consideration, it is found the travel restriction contained in the adjudication order is not in accordance with law. This case is thus remanded to appellee in order that it may consider the sole issue of alternative probationary terms with respect to travel, practice in another state, and monitoring appellant's conduct, if necessary.

The next contention is that the order under review is invalid because appellee violated the Ohio Public Meetings Act. Here, appellant claims the minutes prepared by appellee contain some inaccuracies and that appellee's counsel "deliberately interfered with the court reporter's ability to record the proceedings." Upon consideration and a review of the record, it is found this contention is without merit. An adequate, full and robust record has been presented to this court.

Appellant next asserts that the hearing examiner was biased, non-partial and prejudged, all to his detriment. Appellant claims the hearing officer acted "in complete disregard for Ohio law." Upon consideration, it is found that this contention is groundless.

Appellant next claims the hearing examiner made several improper evidentiary rulings which caused prejudice to him. He first notes rulings on matters

related to claimed influence of Katko, appellee's counsel and unspecified others. A review of the record failed to disclose evidence of prejudice or improper evidentiary rulings relating to this matter.

Appellant also questions the propriety of the ruling prohibiting Dr. Karp from expressing an opinion as to the matter of sanctions to be imposed on appellant. Generally, a witness may be permitted to offer an opinion if that opinion is deemed to be helpful to the finder of fact. Here, the finders of fact have such experience and background that an opinion on such an issue would be out of place. Thus, there is no error in precluding Dr. Karp from offering an opinion on the issue.

On the matter of the question concerning deficient charting in less than one percent of a physician's patients files, it is found that the correct ruling was made inasmuch as it is clear that the question called for information that was irrelevant.

Except as noted herein with regard to the imposition of the travel restriction, this court finds the instant adjudication order to be supported by reliable, probative, and substantial evidence and is in accordance with law. This case is **remanded** to appellee to revise appellant's terms of probation consistent with this decision. In all other respects, the adjudication order is **affirmed**.

Judgment is rendered accordingly.

Julie M. Lynch, Judge

Copies to:

•E0930 - M18

Nicholas E. Subashi, Esq.
50 Chestnut Street, Suite 230
Dayton, Ohio 45440
and
Subodh Chandra, Esq.
1265 West 6th Street, Suite 400
Cleveland, Ohio 44113
Counsel for Appellant

Katherine J. Bockbrader, Esq.
30 East Broad Street, Floor 26
Columbus, Ohio 43215

Sandy Vorhies,
Administrative Law Secretary

STATE MEDICAL BOARD
OF OHIO

2010 JUL 15 PM 2: 40

THE STATE MEDICAL BOARD OF OHIO
ATTN: Case Control Office
30 E. Broad Street, 3rd Floor
Columbus, Ohio 43215

10 CVF07 9949

In the Matter of:	:	Hearing Examiner
MAHENDRA KUMAR MAHAJAN, M.D.	:	R. Gregory Porter, Esq.
	:	Case No. 07-CRF-012

FILED
COMMON PLEAS COURT
2010 JUL -7 AM 9:46
CLERK OF COURTS-CIV

NOTICE OF APPEAL

STATE MEDICAL BOARD
OF OHIO
2010 JUL -7 AM 9: 21

Notice is hereby given that Mahendra Kumar Mahajan, M.D., Appellant, appeals to the Franklin County Court of Common Pleas pursuant to Ohio Rev. Code Section 119.12. This appeal is from the Entry of Order Nunc Pro Tunc of the State Medical Board of Ohio (hereinafter "the Board" or "Appellee") subjecting Appellant's certificate to practice medicine and surgery to probationary terms, conditions, and limitations for a period of at least three years. This Nunc Pro Tunc entry is dated June 23, 2010 and purports to correct certain clerical errors in the Final Order voted and approved by the Board at its May 12, 2010 meeting and mailed on June 3, 2010. The Final Order mailed on June 3, 2010 is the subject of another appeal pending in the Franklin County Court of Common Pleas, Case No. 10 CVF06 9077. Appellant hereby appeals the Entry of Order Nunc Pro Tunc dated June 23, 2010 and also appeals other decisions issued prior to this Entry of Order Nunc Pro Tunc, as set forth more fully below. A copy of the Entry of Order Nunc Pro Tunc is attached hereto as Exhibit A.

The grounds for this appeal are as follows:

(1) The findings and Order of the State Medical Board are contrary to law and are not supported by reliable, probative, or substantial evidence. Specifically, Appellee failed to prove

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by reliable, probative, and substantial evidence that Appellant's care and treatment of the ten patients at issue constitutes a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances in violation of R.C. 4731.22(B)(6). Contrary to the assertion of Appellee, no reliable, probative or substantial evidence was introduced to show that Dr. Mahajan's care and treatment of the ten patients at issue fell below acceptable standards of care. The following is a list of examples demonstrating the lack of reliable, probative or substantial evidence to support the finding that Dr. Mahajan violated R.C. 4731.22(B)(6). The following list is not exhaustive and is simply intended to illustrate just some of the deficiencies with the Order on appeal.

(a) The finding that Dr. Mahajan's care and treatment of these ten patients fell below the standard of care is based entirely upon supposed documentation/charting deficiencies and the improper and legally unsupportable proposition that the failure to document certain aspects of medical care is proof that this undocumented aspect of care did not occur.

(b) The finding that Dr. Mahajan's care and treatment of these ten patients fell below the standard of care is premised upon the improper rejection of Dr. Mahajan's undisputed testimony that he did certain things not documented in the medical record. This improperly shifts the Board's burden to prove its charges against Dr. Mahajan to Dr. Mahajan and requires that he disprove the allegations against him.

(c) The finding that Dr. Mahajan violated R.C. 4731.22(B)(6) is an improper attempt to enforce ad hoc, invalid rules concerning charting that are lacking in

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50 Chestnut Street
Suite 230
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any medical or scientific basis and that have not been promulgated in any rule or standard in compliance with the Administrative Procedures Act.

(d) The testimony of the Board's expert, Robert Karp, M.D. was not competent or credible and his testimony must be disregarded, leaving the Board without any proper evidence to support its allegations against Dr. Mahajan. The following are just some examples of the deficiencies in Dr. Karp's testimony and criticisms:

i. Dr. Karp's practice is too dissimilar from Dr. Mahajan's practice for Dr. Karp to be able to render competent and qualified opinions regarding Dr. Mahajan's medical practice.

ii. Dr. Karp's testimony regarding key accusations of supposedly deficient charting is often demonstrably false, and his criticisms lack any medical or scientific basis.

(2) The Hearing Examiner made numerous erroneous evidentiary rulings that have resulted in substantial prejudice to Dr. Mahajan. The Board affirmed these erroneous evidentiary rulings. For example, at the hearing, the Hearing Examiner would not permit counsel for Dr. Mahajan to conduct a proper cross-examination of the expert relied upon by the Board staff, Robert Karp, M.D. This and other erroneous evidentiary rulings are improper, contrary to the Rules of Evidence, and violate constitutional principles of due process. Appellant incorporates by reference herein the erroneous evidentiary rulings at issue in the Motion of Respondent, Mahendra Kumar Mahajan, M.D., to overrule Hearing Examiner's Evidentiary Rulings and to Reopen Hearing and Respondent's Motion to Reconsider Evidentiary Rulings and to Reopen Hearing, both of which were filed with the Board.

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(3) The Hearing Examiner, and the Board, improperly struck from the record numerous documents and items of evidence submitted by Dr. Mahajan after the hearing held in this matter on January 21 through 23, 2009, but while the hearing record was still open. The hearing record was not closed until September 30, 2009. The Hearing Examiner also improperly redacted numerous filings submitted by Dr. Mahajan to remove any reference to these stricken items. These redactions were also improper in that they were overly broad and not narrowly tailored to redact references to the stricken items. Dr. Mahajan sought reconsideration of these rulings by the Board, but the Board affirmed. For example, the Hearing Examiner struck from the record the affidavit of Joseph H. Sedransk, a statistics professor. This affidavit provided testimony that the non-randomly selected sample of patient records considered in this matter was too small to be of any value in evaluating the overall quality of Dr. Mahajan's record keeping and medical practice.

(4) The Hearing Examiner and the Board improperly denied Appellant's Motion to Introduce Additional Evidence.

(5) The Hearing Examiner improperly ordered Appellant not to serve motions or other filings directly on Board members or otherwise seek direct contact with Board members.

(6) The findings and Order of the State Medical Board are contrary to law in that procedures for conducting the hearing were not in accordance with Ohio Admin. Code § 4731-13 and/or R.C. Chapter 119 thereby denying Appellant due process of law.

(7) The Board, acting through its President, also improperly redacted portions of Appellant's Objections to the Report and Recommendation.

(8) The Board and the Hearing Examiner improperly denied Appellant's Motion to Dismiss.

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(9) The Board, acting through its President, improperly denied Appellant's motion to stay proceedings until the conclusion of *State ex rel. Mahajan v. Ohio State Medical Board,* Case No. 2009-2293, which is presently pending in the Ohio Supreme Court.

(10) The findings and Order of the State Medical Board are arbitrary, unreasonable and unlawful in that the Board has subjected Appellant's license to probation without a proper finding that Appellant has violated any provision of the Medical Practices Act, R.C. 4731.22, identified in the Notice of Opportunity for a Hearing issued to Dr. Mahajan on November 14, 2007.

(11) The probationary terms, conditions, and limitations imposed by the Board against Dr. Mahajan are illegal, unconstitutional, arbitrary, unreasonable, and capricious. For example, Paragraph (A)(6) of the Order requires that Dr. Mahajan obtain permission from the Board for any departures or absences from the State of Ohio. This requirement is unconstitutional and/or unlawful.

(12) The Board's deliberations regarding the Report and Recommendation in this matter at its May 12, 2010 Board meeting demonstrate that the Board's members concluded that Dr. Mahajan was not negligent and/or that his care and treatment of the ten patients at issue did not fall below the standard of care. Thus, there can be no violation of R.C. 4731.22(B)(6), failure to conform to minimal standards of care, when even the Board's members agree that Dr. Mahajan's care and treatment of these ten patients **did not** fall below the standard of care.

(13) The findings and Order of the State Medical Board are arbitrary, unreasonable, and unlawful in that the procedures and proceedings were conducted in a manner denying Appellant equal protection of the law and due process of law.

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Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
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(14) The Order issued by the Board subjecting Appellant's certificate to practice medicine and surgery to probationary terms, conditions, and limitations is invalid because it was not adopted in an open meeting as required by Ohio's Open Meetings Act. The Board's violations of the Open Meetings Act include, but are not limited to, the following:

(a) The Board's General Counsel, Sallie Debolt, refused to permit the court reporter retained by Dr. Mahajan to sit at the front of the hearing room so that she could hear and transcribe the portions of the Board meeting relating to Dr. Mahajan. When this court reporter advised Ms. Debolt that, if she sat in the back of the hearing room as required by Ms. Debolt, she may not be able to hear the proceedings. Mrs. Debolt responded: "I don't care if you can hear or not." As a result, this court reporter was unable to hear and transcribe the entire proceeding. The Affidavit of this court reporter, Rebecca Williams, testifying to these facts has previously been filed with the Board.

(b) The Board's minutes from this meeting are not full, fair, and/or accurate and the Board's minutes improperly omit and/or minimize comments and statements favorable to Dr. Mahajan.

(15) The Hearing Examiner, R. Gregory Porter, Esq., who presided over this matter and issued a Report and Recommendation was biased, partial, and prejudiced to such a degree that his presence adversely affected the Board's decision. The following are a non-exhaustive list of examples of Mr. Porter's conduct that demonstrate his bias:

(a) Mr. Porter, an attorney and not a physician, improperly created his own medical standards, which were not supported by evidence, to justify his findings that Dr. Mahajan's care and treatment of these ten patients violated R.C. 4731.22(B)(6).

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Dr. Susan Stephens, a member of the Board, was highly critical of Mr. Porter's findings and concluded that one of the medical record keeping standards invented by Mr. Porter was "ridiculous."

(b) Mr. Porter recommended that that the certificate to practice medicine and surgery of Dr. Mahajan, a sixty-three year old physician, be indefinitely suspended based solely upon documentation deficiencies and recommended stringent requirements for reinstatement that a physician of Dr. Mahajan's age could not realistically complete. Further, the undisputed evidence establishes that the ten patients at issue in this case improved under Dr. Mahajan's care.

(c) Mr. Porter repeatedly ruled in favor of the Board's staff on evidentiary and procedural matters, frequently without affording Dr. Mahajan an opportunity to oppose the Board's requests or objections. These rulings were erroneous.

(d) Mr. Porter simply ignored law favorable to Dr. Mahajan. For example, Dr. Mahajan cited Mr. Porter to Ohio case law that clearly rejects the proposition that the failure to document an aspect of medical care provided to a patient is proof that this undocumented aspect of care never occurred. The Board's staff never proffered any legal authority to support the proposition that the failure to chart something is proof that this undocumented aspect of patient care did not happen. Mr. Porter simply ignored this dispositive legal issue and found against Dr. Mahajan on this issue in violation of clear Ohio law.

(e) Mr. Porter failed to acknowledge that Dr. Amita Patel was acting on the Board's behalf when she reviewed and approved hundreds of Dr. Mahajan's patient files and failed to proffer any basis for rejecting her opinion that Dr. Mahajan

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Suite 230
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fax: 937-427-8816

complied with the standard of care at all times. Dr. Patel, like Dr. Mahajan, is of Indian descent.

(f) Mr. Porter improperly excluded evidence of the misconduct of the Board Enforcement Attorney, David Katko, who initiated these disciplinary proceedings and improperly redacted references to this evidence from Appellants' pleadings and other filings.

(g) Mr. Porter's bias and prejudice so infected the proceedings and the Findings of Fact and Conclusions of Law in his Report and Recommendation that Dr. Mahajan was deprived of a fair hearing in violation of his due process rights.

(16) The Board failed to include its reasons for modifying and/or disapproving the Hearing Examiner's Report and Recommendations in its Order. For example, as discussed *supra,* the Board's deliberations indicate that it has found that Dr. Mahajan's care and treatment of the ten patients at issue did not fall below the standard of care and, therefore, there could be no violation of R.C. 4731.22(B)(6). Nevertheless, the Board, without providing any explanation in its Order, placed Dr. Mahajan on probation.

(17) The conduct of Board agents and/or employees has deprived Appellant a full and fair record in this matter resulting in prejudice to Appellant. The aforementioned conduct was willful and in bad faith and should result in dismissal of the charges against Dr. Mahajan with prejudice.

(18) The conduct of Board agents and/or employees in pursuing these disciplinary charges against Dr. Mahajan has been motivated by personal animus, prejudice, and/or other improper and illegal motives.

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50 Chestnut Street
Suite 230
Dayton, Ohio 45440
phone: 937-427-8800
fax: 937-427-8816

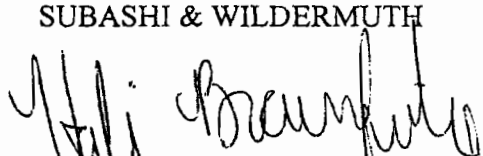
(19) The Entry of Order Nunc Pro Tunc issued on June 23, 2010 was noted voted on, approved, and/or issued in accordance with Ohio law, including R.C. Chapter 119, R.C. Chapter 4731, and regulations promulgated pursuant to R. C. Chapter. 119 and R.C. Chapter 4731. Therefore, the Entry of Order Nunc Pro Tunc is invalid.

(20) The Entry of Order Nunc Pro Tunc issued on June 23, 2010 is not a proper nunc pro tunc entry and is invalid.

For all the foregoing reasons, this Court should reverse the Entry of Order Nunc Pro Tunc, and the disciplinary charges against Dr. Mahajan should be dismissed. In the alternative, this Court should remand this matter to the Board for the introduction and consideration of evidence wrongfully excluded by the Hearing Examiner and the Board. Dr. Mahajan also requests an award of attorney fees pursuant R.C. § 2335.39, as the Board was not substantially justified in initiating this disciplinary action against him.

Respectfully submitted,

SUBASHI & WILDERMUTH



Nicholas E. Subashi (0033953)
nsubashi@swohiolaw.com
Halli J. Brownfield (0082466)
hbrownfield@swohiolaw.com
The Greene Town Center
50 Chestnut Street, Suite 230
Dayton, OH 45440
(937) 427-8800
(937) 427-8816 (fax)

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S&W
Subashi
& Wildermuth

The Greene Town Center
50 Chestnut Street
Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
fax: 937-427-8816

THE CHANDRA LAW FIRM, LLC
Subodh Chandra (0069233)
Subodh.Chandra@StanfordAlumni.org
1265 W. 6th St., Suite 400
Cleveland, OH 44113-1326
(216) 578-1700
(216) 578-1800 (fax)

Attorneys for Respondent
Mahendra Kumar Mahajan, M.D.

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S&W

Subashi
& Wildermuth

The Greene Town Center
50 Chestnut Street
Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
fax: 937-427-8816

CERTIFICATE OF SERVICE

I hereby certify this Notice of Appeal was served via hand delivery this 7th day of July, 2010, upon Appellee, Ohio State Medical Board, 30 East Broad Street, 3rd Floor, Columbus, Ohio 43215, and that the original of this Notice of Appeal was also filed with the Ohio State Medical Board on this date. This Notice of Appeal was also served via regular mail and/or hand delivery upon counsel for Appellee, Karen Unver, Esq., Assistant Attorney General, Office of the Ohio Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215. A copy of this Notice of Appeal was also filed with the Franklin County Court of Common Pleas this 7th day of July, 2010.

Halli Brownfield

Nicholas E. Subashi (0033953)
Halli J. Brownfield (0082466)

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S&W

Subashi
& Wildermuth

The Greene Town Center
50 Chestnut Street
Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
fax: 937-427-8816

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 07-CRF-012
MAHENDRA KUMAR MAHAJAN, M.D.	*	

ENTRY OF ORDER
NUNC PRO TUNC

On May 12, 2010, the State Medical Board of Ohio considered a Report and Recommendation in the Matter of Mahendra Kumar Mahajan, M.D., and issued a Final Order, which is attached hereto and incorporated herein by reference.

Upon further review, it has been determined that the order contained certain clerical errors.

WHEREFORE, it is hereby ORDERED that the Final Order of the State Medical Board of Ohio in the matter of Mahendra Kumar Mahajan, M.D. be and hereby is CORRECTED to read as follows:

It is hereby ORDERED that:

A. **PROBATION**: The certificate of Mahendra Kumar Mahajan, M.D., to practice medicine and surgery in the State of Ohio shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Obey the Law**: Dr. Mahajan shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Mahajan shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Mahajan shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances shall occur every **six** months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any

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

4. **Medical Records Course(s)**: Within the first year of his probation, or as otherwise determined by the Board, Dr. Mahajan shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. 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 course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

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

5. **Monitoring Physician**: Within 30 days of the effective date of this Order, or as otherwise determined by the Board, Dr. Mahajan shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Mahajan and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Mahajan and his medical practice, and shall review Dr. Mahajan's patient charts. The review shall include, at a minimum, the quality of Dr. Mahajan's charting with respect to the documentation of history (including symptoms), relevant physical examination if indicated, differential diagnosis, treatment plan, and medication management to include documentation of the medication prescribed, dosage prescribed, number of doses prescribed, and number of refills authorized. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

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

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Mahajan shall immediately so notify the Board in writing. In addition, Dr. Mahajan shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring

physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Mahajan shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Mahajan's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Mahajan's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

6. **Absences from Ohio**: Dr. Mahajan shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have discretion to waive part or all of the monitoring terms set forth in this Order for occasional periods of absence of 14 days or less.

   In the event that Dr. Mahajan resides and/or is employed at a location that is within 50 miles of the geographic border of Ohio and a contiguous state, Dr. Mahajan may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Mahajan is otherwise able to maintain full compliance with all other terms, conditions and limitations set forth in this Order.

7. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Mahajan is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

8. **Required Reporting of Change of Address**: Dr. Mahajan shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

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

C. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Mahajan violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

D. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Mahajan shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training; and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Mahajan shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

   In the event that Dr. Mahajan provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Mahajan shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Also, Dr. Mahajan shall provide a copy of this Order at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

3. **Required Documentation of the Reporting Required by Paragraph D**: Dr. Mahajan shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

E. **SUPERSEDES PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the September 2005 Consent Agreement between Dr. Mahajan and the Board.

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

Lance A. Talmage, M.D.
Secretary

(SEAL)

June 23, 2010
Date

CERTIFIED MAIL NO. 91 7108 2133 3936 3124 2950
RETURN RECEIPT REQUESTED

CC: Nicholas E. Subashi, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3124 2967
RETURN RECEIPT REQUESTED

Subodh Chandra, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3124 2974
RETURN RECEIPT REQUESTED

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THE STATE MEDICAL BOARD OF OHIO
ATTN: Case Control Office
30 E. Broad Street, 3rd Floor
Columbus, Ohio 43215

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In the Matter of:	:	Hearing Examiner
MAHENDRA KUMAR MAHAJAN, M.D.	:	R. Gregory Porter, Esq.
	:	Case No. 07-CRF-012

NOTICE OF APPEAL

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The grounds for this appeal are as follows:

(1) The findings and Order of the State Medical Board are contrary to law and are not supported by reliable, probative, or substantial evidence. Specifically, Appellee failed to prove by reliable, probative, and substantial evidence that Appellant's care and treatment of the ten patients at issue constitutes a departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances in violation of R.C. 4731.22(B)(6). Contrary to the assertion of Appellee, no reliable, probative or substantial

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evidence was introduced to show that Dr. Mahajan's care and treatment of the ten patients at issue fell below acceptable standards of care. The following is a list of examples demonstrating the lack of reliable, probative or substantial evidence to support the finding that Dr. Mahajan violated R.C. 4731.22(B)(6). The following list is not exhaustive and is simply intended to illustrate just some of the deficiencies with the Order on appeal.

(a) The finding that Dr. Mahajan's care and treatment of these ten patients fell below the standard of care is based entirely upon supposed documentation/charting deficiencies and the improper and legally unsupportable proposition that the failure to document certain aspects of medical care is proof that this undocumented aspect of care did not occur.

(b) The finding that Dr. Mahajan's care and treatment of these ten patients fell below the standard of care is premised upon the improper rejection of Dr. Mahajan's undisputed testimony that he did certain things not documented in the medical record. This improperly shifts the Board's burden to prove its charges against Dr. Mahajan to Dr. Mahajan and requires that he disprove the allegations against him.

(c) The finding that Dr. Mahajan violated R.C. 4731.22(B)(6) is an improper attempt to enforce ad hoc, invalid rules concerning charting that are lacking in any medical or scientific basis and that have not been promulgated in any rule or standard in compliance with the Administrative Procedures Act.

(d) The testimony of the Board's expert, Robert Karp, M.D. was not competent or credible and his testimony must be disregarded, leaving the Board without any proper evidence to support its allegations against Dr. Mahajan. The following

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are just some examples of the deficiencies in Dr. Karp's testimony and criticisms:

i. Dr. Karp's practice is too dissimilar from Dr. Mahajan's practice for Dr. Karp to be able to render competent and qualified opinions regarding Dr. Mahajan's medical practice.

ii. Dr. Karp's testimony regarding key accusations of supposedly deficient charting is often demonstrably false, and his criticisms lack any medical or scientific basis.

(2) The Hearing Examiner made numerous erroneous evidentiary rulings that have resulted in substantial prejudice to Dr. Mahajan. The Board affirmed these erroneous evidentiary rulings. For example, at the hearing, the Hearing Examiner would not permit counsel for Dr. Mahajan to conduct a proper cross-examination of the expert relied upon by the Board staff, Robert Karp, M.D. This and other erroneous evidentiary rulings are improper, contrary to the Rules of Evidence, and violate constitutional principles of due process. Appellant incorporates by reference herein the erroneous evidentiary rulings at issue in the Motion of Respondent, Mahendra Kumar Mahajan, M.D., to overrule Hearing Examiner's Evidentiary Rulings and to Reopen Hearing and Respondent's Motion to Reconsider Evidentiary Rulings and to Reopen Hearing, both of which were filed with the Board.

(3) The Hearing Examiner, and the Board, improperly struck from the record numerous documents and items of evidence submitted by Dr. Mahajan after the hearing held in this matter on January 21 through 23, 2009, but while the hearing record was still open. The hearing record was not closed until September 30, 2009. The Hearing Examiner also improperly redacted numerous filings submitted by Dr. Mahajan to remove any reference to these stricken

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items. These redactions were also improper in that they were overly broad and not narrowly tailored to redact references to the stricken items. Dr. Mahajan sought reconsideration of these rulings by the Board, but the Board affirmed. For example, the Hearing Examiner struck from the record the affidavit of Joseph H. Sedransk, a statistics professor. This affidavit provided testimony that the non-randomly selected sample of patient records considered in this matter was too small to be of any value in evaluating the overall quality of Dr. Mahajan's record keeping and medical practice.

(4) The Hearing Examiner and the Board improperly denied Appellant's Motion to Introduce Additional Evidence.

(5) The Hearing Examiner improperly ordered Appellant not to serve motions or other filings directly on Board members or otherwise seek direct contact with Board members.

(6) The findings and Order of the State Medical Board are contrary to law in that procedures for conducting the hearing were not in accordance with Ohio Admin. Code § 4731-13 and/or R.C. Chapter 119 thereby denying Appellant due process of law.

(7) The Board, acting through its President, also improperly redacted portions of Appellant's Objections to the Report and Recommendation.

(8) The Board and the Hearing Examiner improperly denied Appellant's Motion to Dismiss.

(9) The Board, acting through its President, improperly denied Appellant's motion to stay proceedings until the conclusion of *State ex rel. Mahajan v. Ohio State Medical Board,* Case No. 2009-2293, which is presently pending in the Ohio Supreme Court.

(10) The findings and Order of the State Medical Board are arbitrary, unreasonable and unlawful in that the Board has subjected Appellant's license to probation without a proper

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finding that Appellant has violated any provision of the Medical Practices Act, R.C. 4731.22, identified in the Notice of Opportunity for a Hearing issued to Dr. Mahajan on November 14, 2007.

(11) The probationary terms, conditions, and limitations imposed by the Board against Dr. Mahajan are illegal, unconstitutional, arbitrary, unreasonable, and capricious. For example, Paragraph (A)(6) of the Order requires that Dr. Mahajan obtain permission from the Board for any departures or absences from the State of Ohio. This requirement is unconstitutional and/or unlawful.

(12) The Board's deliberations regarding the Report and Recommendation in this matter at its May 12, 2010 Board meeting demonstrate that the Board's members concluded that Dr. Mahajan was not negligent and/or that his care and treatment of the ten patients at issue did not fall below the standard of care. Thus, there can be no violation of R.C. 4731.22(B)(6), failure to conform to minimal standards of care, when even the Board's members agree that Dr. Mahajan's care and treatment of these ten patients **did not** fall below the standard of care.

(13) The findings and Order of the State Medical Board are arbitrary, unreasonable, and unlawful in that the procedures and proceedings were conducted in a manner denying Appellant equal protection of the law and due process of law.

(14) The Order issued by the Board subjecting Appellant's certificate to practice medicine and surgery to probationary terms, conditions, and limitations is invalid because it was not adopted in an open meeting as required by Ohio's Open Meetings Act. The Board's violations of the Open Meetings Act include, but are not limited to, the following:

(a) The Board's General Counsel, Sallie Debolt, refused to permit the court reporter retained by Dr. Mahajan to sit at the front of the hearing room so that she could

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hear and transcribe the portions of the Board meeting relating to Dr. Mahajan. When this court reporter advised Ms. Debolt that, if she sat in the back of the hearing room as required by Ms. Debolt, she may not be able to hear the proceedings. Mrs. Debolt responded: "I don't care if you can hear or not." As a result, this court reporter was unable to hear and transcribe the entire proceeding. The Affidavit of this court reporter, Rebecca Williams, testifying to these facts has previously been filed with the Board.

(b) The Board's minutes from this meeting are not full, fair, and/or accurate and the Board's minutes improperly omit and/or minimize comments and statements favorable to Dr. Mahajan.

(15) The Hearing Examiner, R. Gregory Porter, Esq., who presided over this matter and issued a Report and Recommendation was biased, partial, and prejudiced to such a degree that his presence adversely affected the Board's decision. The following are a non-exhaustive list of examples of Mr. Porter's conduct that demonstrate his bias:

(a) Mr. Porter, an attorney and not a physician, improperly created his own medical standards, which were not supported by evidence, to justify his findings that Dr. Mahajan's care and treatment of these ten patients violated R.C. 4731.22(B)(6). Dr. Susan Stephens, a member of the Board, was highly critical of Mr. Porter's findings and concluded that one of the medical record keeping standards invented by Mr. Porter was "ridiculous."

(b) Mr. Porter recommended that that the certificate to practice medicine and surgery of Dr. Mahajan, a sixty-three year old physician, be indefinitely suspended based solely upon documentation deficiencies and recommended

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stringent requirements for reinstatement that a physician of Dr. Mahajan's age could not realistically complete. Further, the undisputed evidence establishes that the ten patients at issue in this case improved under Dr. Mahajan's care.

(c) Mr. Porter repeatedly ruled in favor of the Board's staff on evidentiary and procedural matters, frequently without affording Dr. Mahajan an opportunity to oppose the Board's requests or objections. These rulings were erroneous.

(d) Mr. Porter simply ignored law favorable to Dr. Mahajan. For example, Dr. Mahajan cited Mr. Porter to Ohio case law that clearly rejects the proposition that the failure to document an aspect of medical care provided to a patient is proof that this undocumented aspect of care never occurred. The Board's staff never proffered any legal authority to support the proposition that the failure to chart something is proof that this undocumented aspect of patient care did not happen. Mr. Porter simply ignored this dispositive legal issue and found against Dr. Mahajan on this issue in violation of clear Ohio law.

(e) Mr. Porter failed to acknowledge that Dr. Amita Patel was acting on the Board's behalf when she reviewed and approved hundreds of Dr. Mahajan's patient files and failed to proffer any basis for rejecting her opinion that Dr. Mahajan complied with the standard of care at all times. Dr. Patel, like Dr. Mahajan, is of Indian descent.

(f) Mr. Porter improperly excluded evidence of the misconduct of the Board Enforcement Attorney, David Katko, who initiated these disciplinary proceedings and improperly redacted references to this evidence from Appellants' pleadings and other filings.

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& Wildermuth

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Suite 230
Dayton, Ohio 45440

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fax: 937-427-8816

(g) Mr. Porter's bias and prejudice so infected the proceedings and the Findings of Fact and Conclusions of Law in his Report and Recommendation that Dr. Mahajan was deprived of a fair hearing in violation of his due process rights.

(16) The Board failed to include its reasons for modifying and/or disapproving the Hearing Examiner's Report and Recommendations in its Order. For example, as discussed *supra,* the Board's deliberations indicate that it has found that Dr. Mahajan's care and treatment of the ten patients at issue did not fall below the standard of care and, therefore, there could be no violation of R.C. 4731.22(B)(6). Nevertheless, the Board, without providing any explanation in its Order, placed Dr. Mahajan on probation.

(17) The conduct of Board agents and/or employees has deprived Appellant a full and fair record in this matter resulting in prejudice to Appellant. The aforementioned conduct was willful and in bad faith and should result in dismissal of the charges against Dr. Mahajan with prejudice.

(18) The conduct of Board agents and/or employees in pursuing these disciplinary charges against Dr. Mahajan has been motivated by personal animus, prejudice, and/or other improper and illegal motives.

For all the foregoing reasons, this Court should reverse the Order of the Board, and the disciplinary charges against Dr. Mahajan should be dismissed. In the alternative, this Court should remand this matter to the Board for the introduction and consideration of evidence wrongfully excluded by the Hearing Examiner and the Board. Dr. Mahajan also requests an award of attorney fees pursuant R.C. § 2335.39, as the Board was not substantially justified in initiating this disciplinary action against him.

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Subashi
& Wildermuth

The Greene Town Center
50 Chestnut Street
Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
fax: 937-427-8816

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Respectfully submitted,

SUBASHI & WILDERMUTH

Nicholas E. Subashi (0033953)
nsubashi@swohiolaw.com
Halli J. Brownfield (0082466)
hbrownfield@swohiolaw.com
The Greene Town Center
50 Chestnut Street, Suite 230
Dayton, OH 45440
(937) 427-8800
(937) 427-8816 (fax)

THE CHANDRA LAW FIRM, LLC

(per consent)

Subodh Chandra (0069233)
Subodh.Chandra@StanfordAlumni.org
1265 W. 6th St., Suite 400
Cleveland, OH 44113-1326
(216) 578-1700
(216) 578-1800 (fax)

Attorneys for Respondent
Mahendra Kumar Mahajan, M.D.

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The Greene Town Center
50 Chestnut Street
Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
fax: 937-427-8816

CERTIFICATE OF SERVICE

I hereby certify this Notice of Appeal was served via hand delivery this 17th day of June, 2010, upon Appellee, Ohio State Medical Board, 30 East Broad Street, 3rd Floor, Columbus, Ohio 43215, and that the original of this Notice of Appeal was also filed with the Ohio State Medical Board on this date. This Notice of Appeal was also served via regular mail and/or hand delivery upon counsel for Appellee, Karen Unver, Esq., Assistant Attorney General, Office of the Ohio Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215. A copy of this Notice of Appeal was also filed with the Franklin County Court of Common Pleas this 17th day of June, 2010.

Nicholas E. Subashi (0033953)
Halli J. Brownfield (0082466)

S&W

Subashi
& Wildermuth

The Greene Town Center
50 Chestnut Street
Suite 230
Dayton, Ohio 45440

phone: 937-427-8800
fax: 937-427-8816

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BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 07-CRF-012
MAHENDRA KUMAR MAHAJAN, M.D.	*	

ENTRY OF ORDER
NUNC PRO TUNC

On May 12, 2010, the State Medical Board of Ohio considered a Report and Recommendation in the Matter of Mahendra Kumar Mahajan, M.D., and issued a Final Order, which is attached hereto and incorporated herein by reference.

Upon further review, it has been determined that the order contained certain clerical errors.

WHEREFORE, it is hereby ORDERED that the Final Order of the State Medical Board of Ohio in the matter of Mahendra Kumar Mahajan, M.D. be and hereby is CORRECTED to read as follows:

It is hereby ORDERED that:

A. **PROBATION**: The certificate of Mahendra Kumar Mahajan, M.D., to practice medicine and surgery in the State of Ohio shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Obey the Law**: Dr. Mahajan shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Mahajan shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Mahajan shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances shall occur every **six** months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any

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

4. **Medical Records Course(s)**: Within the first year of his probation, or as otherwise determined by the Board, Dr. Mahajan shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. 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 course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

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

5. **Monitoring Physician**: Within 30 days of the effective date of this Order, or as otherwise determined by the Board, Dr. Mahajan shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Mahajan and who is engaged in the same or similar practice specialty.

   The monitoring physician shall monitor Dr. Mahajan and his medical practice, and shall review Dr. Mahajan's patient charts. The review shall include, at a minimum, the quality of Dr. Mahajan's charting with respect to the documentation of history (including symptoms), relevant physical examination if indicated, differential diagnosis, treatment plan, and medication management to include documentation of the medication prescribed, dosage prescribed, number of doses prescribed, and number of refills authorized. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

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

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Mahajan shall immediately so notify the Board in writing. In addition, Dr. Mahajan shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring

physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Mahajan shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Mahajan's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Mahajan's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

6. **Absences from Ohio**: Dr. Mahajan shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have discretion to waive part or all of the monitoring terms set forth in this Order for occasional periods of absence of 14 days or less.

   In the event that Dr. Mahajan resides and/or is employed at a location that is within 50 miles of the geographic border of Ohio and a contiguous state, Dr. Mahajan may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Mahajan is otherwise able to maintain full compliance with all other terms, conditions and limitations set forth in this Order.

7. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Mahajan is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

8. **Required Reporting of Change of Address:** Dr. Mahajan shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

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

C. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Mahajan violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

D. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Mahajan shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training; and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Mahajan shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

   In the event that Dr. Mahajan provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Mahajan shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Also, Dr. Mahajan shall provide a copy of this Order at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

3. **Required Documentation of the Reporting Required by Paragraph D**: Dr. Mahajan shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

E. **SUPERSEDES PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the September 2005 Consent Agreement between Dr. Mahajan and the Board.

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

Lance A. Talmage, M.D.
Secretary

(SEAL)

June 23, 2010
Date

CERTIFIED MAIL NO. 91 7108 2133 3936 3124 2950
RETURN RECEIPT REQUESTED

CC: Nicholas E. Subashi, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3124 2967
RETURN RECEIPT REQUESTED

Subodh Chandra, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3124 2974
RETURN RECEIPT REQUESTED

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

May 12, 2010

Mahendra Kumar Mahajan, M.D.
2614 Lantz Road
Beavercreek, OH 45434

RE: Case No. 07-CRF-012

Dear Doctor Mahajan:

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 May 12, 2010, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

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

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

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3936 3133 2286
RETURN RECEIPT REQUESTED

Cc: Nicholas E. Subashi, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3133 2293
RETURN RECEIPT REQUESTED

Subodh Chandra, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3936 3114 1161
RETURN RECEIPT REQUESTED

Mailed 6-3-10

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 May 12, 2010, 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 Mahendra Kumar Mahajan, M.D., Case No. 07-CRF-012, as it appears in the Journal of the State Medical Board of Ohio.

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

Lance A. Talmage, M.D.
Secretary

(SEAL)

May 12, 2010
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *

* CASE NO. 07-CRF-012

MAHENDRA KUMAR MAHAJAN, M.D. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on May 12, 2010.

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

It is hereby ORDERED that:

A. **PROBATION**: The certificate of Mahendra Kumar Mahajan, M.D., to practice medicine and surgery in the State of Ohio shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Obey the Law**: Dr. Mahajan shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Mahajan shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Mahajan's certificate is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Mahajan shall appear in person for an interview before the full Board or its designated representative during the third month

following the month in which Dr. Mahajan's certificate is restored or reinstated, or as otherwise directed by the Board. Subsequent personal appearances shall occur every **six** months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Medical Records Course(s)**: Within the first year of his probation, or as otherwise determined by the Board, Dr. Mahajan shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. 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 course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

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

5. **Monitoring Physician**: Within 30 days of the date of Dr. Mahajan's reinstatement or restoration, or as otherwise determined by the Board, Dr. Mahajan shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Mahajan and who is engaged in the same or similar practice specialty.

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

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

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Mahajan shall immediately so notify the Board in writing. In addition, Dr. Mahajan shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Mahajan shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Mahajan's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Mahajan's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

6. **Absences from Ohio**: Dr. Mahajan shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have discretion to waive part or all of the monitoring terms set forth in this Order for occasional periods of absence of 14 days or less.

   In the event that Dr. Mahajan resides and/or is employed at a location that is within 50 miles of the geographic border of Ohio and a contiguous state, Dr. Mahajan may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Mahajan is otherwise able to maintain full compliance with all other terms, conditions and limitations set forth in this Order.

7. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Mahajan is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

8. **Required Reporting of Change of Address:** Dr. Mahajan shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

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

C. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Mahajan violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

D. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Mahajan shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training; and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Mahajan shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

   In the event that Dr. Mahajan provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Mahajan shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Also, Dr. Mahajan shall provide a copy of this Order at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

3. **Required Documentation of the Reporting Required by Paragraph D**: Dr. Mahajan shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

E. **SUPERSEDES PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the September 2005 Consent Agreement between Dr. Mahajan and the Board.

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

Lance A. Talmage, M.D.
Secretary

(SEAL)

May 12, 2010
Date

STATE MEDICAL BOARD
OF OHIO

2010 APR -5 PM 4:41

BEFORE THE STATE MEDICAL BOARD OF OHIO

In the Matter of	*	
		Case No. 07-CRF-012
Mahendra Kumar Mahajan, M.D.,	*	
		Hearing Examiner Porter
Respondent.	*	

REPORT AND RECOMMENDATION

Basis for Hearing

By letter dated November 14, 2007, the State Medical Board of Ohio [Board] notified Mahendra Kumar Mahajan, M.D., that it intended to determine whether to impose discipline against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action upon the following allegations:

(1) From in or about 2000 to in or about 2006, [Dr. Mahajan] undertook the care of Patients 1 – 10, as identified on [a confidential] Patient Key in the course of [his] psychiatric practice * * *.

(a) [Dr. Mahajan] failed to complete and/or document a psychiatric evaluation of patients 1, 3, 4, 5, 6, 7, 9 and 10.

(b) [Dr. Mahajan] failed to order, review and/or document baseline and/or follow-up laboratory evaluations of patients 1, 3, 4, 5, 6, 7 and 9. Further, [Dr. Mahajan] failed to maintain any laboratory results in [his] patient record for Patients 2 and 8.

(c) [Dr. Mahajan] failed to order and/or document therapeutic levels of Depakote for Patients 2 and 8 and of Tegretol for Patient 8.

(d) [Dr. Mahajan] failed to document DSM-IV or DSM-IV-TR criteria having been met for any psychiatric diagnoses.

(e) [Dr. Mahajan] failed to properly document the performance of initial or ongoing discussion of informed consent regarding diagnoses, why a specific medication was recommended, the medication's intended benefits, potential medication side effects, and/or recommended duration of use or alternative medications for Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10.

(f) [Dr. Mahajan] failed to consistently follow up on medication changes, additions and deletions [for] Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. [He] inappropriately prescribed to Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 on an ad hoc basis.

(g) [Dr. Mahajan] failed to document the presence or absence of adverse effects for medications prescribed by [him] to Patients 1, 2, 3, 4, 5, 6, 7, 8 and 9.

(h) [Dr. Mahajan] failed to discuss and/or document the discussion, either initially or in follow-up, of Tardive Dyskinesia for Patients 2, 5, 7, 8, 9 and 10 [to whom he] prescribed anti-psychotic medications * * *. Further, despite the fact that [he] prescribed anti-psychotic medications to Patients 2, 5, 7, 8, 9 and 10, [Dr. Mahajan] failed to perform and/or document Abnormal Involuntary Movement examinations at baseline or during treatment.

The Board further alleged that Dr. Mahajan's acts, conduct, or omissions as set forth above constitute:

- "'[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,' as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code"; and/or

- "'[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code."

Finally, the Board advised Dr. Mahajan of his right to request a hearing in this matter, and received his written request on December 11, 2007. (State Exhibits 14-A, 14-D)

Appearances at Hearing

Richard Cordray, Attorney General, and Barbara J. Pfeiffer, Assistant Attorney General, for the State of Ohio
Nicholas E. Subashi, Esq., for Dr. Mahajan

Hearing Dates: January 21 through 23, 2009

PROCEDURAL MATTERS

1. The hearing record was held open to give the parties an opportunity to submit written closing arguments. Following extensions of time requested by the Respondent, the closing arguments and replies were received in a timely manner. However, prior to and after the filing of the parties' closing arguments and reply briefs, both parties a number of motions, memoranda, and replies concerning various issues. These were resolved by several entries, the last of which was filed September 30, 2009. The hearing record closed on that date.

2. The following exhibits were received post-hearing, and were marked by the Hearing Examiner and admitted to the record:

   a. State's Exhibit 17: May 1, 2009, Closing Brief of the State Medical Board of Ohio.

   b. Respondent's Exhibit SS: May 4, 2009, Closing Argument Brief of the Respondent. This document was redacted by the Hearing Examiner and attachments were removed per entry dated June 29, 2009.

   c. State's Exhibit 18: May 15, 2009, Reply Closing Brief of the State Medical Board of Ohio.

   d. Respondent's Exhibit TT: May 18, 2006, Reply Brief of the Respondent. This document was redacted by the Hearing Examiner and attachments were removed per entry dated June 29, 2009.

3. The following documents were received post-hearing and were marked by the Hearing Examiner. These documents were not admitted to the record, but are held as proffered material for the Respondent per the June 29, 2009, entry:

   a. Respondent's Exhibit UU: Unredacted copy of the Respondent's May 4, 2009, Closing Argument Brief, with attachments.

   b. Respondent's Exhibit VV: Unredacted copy of the Respondent's May 18, 2009, Reply Brief, with attachments.

   c. Respondent's Exhibit WW: Unredacted copy of Respondent Mahendra Kumar Mahajan, M.D.'s May 11, 2009, Response to the Hearing Examiner's April 29, 2009 Entry, with attachments.

4. During the hearing, Dr. Mahajan testified at length; however, English is not Dr. Mahajan's first language, he was clearly very nervous, and he was at times difficult to understand. At the end of the hearing, Dr. Mahajan requested an opportunity to review the transcript of his testimony and provide an errata. The Hearing Examiner granted the request with the proviso that the Hearing Examiner retained the authority to accept or reject any of the corrections offered in Dr. Mahajan's errata. (Hearing Transcript at 933-937)

   Following his review of the transcript and Dr. Mahajan's errata, the Hearing Examiner determined that all of his suggested changes are acceptable. Accordingly, Dr. Mahajan's errata is attached to and incorporated within the official transcript errata and should be read in conjunction with Dr. Mahajan's testimony in Hearing Transcript Volume II.

5. In all instances where Dr. Mahajan is quoted in the Summary of the Evidence, below, the quotation includes the changes addressed in Dr. Mahajan's errata.

SUMMARY OF THE EVIDENCE

All exhibits and the transcript 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

Mahendra Kumar Mahajan, M.D.

1. Mahendra Kumar Mahajan, M.D., obtained his medical degree in 1971 from the Banaras Hindu University in Varanasi, India. Following that, he trained and served in hospitals in New Delhi. After moving to the United Kingdom, Dr. Mahajan became interested in psychiatry, and participated in a psychiatry residency at the University of Newcastle. After one and one-half years, he became a registrar at North Tees General Hospital in Stockton-on-Tees. (Hearing Transcript [Tr.] at 327-331; Respondent's Exhibit [Resp. Ex.] BB)

2. Dr. Mahajan testified that, in January 1977, he moved to the United States and entered a residency in psychiatry at the Ohio State University. After that, Dr. Mahajan completed a fellowship in child psychiatry at the same institution. (Tr. at 332-335; Resp. Ex. BB)

3. Dr. Mahajan is certified in psychiatry by the American Board of Psychiatry and Neurology [ABPN], and also holds ABPN certification in the subspecialties of child and adolescent psychiatry and forensic psychiatry. (Resp. Ex. BB)

4. Since 1982, Dr. Mahajan has been engaged in the private practice of child and adolescent psychiatry, as well as adult psychiatry, in Dayton, Ohio. Currently, Dr. Mahajan practices solely outpatient psychiatry. Dr. Mahajan testified that his wife, who is a licensed therapist, practices with him. (Tr. at 326; Resp. Ex. BB) In addition, he has held the following positions:

   - From 1985 to 1998, he served as medical director of the Child and Adolescent Psychiatric Inpatient Unit at Dettmer Hospital in Troy, Ohio.
   - From 1997 to 1998, he served as medical director of the Adult Mental Health Inpatient Unit at Good Samaritan Hospital.
   - From 1999 to 2004, he served as medical director of the Child and Adolescent Psychiatric Inpatient Unit at Upper Valley Medical Center in Troy.

   (Resp. Ex. BB) Further, Dr. Mahajan has served as a psychiatric consultant at various places in his community, including Miami County schools, a nursing home, and a VA medical center. (Resp. Ex. BB)

5. Dr. Mahajan testified that he holds current medical licenses in Ohio and Indiana, and an inactive license in Florida. (Tr. at 337)

6. Dr. Mahajan testified that, between 2000 and 2006 he had had approximately 3,400 active patient charts, including adult patients as well as children and adolescents. Dr. Mahajan further

testified that he sees patients from 9:00 a.m. until 7:00 p.m., and sees about 30 to 35 per day. With respect to new patient initial visits, Dr. Mahajan testified that he usually sees the patient for 20 to 25 minutes, but that he will see them for as long as it takes. (Tr. at 384-385, 565-570)

State's Expert Witness: Robert A. Karp, M.D.

7. Robert A. Karp, M.D., testified as an expert witness on behalf of the State. Dr. Karp obtained his medical degree in 1982 from the Chicago Medical School, Finch University of the Health Sciences, in Chicago, Illinois. In 1986, he completed a four-year psychiatry residency at Northwestern University, Northwestern Memorial Hospital, in Chicago. Dr. Karp is a diplomate of the American Board of Psychiatry and Neurology and a fellow of the American Psychiatric Association. (Tr. at 20-21, 25; States Exhibit [St. Ex.] 11)

8. Since 2007, Dr. Karp has worked as a psychiatrist in the Forensic Unit at Northcoast Behavioral Healthcare [Northcoast Toledo], a state hospital in Toledo, Ohio. In addition to his position at Northcoast Toledo, Dr. Karp is a Clinical Assistant Professor at the University of Toledo College of Medicine, Department of Psychiatry. (Tr. at 17-28; St. Ex. 11)

   Dr. Karp further testified that, prior to working for Northcoast Toledo, he had spent approximately 20 years working as medical director of four community mental health centers, serving inpatients. Dr. Karp testified that, during that time, he treated thousands of patients including children and adolescents. Moreover, Dr. Karp testified that, although he is does not hold special qualifications in child and adolescent psychiatry, he has treated between 500 and 800 children and adolescents during his service at rural community mental health centers. Nevertheless, Dr. Karp testified that he does not hold himself out as an expert in child and adolescent psychiatry. (Tr. at 21-24, 202-203, 287; St. Ex. 11)

9. Dr. Karp acknowledged that, since 1991, he has not operated his own private practice of psychiatry. (Tr. at 201-202)

10. Dr. Karp's professional background and credentials are more fully set forth in his curriculum vitae and testimony. (St. Ex. 11)

<u>Dr. Karp's Review</u>

11. Dr. Karp testified that he had been asked by the Board to review the medical records for Patients 1 through 10, and to address two questions:

    > The first question was whether or not the records met a minimal standard of care regarding the choice and use of medications. The second question was whether or not the medical records met the minimal standard of care in the provision of care that a reasonable or average practitioner would deliver to patients in similar circumstances.

    (Tr. at 31-32)

12. Dr. Karp testified that Dr. Gutheil is one of the leading experts in the United States concerning the interrelationship between psychiatry and the law. Nevertheless, Dr. Karp testified that he disagrees with Dr. Gutheil's opinion that Dr. Mahajan's care, treatment, and medical recordkeeping with respect to Patients 1 through 10 complied with the standard of care. (Tr. at 195-198)

Respondent's Expert Witness: Thomas Gutheil, M.D.

13. Thomas Gutheil, M.D., obtained his medical degree in 1967 from Harvard Medical School. He completed an internship in pediatrics at Bronx Municipal Hospital Center in New York City in 1968. From 1968 through 1971, Dr. Gutheil participated in a residency in psychiatry at Massachusetts Mental Health Center [MMHC] in Boston, and was a clinical fellow in psychiatry at Harvard Medical School. Dr. Gutheil is currently a Professor of Psychiatry at Beth Israel-Deaconess Medical Center, Harvard Medical School, and has also been associated with MMHC for 34 years. He was certified in Psychiatry by the ABPN in 1974, by the American Board of Forensic Psychiatry in 1982, and obtained additional qualifications in forensic psychiatry from the ABPN in 1994, which he recertified in 2003. (Resp. Ex. FF)

    Dr. Gutheil's background and credentials, including his publications, are more fully set forth in his curriculum vitae and testimony. (Resp. Ex. FF)

<u>Dr. Gutheil's Review</u>

14. Dr. Gutheil testified that, in preparation for his testimony, he had reviewed the medical records for Patients 1 through 10, the Board's November 14, 2007, notice of opportunity for hearing sent to Dr. Mahajan [Notice], and Dr. Karp's report. (Tr. at 682, 751-752) In addition, Dr. Gutheil testified:

    > Well, I want to be sure it's clear that in relation to the records, the medical records of the patients, *they also include Dr. Mahajan's responses to some of the charges from the Board in there with the record itself.* So that's arguably a separate issue but it was combined with the record material.

    (Tr. at 682-683) (Emphasis added)

    Dr. Gutheil identified State's Exhibits 15A through 15J as Dr. Mahajan's responses to the Board's allegations for Patients 1 through 10, respectively. (Tr. at 750-754)

15. When asked if he would agree that his report would have been quite different without having had Dr. Mahajan's responses to the allegations presented along with the medical records and other material, Dr. Gutheil responded:

    > I think it seems like a perfectly good question, and the answer is I don't know. First of all, I read whatever I'm given and ask in my contract with the attorney for everything. It says send me all stuff. Sometimes they do; sometimes they don't.

> Number two, I can't predict what aspects of what part of the report would be different without this content. And having read it, I can't ignore it, so I'm kind of in a box about that.

(Tr. at 798)

16. Dr. Mahajan's responses to the Board's allegations as provided to Dr. Gutheil are very similar to the opinions Dr. Mahajan provided in his expert witness report. (St. Ex. 15A-15J; Resp. Ex. AA)

Respondent's Expert Witness: Daniel S. Polster, M.D.

17. Daniel S. Polster, M.D., obtained his medical degree in 1996 from the Case Western Reserve University School of Medicine [CWRU] in Cleveland, Ohio. From 1996 through 2000, Dr. Polster completed an internship and residency in psychiatry at University Hospitals of Cleveland, including serving as Chief Resident from 1999 through 2000. Dr. Polster was certified in psychiatry by the ABPN in 2001. (Resp. Ex. HH)

    Since 2000, Dr. Polster has served as a Clinical Instructor in the Department of Psychiatry at CWRU, and as a staff psychiatrist at Parma Community General Hospital. In addition, Dr. Polster testified that, since 2000, he has also seen many adult patients in his private practice. Dr. Polster testified that his youngest patients are 18, and that he does not accept patients younger than 18. (Resp. Ex. HH; Tr. at 817-818, 839-841)

18. Dr. Polster has been licensed to practice medicine in Ohio since 1997. (Resp. Ex. HH)

19. Dr. Polster's background and credentials are set forth more fully in his curriculum vitae. (Resp. Ex. HH)

<u>Dr. Polster's Review</u>

20. In his report, Dr. Polster stated that, in forming his opinions in this matter, he had reviewed the ten patient charts, Dr. Karp's report, Dr. Mahajan's responses to the allegations, and "Dr. Mahajan's further responses to questions [Dr. Polster] posed about these patients." (Resp. Ex. GG at 1)

21. Dr. Polster testified that, during his review of the patient records, he had submitted written questions to Dr. Mahajan and Dr. Mahajan provided written responses to those questions. Dr. Polster's questions and Dr. Mahajan's answers were admitted to the record as State's Exhibits 16A and 16B, respectively. (Tr. at 846)

    Dr. Polster testified that, had he not been able to question Dr. Mahajan, his report "probably would have been less complete," although "it is difficult to say what [he] would have done without that information." (Tr. at 846-848)

Psychiatric Medical Documentation, in General

Opinion of Dr. Karp

22. Dr. Karp testified concerning what he expects to see in a psychiatric patient medical record:

> The minimal thing that I look for is a complete and legible prescription record which reflects all medications prescribed, their amounts, and their refills, with no unexplained gaps from the inception of treatment to the end of treatment.[1] In terms of other records that I expect to find, these include an initial evaluation, which to some degree should conform to expected guidelines in the performance of child, adolescent, and adult evaluations as, for example, reflected in practice parameters or guidelines published by the American Academy of Child Psychiatry and the American Psychiatric Association.
>
> I certainly do not expect to see an initial evaluation including all elements as recommended in the practice parameters or guidelines. But I do expect to see some semblance of understanding of the patient's presenting problem, its development over time, sufficient to formulate a reasonable psychiatric diagnosis which then should be associated with an initial and reasonable treatment plan.
>
> In addition to the initial evaluation, I expect to find all notes, titled something, whether it's a progress note or some other kind of assessment, but with the patient's name or some identification that is unique to a specific patient and signed by the physician as well as dated and if inpatient or outpatient time.
>
> I expect to find on a progress note the basic elements of the encounter chronologically arranged and specific to that encounter. I expect to find in a medical record the treatments that were rendered and their effect. I also expect to find that when a treatment is delivered, modified, changed, or discontinued, that there is some rationale or explanation for the change and its effect in terms of the follow-up or the next note.
>
> I do not expect, in terms of a minimal standard, an awful lot of verbiage. An example might be among my internal medical colleagues in the military and outpatient who have described—who have identified a problem with elevated cholesterol, specify that in their record as simply as arrow going up, the number of cholesterol, and a prescription of medication. And on follow-up reports, the internist checking the follow-up cholesterol and commenting whether or not that was under sufficient control with their current treatment.

---

[1] Dr. Karp added that, because he could find no prescription logs in the medical records, he had been unable to determine whether there had been any gaps or overlaps in Dr. Mahajan's prescribing to Patients 1 through 10. (Tr. at 71)

> In addition to the data that I expect to be contained, I expect that the majority of the record will be legible. I don't expect necessarily when it comes to a doctor that all records will be legible, but the majority will be, and that the legibility will be sufficient to understand the treatment that was provided.
>
> In addition to the records that I've talked about so far or the material contained in the records, I have several other expectations. For example, when it comes to a child and adolescent, I expect there to be, first, a reasonable detailing of the patient's developmental histories and milestones, and secondly, some reflection in the record of the patient—that is, the child or adolescent's own view of their illness and symptoms over time, not simply [the] parent.
>
> Finally, I expect in terms of comprehensiveness that when problems ensue in treatment—and the truth is, in the work of a psychiatrist, there are always going to be some issues or problems—that if a problem comes up, it is identified in some way and discussed. For example, if the patient is experiencing a sleep disturbance or racing thoughts, that the symptoms do not appear out of context; that is, there must be some context provided, some narrative, if you will, that describes where in the place of things, where in the place of the patient's symptoms, history, illness, and treatment the particular symptom occurs. It occurs in relation to what? Those are my minimal expectations of the medical record.

(Tr. at 41-45)

23. With reference to Dr. Mahajan's medical recordkeeping, Dr. Karp stated in his report:

> In general, Dr. Mahajan's notes each encompass between 5-15 words, and very rarely include any subjective findings. The physician frequently uses the phrase: "Overall doing good," but rarely includes any specifics. * * * Rarely does he document a mental status examination, and only the inpatient records indicate a fairly comprehensive MSE. When Dr. Mahajan documents a MSE, he does so by checking or circling elements of the pre-formatted progress notes, and rarely addresses all elements of the MSE, especially in following-up his many changes of medications.
>
> * * *
>
> No notes are written in the standard SOAP format. However, had Dr. Mahajan actually used, in full, his pre-formatted notes, these would have sufficed as archival documents and as records of ongoing treatment.

(St. Ex. 12 at 2)

24. Dr. Karp was cross-examined extensively concerning whether a physician could provide good medical care without appropriate charting. (Tr. at 261-267) In that regard, Dr. Karp testified:

> I have a hard time with that because good charting or at least a minimal charting is part of good medical care. Good medical care is not simply performance; it is also—it also requires documentation. If you were to tell me that the person met—the charting wasn't good but met the minimal standard of care and they did perform well, then I'd have to say they delivered good medical care.

(Tr. at 267)

Opinion of Dr. Gutheil

25. Dr. Gutheil testified that the standards for documentation for outpatient office practice are less rigorous than for inpatient practice. Dr. Gutheil further testified that no practitioner can write down everything that happens during a patient visit. (Tr. at 692-693, 708-712)

26. Dr. Gutheil testified that listing only positive findings is common practice in office psychiatry. He further testified that Dr. Mahajan frequently documented the patients' sleeping and eating, "which are rough indicators of the effect of the stimulant medication." Moreover, Dr. Gutheil testified that, "in an ongoing office practice, to say 'stable' is really to summarize the patient's condition and further details are not required unless something of significance develops." (Tr. at 697)

27. Dr. Gutheil testified that, when dealing with ADHD, which most of the patients had, questions concerning home and school behavior are most important. Dr. Gutheil testified that Dr. Mahajan did a good job documenting such behavior for those patients. (Tr. at 700-701)

28. Dr. Gutheil testified that many records show that the patient improved. Dr. Gutheil testified that that is important to consider because it is evidence, though not proof, that something is being done correctly. Moreover, Dr. Gutheil testified that he saw no evidence in any of the patient charts that any patient was harmed by Dr. Mahajan's treatment. (Tr. at 702-703)

Opinion of Dr. Polster

29. Dr. Polster testified concerning Dr. Karp's report:

> [T]he thing that struck me about Dr. Karp's report—it was a very well written report, but it's focused really on the issues of documentation, what was missing from the chart, what wasn't provided in the chart, as opposed to the quality of the actual medical care. And he thought it was lacking—you know, if it's going to be critical of Dr. Mahajan's care, it lacked actual criticism of the care that was provided but rather the documentation.

(Tr. at 827)

30. Dr. Polster disagreed with Dr. Karp's opinion that you cannot provide good medical care without good charting. Dr. Polster testified that there are many excellent physicians who provide good medical care "but with all ranges of charting," particularly in the past when there was less focus on documentation. (Tr. at 825) Dr. Polster further testified:

> You know, certainly we live in a world now in which we attempt to practice defensive medicine, which means that we chart—we tend to chart compulsively. I do, and many physicians will chart compulsively, probably in excess of what is necessary, but that's the result of having to—having our charts called into question and having to answer questions about why we did the things that we did do. I certainly know I've inherited patients in my own practice and have received them from older physicians whose chart notes are scant at best. One line here, one line there. But I have no doubt that they provided very good medical care and the patients would attest to that.

(Tr. at 825-826)

31. Moreover, Dr. Polster stated in his report:

> I am concerned with equating good "medico-legal" documentation with acceptable medical care. Although [Dr. Mahajan's] documentation can be concerning when it comes to the modern practice of "defensive" medicine, it was more likely to be acceptable in years past and, in my opinion, one should not judge Dr. Mahajan's skills as a practitioner based on his skills as a record-keeper.

(Resp. Ex. GG at 8)

Testimony and Opinion of Dr. Mahajan

32. Dr. Mahajan testified concerning his medical documentation:

> About 2000, documentation standards started increasing. Whenever I found out how, what—I improved it. But a practitioner who has to do in 15 minutes evaluation, has to provide follow-up. Psychiatrists before used to do the evaluation, then they would direct, "you do therapy, you do this." Now therapists, counselors, high school trained counselors, they send us the patients. A lot of mistakes. Internists, they are treating them—when it becomes complicated, refer to a child psychiatrist. So environment has become difficult.
>
> Insurance companies, twice they came [to my office for audits]. Whatever feedback they gave, we improved. Improved in the documentation. I have it here. And from 2000 until now, constantly I've been looking at how can I improve the quality. Quality—not somebody comes and looks at it, but it is how do I find out more information when I have to see them in every two

> months because when they come this—and how do I improve the documentation? I have done it. I have done whatever has been told.
>
> Look at—if somebody documents too much, that's where I will have a question, how can you do it in private practice in ten minutes? You cannot do a good job. If your documentation is scanty, that means you are thinking. But it has to be logical. Now standard documentation is poor quality. That's what I want to say, because my way of looking at it is medical students document so much. They don't know much. Look at real pattern in the private practices. Their documentation is scantier.

(Tr. at 378-379; see also Resp. Ex. MM) Dr. Mahajan further testified that he believes his documentation compares well with that of other physicians. (Tr. at 379-380)

Legibility of Dr. Mahajan's Medical Records for Patients 1 through 10

Dr. Karp

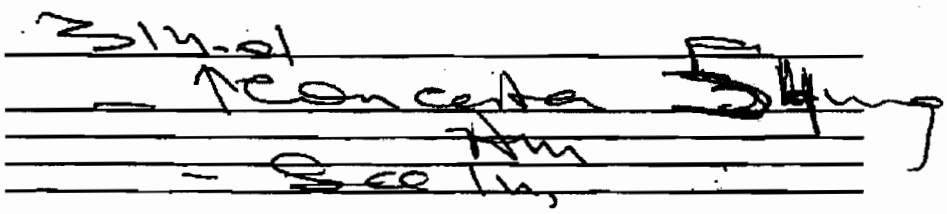
33. Dr. Karp noted that Dr. Mahajan's progress notes are handwritten, and that he found that "most are only partly legible * * *." (St. Ex. 12 at 2) Elsewhere in his report, Dr. Karp rated the quality of the progress notes, giving a score of zero (with "5" being excellent and "1" being poor) for the category "If handwritten, all notes legible." (St. Ex. 12 at 9)

34. It is clear that Dr. Karp struggled with Dr. Mahajan's handwriting. For example:

- Referring to Patient 1's visit on January 16, 2002, Dr. Karp testified that Dr. Mahajan had increased Patient 1's dose of Concerta. Dr. Karp found that Concerta was a reasonable medication, but testified that he had had trouble reading the dose. Dr. Karp further testified that it appears to say 34 mg; however, Concerta is available only in 18 mg increments, so 34 mg could not be correct. (Tr. at 51; St. Ex. 1 at 105)

- Dr. Mahajan responded that one can easily read that the dose of Concerta is 54 mg, which is a multiple of 18 and a dose that is available. (Tr. at 555-556; St. Ex. 1 at 105; Resp. Ex. A at 21)

- The relevant part of Dr. Mahajan's January 16, 2002, progress note is excerpted below. This excerpt in the printed Report and Recommendation closely approximates the actual size of the printed note in State's Exhibit 1 at page 105:



(St. Ex. 1 at 105)

The Hearing Examiner agrees with Dr. Mahajan's statement that the 54 mg dose is easily discernible. The Hearing Examiner also agrees with Dr. Karp's assessment that Dr. Mahajan's handwriting can be difficult to read and, as will be reflected later in this report, some notations are illegible.

Opinion of Dr. Gutheil

35. With respect to the legibility of Dr. Mahajan's handwriting, Dr. Gutheil testified that, although it takes some getting used to, Dr. Mahajan's handwriting becomes easier to read after spending some time with it. (Tr. at 694)

Testimony of Dr. Mahajan

36. Dr. Mahajan testified that his handwriting is affected by a nerve condition in his right hand. (Tr. at 554)

Patients 1 through 10

37. The allegations in this matter concern Dr. Mahajan's care and treatment of 10 patients. Of those patients, Patients 3 and 4 are adults. All other patients were children or adolescents during the relevant time period. (St. Ex. 1 – 10)

The relevant time period for this matter, as set forth in the November 14, 2007, notice of opportunity for hearing [Notice] is "[f]rom in or about 2000 to in or about 2006." (St. Ex. 14A)

Patient 1

38. Patient 1, a male born in 1994, first visited Dr. Mahajan on August 23, 2001. At that time he was six years old. The latest visit included in the State's copy of the medical record occurred on July 11, 2006. (St. Ex. 1)

Patient 1's Initial Visit on August 23, 2001

39. Dr. Mahajan's medical record for Patient 1's first visit includes the following:

- A Child Information questionnaire completed by Patient 1's mother. Among other things, she indicated that the purpose of the consultation was"[t]o go over testing results from psychologist." She also answered questions concerning such things as Patient 1's developmental history, including his ages when he crawled (5 months) and sat without support (11 months); health history, in which she noted only foot surgery in 1999 and bladder surgery in 2001 (no childhood illnesses are listed); school information; behavioral symptoms, which she listed as undereating, bed wetting,

sleep disturbance, hyperactive, and easily distracted at present, and depression in the past; family history of depression; (St. Ex. 1 at 115-123)

- A completed 20-question questionnaire that asks whether and how frequently Patient 1 experienced certain things during the previous week, such as "I felt like I couldn't pay attention to what I was doing last week." (The response was "3" for "Most or all of the time [5-7days].") In answer to, "I felt scared this week," the response was "1" for "Some or a little of the time [1-2 days]". (St. Ex. 1 at 125)

- A completed 48-question questionnaire labeled "CPRS-48" that instructs the parent to "[r]ead each item below carefully and decide how much [the parent thinks his or her] child has been bothered by the problem during the past month." The parent responds by circling one of four choices, Zero for "Not at All," one for "Just a Little," two for "Pretty Much," and three for "Very Much." For example, Patient 1's mother circled zero for item 20, "Quarrelsome," and two for item 21, "Pouts and sulks." (St. Ex. 1 at 127)

- Report of a Wechsler Intelligence Scales for Children-III and a Wechsler Individual Achievement Test administered by a psychologist for the school district on March 15 and April 12, 2001. The results do not appear to be complete: it consists only of Section IV - General Intelligence, and Section III – Academic Performance, Educational Functioning, Curriculum. (St. Ex. 1 at 201-205)

- Miscellaneous forms (insurance, et cetera). (St. Ex. 1 at 5, 25-26)

- Dr. Mahajan's progress note for the first visit. (St. Ex. 1 at 113)

In addition, Dr. Mahajan's medical record for Patient 1 includes a number of school-related documents, most of which post-date Patient 1's first visit. (St. Ex. 1 at 133-227)

40. Dr. Mahajan's Psychiatric Initial Evaluation Visit for Patient 1, dated August 23, 2001, is reproduced below. The patient's name has been redacted and the size of the document has been slightly reduced to fit the page. In the first section of the note reproduced below, labeled Presenting Problems, Dr. Mahajan recorded: "6 yrs – old – ADHD[,] unable to sit still[,] hyper." In the next section, labeled Mental Status Exam, Dr. Mahajan simply drew a line across all the categories[2] indicating "Not Within Normal Limits (explain)" and wrote, "Fidgety." Dr. Mahajan checked a box indicating that Patient 1 was not a danger to himself or others. His diagnosis, noted in the space for Axis I, was "314.01."[3] In the space for Plan, Dr. Mahajan recorded "Concerta 18 mg [one tablet] AM" and "See 6 wks." The quantity of tablets and number of refills of medication prescribed were not recorded. "Yes" and "No" checkboxes next to a statement that "Patient/Guardian understands and consents to medication" were left blank. (St. Ex. 1 at 113)

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[2] The categories listed are: personal hygiene, speech, thought process, description of thought, judgment/insights, mood, and affect. (St. Ex. 1 at 113)

[3] Dr. Karp testified that 314.01 is the DSM code for Attention Deficit Hyperactivity Disorder [ADHD]. (Tr. at 83)

Mahendra K. Mahajan, M.D.
Psychiatric Initial Evaluation Visit

Name: [Patient 1] Date: 8/23/07 Time In/Out:

Presenting Problems: 6 yrs - old - ADHD
unable to sit still
hyper.

Mental Status Exam:

	Within Normal Limits	Not Within Normal Limits (explain)
Personal Hygiene:		
Speech:		
Thought Process:		
Description of Thought:		Fidgety
Judgement / Insights:		
Mood:		
Affect:		

Is patient a danger to self or others? ☐ Yes ☒ No If Yes please explain:

Diagnosis:

Axis I	Axis II	Axis III	Axis IV	Axis V
314				

Plan: - Concerta 18 mgt A
- See 4 [illegible]

Medications Prescribed:

Medication Name	Dose (Mg)	Dosing Schedule	Count #	# of Refills
1.				
2.				
3.				
4.				
5.				
6.				

Samples Given: ☐ Yes ☐ No If Yes please list:

Patient / Guardian understands and consents to medications. ☐ Yes ☐ No

Next Visit:	One Month	Two Months	Three Months	Other:

Physician's Name: Mahendra K. Mahajan, M.D. Physicians Signature:

113

(St. Ex. 1 at 113)

Testimony of Dr. Mahajan Concerning Patient 1's Initial Visit

41. Although the notations in the chart do not reflect the number of tablets prescribed, Dr. Mahajan testified that he had prescribed 30 tablets of Concerta 18 mg to Patient 1 during Patient 1's first visit on August 23, 2001. When asked how he knows that, Dr. Mahajan replied, "Because there is a system there." The system was not described. (Tr. at 594-595; St. Ex. 1 at 113)

September 20, 2001, Visit

42. Dr. Mahajan's progress note for Patient 1's second visit on September 20, 2001, states "Overall doing well," "Sleeping [checkmark] eating [checkmark],"[4] and that there were no new problems. He documented his diagnosis as "314.01," and noted that he would "cont. Concerta 18 mg AM." He checked boxes indicating that Patient 1 was not a danger to himself or others, that no samples were given, and that "Patient/Guardian understands and consents to medications." Finally, he noted that he would see Patient 1 again in two months, and signed the note. (St. Ex. 1 at 111)

November 15, 2001, Visit

43. With respect to Patient 1's November 15, 2001, visit, Dr. Mahajan noted that Patient 1 came with his grandmother and had "hit another kid." Under Current (new) Medical Problems, Dr. Mahajan wrote, "None new. 2F," the latter evidently referring to grades. The diagnosis is "314.01." Under Plan, Dr. Mahajan wrote "↑ Concerta 36 mg AM" and, although difficult to decipher, the Hearing Examiner believes the note says "G.M. [grandmother?] states he is not giving her meds" and "See 1m." In the area for the Mental Status Exam, Dr. Mahajan wrote in the Not Within Normal Limits section, "hyper—." He checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, and that "Patient/Guardian understands and consents to medications." (St. Ex. 1 at 109) (Emphasis in original)

December 14, 2001, Visit

44. With respect to Patient 1's December 14, 2001, visit, Dr. Mahajan recorded that Patient 1 was taking his medication, eating and sleeping okay, and "doing well at home, but school grades poor, beh. [behavior?] bad." Dr. Mahajan noted a diagnosis of "314.01," "Concerta 36 mg AM," and to see Patient 1 again in one month. He checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, and that "Patient/Guardian understands and consents to medications." (St. Ex. 1 at 107)

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[4] For the remainder of this report, a checkmark used in this sense will be interpreted to simply mean "okay."

January 16, 2002, Visit

45. With respect to Patient 1's January 16, 2002, visit, under Current Presenting Problem, Dr. Mahajan wrote "[illegible] – hyper" and eating and sleeping okay. Dr. Mahajan further noted there were no new medical problems, a diagnosis of "314.01," "↑ Concerta 54 mg AM," "64 lb," and to see Patient 1 in one month.[5] In the area for the Mental Status Exam, Dr. Mahajan drew a line through all the spaces in the Within Normal Limits section and wrote in the Not Within Normal Limits section, "hyper." Finally, he checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, and that "Patient/Guardian understands and consents to medications." (St. Ex. 1 at 105)

February 13, 2002, Visit

46. On his progress note for Patient 1's February 13, 2002, visit, Dr. Mahajan wrote "Overall doing well." He indicated that Patient 1 was eating and sleeping okay, and that there were no new medical problems. He also wrote "school problem not doing work." His diagnosis was "314.01." Dr. Mahajan discontinued the Concerta and prescribed "Metadate CD 40 mg AM" and to see Patient 1 again in one month. In the Mental Status Exam area, Dr. Mahajan drew a line through the spaces under Within Normal Limits and wrote "Fidgety." He checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, that there is no chemical dependency or abuse issue, and that "Patient/Guardian understands and consents to medications." (St. Ex. 1 at 103) (Emphasis in original)

Dr. Karp's Opinion Concerning this Visit

47. Dr. Karp testified concerning Dr. Mahajan's note for Patient 1's February 13, 2002, visit:

> Under current presenting problem of Dr. Mahajan's template, it basically says overall doing well, and then the Concerta is discontinued. And below that is written another medication for ADHD, * * * [Metadate CD], with no explanation for the change.
>
> There follows in this and virtually every other patient in the records that are reviewed changes that almost seem ad hoc in the sense that they often follow statements that overall the patient is doing well, and then the medication disappears, is deleted, discontinued, modified, changed, or changed to another medication.
>
> As an expert, or at least as someone who practices psychiatry, I personally found it very difficult to go through this record and establish in my own mind a reasonable coherency to the treatment as represented in the record.

(Tr. at 51-52; See St. Ex. 1 at 103)

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[5] Note that, with reference to the milligram dose of Concerta, it appears that Dr. Mahajan originally wrote "36" and overwrote that with "54." Dr. Karp clearly had difficulty reading the note. (St. Ex. 1 at 105; Tr. at 51, 555-556)

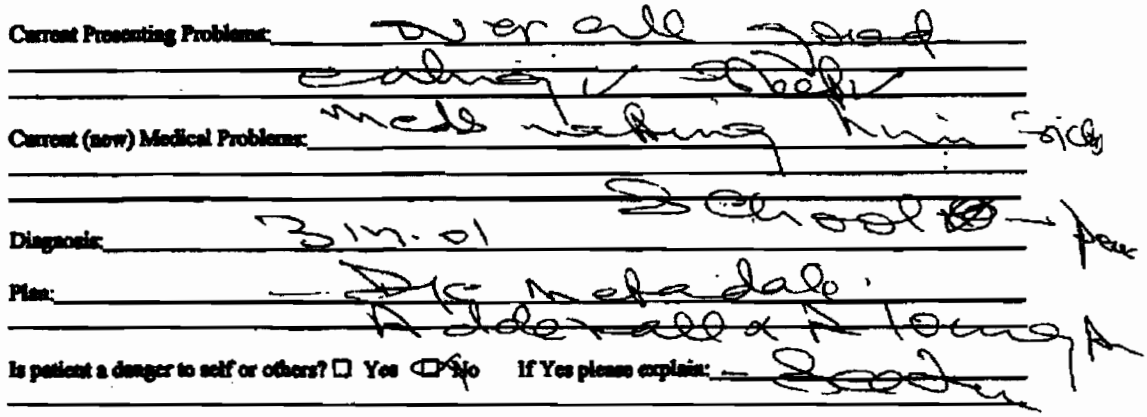
March 13, 2002, Visit

48. Patient 1 next visited Dr. Mahajan on March 13, 2002. Dr. Mahajan documented "Overall doing good," eating and sleeping okay," "*meds making him sick*," and "school – poor." (Emphasis added.) Dr. Mahajan further noted "314.01" as the diagnosis, that he discontinued Metadate, and that he placed Patient 1 on Adderall XR 10 mg AM. He also drew a line through all the spaces under Within Normal Limits in the Mental Status Exam section, and documented that he would see Patient 1 again in two months. Finally, he checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, that there is no chemical dependency or abuse issue, and that "Patient/Guardian understands and consents to medications." (St. Ex. 1 at 101)

Dr. Karp's Opinion Concerning this Visit

49. Dr. Karp testified concerning Patient 1's March 13, 2002, visit that Patient 1 was doing well overall; nevertheless, Metadate was discontinued and Adderall XR 10 mg added. Dr. Karp did not testify concerning the statement on the note, "meds making him sick." (Tr. at 52-53; St. Ex. 1 at 101)

50. An excerpt from the March 13, 2002, progress note follows. It is slightly reduced in size from the original printed page in State's Exhibit 1, page 101:


Current Presenting Problems:
Current (now) Medical Problems:
Diagnosis:
Plan:
Is patient a danger to self or others? ☐ Yes ☒ No If Yes please explain:

(St. Ex. 1 at 101)

While Dr. Mahajan's handwriting is not easy to read, the Hearing Examiner finds that the phrase, "meds making him sick," is legible on the line following "Current (new) Medical Problems."

Dr. Mahajan's Opinion Concerning the February 13 and March 13, 2002, Visits

51. In his written report, Dr. Mahajan stated: "On 2-13-02, a change was made from Concerta to Metadate due to an insurance/co-pay issue;[6] however, it was discontinued on 3-13-02 due to the side effects noted. The patient was then placed on Adderall XR 10 mg." (Resp. Ex. AA at 4)

52. Concerning the issue of changing medications and documenting such changes for Patient 1's February 13 and March 13, 2002, visits, Dr. Mahajan offered the following confusing testimony:

> Now, [Patient 1] had Concerta—went from Concerta to Metadate. We have to look at the changes in economy and what the formulary says. Metadate was coming out at that time with their drug. Heavy advertisement. They were indicating that their Metadate lasts for 12 hours, as good as Concerta, because Concerta was the main competition.
>
> This mother had heard it. And I don't know how she was going to, but there was a demand. I did not see anything wrong with it, but I knew after 4:00 o'clock it will not work. But I changed it.
>
> * * *
>
> If I had to document this, I write—spend my time that I could spend with the patient explaining them about the medication. They don't have the money. They have heard about this. There is advertisement in this. That's why we are changing to Metadate. What good is that? Okay. Now, that's one.
>
> Okay. Now, due to—it was insurance co-pay. However, it was discontinued on 3-13 visit due to side effects noted.[7] Now, here another issue I want to bring up about attention deficit disorder. Many times it is overlooked. Many times it is overdiagnosed. Many times it depends on the education, how much knowledge there is, what else—who's the counselor, what changes they are making.
>
> So they may start—mothers may look at the side effects. They may say focus on one, and child doesn't want to be on it. So, Mom, I'm nauseous. Okay. We'll go to the doctor and we'll get off of it. So she complained of it? No, I'm not for medication. So if they complain of it, I'm not pushing. They have to progress at their own pace.

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[6] The insurance/co-pay issue was not documented in the medical record. In fact, one might have surmised that the reason for the change had been the school problems referenced in the note. (St. Ex. 1 at 103)

[7] Dr. Mahajan documented on March 13, 2002, "Meds making him sick." (St. Ex. 1 at 101)

Demand, Adderall. Adderall company is pushing for it. So they are the same kind. Adderall and Concerta differences, they both release norepinephrine and Dopamine. Concerta pushes the Dopamine later. Therefore, motivation factor is less. General rule by child psychiatrists is [to] use Ritalin first. Later on you will need to use Dopamine, these kind of stimulants. So we tend to take it away, not first. But second line, we can use it.

Okay. * * * Adderall XR lasts for eight hours. Claimed by the drug companies, 12 hours. I'm speaker for that. I'm speaker for Concerta. I'm speaker for Metadate. But these drug reps, they only bring me cookies for my kids. They don't bring me anything. I speak only from my experience. I'm not going to prostitute that. So everything is based on my experience.

Now, patient was stable, improving on Adderall XR. This report of improvement is not based on my standard. It is based on their report. And there can be lots of doubts. Now, let me share with you, when they come, ADHD—September to October 15th, six weeks. You don't need to give them the medicine [early in the school year]. They usually do well. We hear the reports that he was getting grades—A grades and now he started failing. It is not that. It is in the first six weeks that happens. Then, next six weeks, they start denying the problem. Kids, oh, I didn't do it because I didn't want to. All right. But parents don't know. They give them benefit of doubt.

From January to May, we have to constantly increase the dosage because attention span, more is required and, therefore, more Ritalin is required, which is two milligrams per pound, around that. And otherwise it's one milligram per pound. More attention, we need more.

Now, so, this is the variation. At that time, I may take him to the high point, watch him more closely, but I'm not going by only what they are saying because I don't have a black glass. But at the same time, as long as it's not affecting the kid, I'm going to go with that.

Also, the evidence. We have to talk about the evidence base. Evidence base says without hurting the kid. And most evidence consists of for ADHD and obsessive compulsive. There's no other evidence definite for bipolar. There is for schizophrenia—for bipolar—because bipolar is I can be sleep deprived, I'll have mood swings.[8] I did not have my coffee, I can have mood swings. I don't want to jump on those diagnoses for the kids quickly unless I have the proof because they're not getting insurances later.

(Tr. at 415-420)

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[8] Obsessive-compulsive disorder, bipolar disorder, and schizophrenia were not at issue in Patient 1's case, according to the medical record. (St. Ex. 1)

May 16, 2002, Visit

53. Patient 1 next visited Dr. Mahajan on May 16, 2002. Dr. Mahajan documented "doing lot better" and "mild [illegible] problems." He checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, that there is no chemical dependency or abuse issue, and that "Patient/Guardian understands and consents to medications." He also drew a line through all the spaces under Within Normal Limits in the Mental Status Exam section. He continued Patient 1 on Adderall XR 10 mg. (St. Ex. 1 at 99)

June 21, 2002, Visit

54. With respect to Patient 1's visit on June 21, 2002, Dr. Mahajan documented "Doing well," school grades ↑," and "No side effects." He checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, that there is no chemical dependency or abuse issue, and that "Patient/Guardian understands and consents to medications." He also drew a line through all the spaces under Within Normal Limits in the Mental Status Exam section. He continued Patient 1 on Adderall XR 10 mg. (St. Ex. 1 at 97)

November 21, 2002, Visit

55. Five visits later, on November 21, 2002, Dr. Mahajan documented "gets poor attention in PM, otherwise better." Dr. Mahajan increased Patient 1's Adderall XR to "10 mg AM – noon." He checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, that there is no chemical dependency or abuse issue, that no tests were ordered, and that "Patient/Guardian understands and consents to medications." The page also contains a note dated December 2, 2002, that says "Clonidine 0.1 mg #30 1 RF."[9] (St. Ex. 1 at 87)

    In addition, two separate pages have notes dated December 4, 2002, indicating that the prescription for clonidine had been called in to a pharmacy. Neither contains a reason for the prescription. (St. Ex. 1 at 83, 85)

January 30, 2003, Visit and Subsequent Visits through but not Including October 21, 2004

56. Patient 1's next visit was January 30, 2003. Dr. Mahajan documented "overall doing well" and "good compliance [with] meds." He continued Patient 1 on Adderall XR 10 mg twice per day and noted "Clonidine 0.1 mg qh." He checked boxes indicating that Patient 1 is not a danger to himself or others, that no samples were given, that there is no chemical dependency or abuse issue, that no tests were ordered, and that "Patient/Guardian understands and consents to medications." (St. Ex. 1 at 81)

57. Dr. Mahajan continued Patient 1 on that regimen through October 21, 2004. Nevertheless, it is not clear why, following the September 11, 2003, visit, Dr. Mahajan stopped

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[9] For the clonidine prescription, Dr. Mahajan *did* document the quantity prescribed and number of refills. (St. Ex. 1 at 87)

documenting Adderall as "Adderall XR." For subsequent visits through October 21, 2004, Dr. Mahajan documented prescribing "Adderall 10 mg BID." There was no indication in the medical record that he intended to change the medication, so it is not clear whether he actually changed it or whether he (or an assistant, as some of the later documentation was written in different handwriting) simply stopped writing "XR." (St. Ex. 1 at 59-81)

October 21, 2004, Visit and Subsequent Visits through July 11, 2006

58. Dr. Mahajan's progress note for October 21, 2004, under Symptoms/Complaints, states, in legible handwriting: "Some poor grades. Taking second dose of Adderall @ 11:30 or 12:00 noon. Appetite fair-poor. Would like a note asking school to give medicine later. Meds wear off in PM." Dr. Mahajan continued the clonidine prescription, discontinued Adderall 10 mg BID, and prescribed Adderall XR 20 mg to be taken in the morning. He checked boxes indicating, among other things, that "Patient/Guardian understands and consents to medications." (St. Ex. 1 at 59)

59. Beginning with Patient 1's June 9, 2005, visit, Dr. Mahajan began documenting "Patient/Guardian understands/side effects and consents to medications" although the checkboxes were left blank for a few visits. (St. Ex. 1 at 35-47)

60. Dr. Mahajan continued Patient 1 on that regimen through July 11, 2006, the last visit documented in State's Exhibit 1. (St. Ex. 1 at 35-59)

Dr. Karp's Opinion Concerning the October 21, 2004, Visit

61. Dr. Karp testified regarding Patient 1's visit on October 21, 2004:

> The prescriptions on this page are perfectly reasonable for a patient with ADHD, but it is difficult to read why, for example, the doctor discontinued regular Adderall and placed the patient on XR. Again, that's reasonable in terms of prescription, but in terms of documenting the rationale, it's absent.

(Tr. at 49-50)

62. Dr. Karp did not address the statement on the progress note that the patient/guardian wanted a note for the school to give Patient 1 his second dose later in the day because "[m]eds wear off in PM." (St. Ex. 1 at 59)

Dr. Mahajan's Opinion Concerning the October 21, 2004, Visit

63. Dr. Mahajan testified that, during Patient 1's October 21, 2004, visit, he had learned that Patient 1

> was not taking medicines at all. And I asked them to get the medicines from school and destroy it, because otherwise there would be 30 pills sitting there. And I had to give them long-acting Adderall. It was total 20 milligrams and I

> gave XR 20 in the morning. And this is very easy to understand if you were a child psychiatrist.

(Tr. at 555)

Dr. Mahajan's Record for Patient 1, in General

64. For Patient 1's visits on June 2002, September 2003, May 2004, July 2004, February 2005, April 2005, June 2005, July 2005, September 2005, and November 2005, Dr. Mahajan documented that there were "No side effects" or "No SE." (St. Ex. 1 at 35-97)

Opinion of Dr. Karp Concerning Patient 1, in General

65. Dr. Karp testified:

> This is the case of a 6-year-old who presented with an apparent history of hyperactivity. Regarding Patient 1, I could not find any comprehensive psychiatric evaluation performed by the doctor, * * * no documentation or discussion of the patient's childhood or medical illnesses.
>
> I could not find any coherent prescription record. And in this case, Dr. Mahajan prescribed controlled substances. I had no idea reading record 1 the amounts of the prescriptions that he gave, and indeed some of the progress notes made it pretty hard for me to read even the name of the prescription, not to mention the amount or pattern of use.

(Tr. at 47)

66. Dr. Karp further testified that he could find no documentation of a comprehensive mental status examination in Patient 1's medical record. Dr. Karp testified concerning the importance of performing or documenting a mental status examination:

> [A] comment that I would make regarding my review of Patient 1 is a comment unique to psychiatry. In psychiatry, we do not have a laboratory evaluation that allows us to make a specific diagnosis such as ADHD. Part of the way that psychiatrists are universally taught to make a diagnosis is to create in some way a database through which we can extract enough information to make a sensible diagnosis. One of the central elements of such a diagnosis or a diagnostic assessment by a psychiatrist is the documentation of a fairly organized mental status examination.
>
> Commonly in outpatient practice a comprehensive mental status examination is not done routinely. It is done, however, or should be done at the beginning of treatment. Elements of the mental status should reflect and be reflected in the record when there is a change. For example, if a patient is reporting auditory hallucinations or voices for the first time during the course of treatment, it is

> critical that the mental status examination reflect the presence or absence of other psychiatric symptomatology. Why? Because it is the organization of the mental status and its reflect [sic] in the record that allows us and allows peer reviewers to understand whether or not, in fact, the psychiatric symptoms were part of a psychiatric diagnosis or perhaps something else.

(Tr. at 53-55)

Dr. Karp further testified concerning the purpose of a mental status examination:

> In psychiatry, the purpose of a mental status examination is the more or less exact equivalent of the physical examination provided by family physicians or internists. Its purpose is to document observations that elucidate in words psychopathology; that is, the observed signs or absence of signs of a mental illness. It is our physical examination, our CBC or chem panel, all rolled up into one and it provides the essential data critical to making a reasonable diagnosis.

(Tr. at 58)

Opinion of Dr. Mahajan Concerning Patient 1, in General

67. Dr. Mahajan disagreed with the allegation that he had failed to complete or document a psychiatric evaluation of Patient 1. Dr. Mahajan further testified that he had obtained a complete patient, social, and family history of the patient, as well as developmental history, past or current psychiatric history, and behavioral symptoms. (Tr. at 405)

68. Dr. Mahajan compared his documentation to that of a family physician. He said that a family physician could either write down "cough" as his or her diagnosis, or could dictate ten pages of notes. Dr. Mahajan asked, which is better? He testified to the effect that, ultimately, the documentation is for him, because he has to document what he is treating. (Tr. at 399-400)

69. When asked what his working diagnosis had been for Patient 1, Dr. Mahajan replied:

> Sir, it was ADHD, and I used the code because I did not create this code. There are reasons for these codes. One, it is privacy. I do not want my secretaries, everyone to know. It is a common practice, two. Third, [suppose] I write 314.01. .01, attention deficit, and word by word I am specifying, how has it helped me? Because for attention deficit, only essential function is poor attention span. Nothing else. It can't—then there are different parts to that. I'm trying to help me in that, too.
>
> When I write—any physician writes the diagnosis, we don't have any specific test. And whatever patient tells [us] is our blood test. So we have chances of being wrong 100 percent of the time. We have to be willing to change the

> diagnosis. We are not that big. We are guides, not gods. So it was written, but that's not written in blood, sir.

(Tr. at 408-409)

70. Dr. Mahajan testified that he did not fail to order or document baseline and/or follow-up laboratory evaluations of Patient 1; rather, in his clinical judgment, such testing was not indicated for Patient 1. (Tr. at 405-406)

71. With respect to Patient 1's first visit, when asked if the parent or guardian had been provided with any kind of medication consent form, Dr. Mahajan replied:

> On the first visit, intention is yes. Give it—I discuss it with them. Normally they're supposed to take it, sign it, and give it to the receptionist. Now, on the consent, I don't want it to make a—to make it a pressured process. After they hear it from me, they need to—whatever they want to do. Also, it is a trial basis medicine. Think about it, read about it. If you agree, then only sign it.

(Tr. at 595-596)

Next, Dr. Mahajan testified that he had obtained consent before he wrote the prescription for Concerta 18 mg. When asked if there is a written form in the medical record that reflects that, Dr. Mahajan replied, "Absolutely." After reviewing his chart, Dr. Mahajan referred to a consent form that was signed on May 22, 2003, approximately 21 months after the first visit. Dr. Mahajan acknowledged that he had erred to have waited so long to obtain consent. (Tr. at 596-599; St. Ex. 1 at 31)

In addition, near the top of the May 22, 2003, consent form, there are three columns that list classes of medications. None of the classes are checked, nor is any specific medication noted on the form. Dr. Mahajan testified that the appropriate class of medication would have been psychostimulants, and acknowledged that that had not been checked. (Tr. at 599-600; St. Ex. 1 at 31)

72. Dr. Mahajan testified that Patient 1 and his family gave informed consent with respect to the medications he prescribed. (Tr. at 411-412)

73. Dr. Mahajan testified that his care and treatment of Patient 1 did not violate Sections 4731.22(B)(2) or (6), Ohio Revised Code. (Tr. at 426-427)

74. Dr. Mahajan testified that he continues to see and treat Patient 1. Moreover, Dr. Mahajan noted that Patient 1's father provided a letter of support. (Resp. Ex. K at 13; Tr. at 388-389)

Opinion of Dr. Polster Concerning Patient 1, in General

75. Dr. Polster stated in his report: "There was NO NEED to draw any baseline or follow-up laboratory studies in this case." (Resp. Ex. GG at 1) (Emphasis in original)

76. Dr. Polster further stated in his report: "Dr. Mahajan frequently discusses medications and side effects with patients and families though his documentation of this can be brief. In this case, there is an informed consent form signed by the parent on May 22, 2003." (Resp. Ex. GG at 1)

Patient 2

1. Patient 2, a male born in 1992, first saw Dr. Mahajan on March 3, 2003. The last visit included in the State's copy of the medical record occurred on April 25, 2006. (St. Ex. 2 at 55, 131; Tr. at 74)

March 3, 2003, visit

2. Dr. Mahajan's medical record for Patient 2's first visit includes the following:

- A Child Information questionnaire completed by Patient 1's mother. Among other things, the mother reported that Patient 2 had been treated for ADHD and bipolar disorder, and had had a mental health hospitalization in 1999. She also reported that Patient 2 had been suicidal in the past and that he had reported hearing voices. Further, she reported that he was currently taking Ritalin and had been taking it for "about three to six months." In addition, he had taken Depakote and clonidine from 1999 through 2001, and Prozac in 1999. He had previously been treated by another psychiatrist from 1995 through 2003, "off and on last 1-03." She indicated that the purpose of Patient 2'a visit concerned "lack of attention, [and] severe behavioral issues." (St. Ex. 2 at 139-145)

  On the Behavioral Symptoms section of the questionnaire, she answered that Patient 2 currently exhibited the following: Mood swings, overeating, poor motivation and apathy, sleep disturbance ("wakes up at least once a night"), excessive sexual interest, stealing, unruly, aggressive, hyperactive, excessive worrying, depression, suspicious and distrustful, compulsions and repetitions, and easily distracted. (St. Ex. 2 at 139, 145)

- A completed 48-question questionnaire labeled "CPRS-48" that instructs the parent to "[r]ead each item below carefully and decide how much [the parent thinks his or her] child has been bothered by the problem during the past month." The parent responds by circling one of four choices, Zero for "Not at All," one for "Just a Little," two for "Pretty Much," and three for "Very Much." For example, Patient 1's mother circled three for item 20, "Quarrelsome," and one for item 21, "Pouts and sulks." (St. Ex. 2 at 149)

- A completed Child/Adolescent Intake Interview form. Under the Presenting Problems section, Dr. Mahajan or a staff member noted among other things that Patient 2 had been treated by another psychiatrist for five or six years for ADHD and bipolar disorder, that Patient 2 was off medications from June 2001 to June 2002, and that "[a]fter about 9 mths his behavior symptoms came back which are inability of

focus, defiance, and negative attention." Under Behavioral Disorders, a number of symptoms are checked in the areas for ADHD and "ODD."[10] It was noted that Patient 3 had for six months been taking Ritalin 20 mg twice per day, that "several med tried in past 6 mth," and that Patient 2 had previously taken Depakote and clonidine for approximately one year. A mental status exam was normal across the categories of General Information, Speech, Thought Process, and Judgment/Insights." Patient 2's affect was noted to be "[b]lended." Nothing was recorded in the categories of Description of Thought, Hallucinations, or Mood. (St. Ex. 2 at 133-137)

In addition, Dr. Mahajan or his staff documented, under Additional Pertinent Information, "10 yr old w male brought in for continuation of care. Has been on several different meds for ADHD & recently (2 yr ago) [diagnosed] as Bipolar. Currently displaying negative symptoms. He sees counselor at Wright Health & will continue." The Initial Diagnostic Impression was noted to be Axis I ADHD and Axis V 70. The Initial Recommendation[]" was "Psychiatric Evaluation." (St. Ex. 2 at 137)

- In his progress note for the first visit, Dr. Mahajan documented that Patient 2 was taking Ritalin 20 mg twice per day, "can't stay on task," "[illegible] nightmare," "no chores around house," and "school → still failing in reading." In the Mental Status Exam section he drew a line indicating normal through most or possibly all of the categories and wrote on the line for "Mood" a word that is essentially illegible but may say "distractible." Dr. Mahajan recorded the diagnosis as Axis I "314.01." He documented his plan to discontinue Ritalin and prescribed "Adderall XR 20 mg AM" and "Clonidine 0.1 mg ½ 4 PM." He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He instructed Patient 2 to see him again in one month. (St. Ex. 2 at 131)

- Miscellaneous forms (insurance, et cetera). (St. Ex. 2 at 23, 31-41)

March 31, 2003, visit

77. On his progress note for Patient 2's March 31, 2003, visit, Dr. Mahajan documented that Patient 2 was eating and sleeping okay, "Doubt progress," and "good compliance." He recorded a diagnosis of "314.01" and prescribed "Adderall XR 20 mg AM" and "Clonidine 0.1 mg ½ 4 PM." He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good across all categories.[11] (St. Ex. 2 at 129)

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[10] ODD means "oppositional defiant disorder." (Tr. at 433)

[11] The categories were medication compliance, impulse control, stress management, problem solving, and support system. (St. Ex. 2 at 129)

April 28, 2003, visit

78. On April 28, 2003, Dr. Mahajan documented "grades going up" and "some forgetting." He noted a diagnosis of "314.01" and prescribed "Adderall XR 20 mg" and "Clonidine 01. mg ½ 4 PM." He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good across all categories. (St. Ex. 2 at 127)

May 29, 2003, visit

79. Dr. Mahajan's progress note for Patient 2's May 29, 2003, visit states:

> Beh. is not improving. School is v. concerned about being disrespectful, mean spirited. Not having stable moods, got kicked off the bus several times. Poor motivation, uncooperative, oppositional [d]efiant.
>
> Med compliance — some difficulty complying
> Sleep — disruptive.

(St. Ex. 2 at 125) In the space for Diagnosis, Dr. Mahajan stated, "Token economy education given." No diagnosis is noted. Dr. Mahajan discontinued Adderall and prescribed "Lexapro 10 mg AM" and "Zyprexa 2.5 mg qhs."[12] Clonidine was not mentioned. He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good across all categories. (St. Ex. 2 at 125)

June 26, 2003, visit

80. On June 26, 2003, Dr. Mahajan documented "Needing reminder" and "Adderall XR 20 mg helped." The diagnosis is "314.01." He prescribed "Adderall XR 20 mg AM" and "Zyprexa 2.5 mg qhs." He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good across all categories. He instructed Patient 2 to see him again in one month. (St. Ex. 2 at 123)

81. When Dr. Gutheil was asked if the patient was still taking Lexapro, he noted that there's no evidence in the June 26, 2003, note that Patient 2 was still taking Lexapro. When asked if the

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[12] "Qhs" means "[e]very night at bedtime." (Tr. at 806) Further, Dr. Karp testified that Zyprexa is FDA-approved to treat psychotic symptoms, which could be associated with schizophrenia, major depression, or bipolar disorder. (Tr. at 91)

patient was instructed to discontinue Lexapro, Dr. Gutheil testified that he cannot tell from the progress note but that "its absence is suggestive." (Tr. at 778-779; St. Ex. 2 at 123)

July 24, 2003, visit

82. Dr. Mahajan documented in his July 24, 2003, progress note "No change [with] meds according to parent" and "No testing in past." His diagnosis is "314.01." Dr. Mahajan noted as his plan, "He'll do psych [illegible]," "Dr. Cordell name given." Finally, Dr. Mahajan discontinued Patient 2's medications and instructed Patient 2 to see him as needed. (St. Ex. 2 at 121)

October 27, 2003, visit

83. At Patient 2's next visit on October 27, 2003, Dr. Mahajan noted the mother's report that Patient 2 was not doing well without medication and that he was "having problems in school, fights." Dr. Mahajan's diagnosis is "314.01." Dr. Mahajan prescribed "Adderall XR 20 mg AM" and "Zyprexa 2.5 mg qhs." He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good across all categories. (St. Ex. 2 at 119)

    Another note on that same page dated November 17, 2003, states, "Grandmother came – does not know anything. Wants Concerta 36 mg AM #30. Another note states "given 1 m. Adderall," evidently referring to the prescription given on October 27. (St. Ex. 2 at 119)

84. Dr. Gutheil testified that it appears to him that as of October 27, 2003, Patient 2 was taking Adderall and Zyprexa and that this regimen changed on November 17, 2003, to Adderall and Concerta. Dr. Gutheil testified: "It seems to be different days, but I can't be sure from this record alone." (Tr. at 784-785; St. Ex. 2 at 119)

    Dr. Gutheil acknowledged that there is no indication on the progress note whether Patient 2 was advised to discontinue Adderall before receiving the Concerta. (Tr. at 784)

Report of Psychological Evaluation

85. Dr. Mahajan's medical record for Patient 2 includes a report of psychological evaluation from a psychologist, Antoinette S. Cordell, Ph.D., dated October 8, 2003. It indicates that the evaluation had been requested by Patient 2's mother. A cover sheet indicates that the report was mailed to Dr. Mahajan on October 16, 2003. (St. Ex. 2 at 151-159) Dr. Cordell's diagnoses were:

Axis I:	300.4 Dysthymic disorder and 314.01 ADHD, combined type
Axis II:	V71.09
Axis III	None
Axis IV:	Psychosocial stressors: Family, school

Axis V: Current GAF: 42
Highest GAF: 48

(St. Ex. 2 at 157)

86. Dr. Mahajan progress note for October 27, 2003, does not mention Dr. Cordell's report, nor do any subsequent progress notes. (St. Ex. 2 at 119)

December 12, 2003, visit

87. On December 12, 2003, Dr. Mahajan noted "grades are dropping" and "not doing well." In addition, he noted, "Told mother if we can hospitalize mother wants to." Dr. Mahajan documented a diagnosis of "314.01" and prescribed "Concerta 36 mg AM," "Depakote 250 mg AM [and] qhs," and "Clonidine 0.1 mg qhs." Zyprexa is not mentioned. He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good across all categories. (St. Ex. 2 at 115)

88. Dr. Mahajan testified that Patient 2 was aggressive and a "[t]otally out of control kid." At one point Patient 2's mother had wanted Patient 2 to be hospitalized for his behavior, but Dr. Mahajan declined to do that because Patient 2 was not suicidal and did not meet the criteria for hospitalization. Instead, Dr. Mahajan placed Patient 2 on a low dose of Depakote based on the mother's representation that Patient 2 had previously responded to that medication. (Tr. at 427-429)

89. When asked to correlate Dr. Mahajan's prescriptions with the symptoms and complaints presented on December 12, 2003, Dr. Gutheil replied:

> Again, that's going a little bit outside my expertise.[13] But, basically, there is a problem expressed in the form of "grades dropping, not doing well." So there's a change of medication which is to some degree—and, again, be careful of being outside my field here. The next session shows some improvement, so apparently that was the appropriate move to make. But I can't—since I don't do this kind of work—make a correlation to reasonable medical certainty.

(Tr. at 786)

January 9, 2004, visit

90. On January 9, 2004, Dr. Mahajan documented "irritability ↓" and "[illegible] – good." He documented the diagnosis "314.01" and "cont. all" medications. He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance

[13] Dr. Gutheil explained that he does not treat children. (Tr. at 786)

abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good across all categories. (St. Ex. 2 at 113)

March 2 through March 7, 2004, hospitalization at Upper Valley Medical Center

91. On March 2, 2004, Patient 2 was admitted to Upper Valley Medical Center [UVMC]. In his History and Physical report, Dr. Mahajan noted that Patient 2 "is an 11-year-old male who was brought to the crisis center by his mother and stepfather. He was out of control and not manageable." Dr. Mahajan documented the following in the History of Present Illness:

> This is his first psychiatric admission here. He was being seen. He was treated at Kettering Youth Services in 2000. The patient said to his mother that he hoped his mother would be in a car wreck. He was so out of control that both parents still could not control him. The patient fabricates stories. He left a note on his door that he was tired of all the crap and called his grandmother to come and get him. The mother states that the patient has threatened to stab himself and her with a screw driver. He had a plan to strangle himself. The patient has suicidal thoughts from time to time. He refuses to follow the rules and rarely does what is told without conflict. The patient was sexually molested by a relative when he was 8 years old. The patient is very angry with God for allowing this to happen to him. He feels that no one cares about him. Different behavioral plans have been tried without any benefit.

(St. Ex. 2 at 173) Moreover, Dr. Mahajan recorded the following mental status examination:

> The patient is a cooperative male who was agitated and angry at the crisis center. He was internally pre-occupied. Eye contact was avoided. He was crying. He was oriented x3. He had suicidal thoughts. Affect was flat. Mood was depressed. Speech was coherent. There was no evidence of any delusions or hallucinations. Judgment was poor. Impulse control was poor. Insight was poor. Intellectual functions were in average range clinically.

(St. Ex. 2 at 175) Dr. Mahajan's physical examination of Patient 2 revealed nothing abnormal. His diagnostic impression was "Axis I: Bipolar disorder, mixed, moderate, recurrent," and ADHD. Axis IV was noted to be "Code 2," and Axis V was documented as "Global Assessment of Functioning – 20." Dr. Mahajan noted his plan as follows: "The patient will be enrolled in the program. He will participate in individual and group therapy. He will be assessed for medications. Follow-up will be at the mental health center." (St. Ex. 2 at 175)

92. On March 7, 2004, Dr. Mahajan discharged Patient 2 with instructions to meet with an outpatient therapist on March 16, and recommended that Patient 2 and his family would

benefit from "Further outpatient work on coping skills, social skills," and for Patient 2 to "[p]articipate in age appropriate, positive, peer group activities." Dr. Mahajan prescribed "Concerta 72 mg every morning" and "Zyprexa 5 mg at bedtime." His discharge diagnoses were "Bi-polar Disorder mixed moderate recurrent, ADHD." (St. Ex. 2 at 171)

93. Dr. Karp found that a history and physical examination was documented by Dr. Mahajan on March 2, 2004, at the time of Patient 2's admission to UVMC. In conjunction with that, Dr. Mahajan also documented a psychiatric evaluation, Patient 2's chief complaint and HPI, a mental status examination, a diagnosis, and a treatment plan. (Tr. at 75-77; St. Ex. 2 at 173-175)

    Dr. Karp testified that the mental status examination documented by Dr. Mahajan during Patient 2's March 2004 hospitalization is "probably the most complete mental status [examination] that the doctor records in any of the patient records." Moreover, Dr. Karp stated that, if Dr. Mahajan had documented "similar mental status examinations throughout the course of his records or patient contacts, [he] would find that * * * pretty reasonable." (Tr. at 77)

March 8, 2004, visit

94. Patient 2 next visited Dr. Mahajan on March 8, 2004, the day following his discharge from UVMC. Dr. Mahajan documented "Doing little better," "Sleep & appetite no changes," "No side effects," School grades fluctuation," and "Med compliance is good." Dr. Mahajan documented a diagnosis of "314.01" and prescribed "Concerta 72 mg AM" and "Zyprexa 5 mg qhs." He checked boxes indicating that Patient 2 was not a danger to himself or others, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal. (St. Ex. 2 at 111)

April 5, 2004, visit

95. On April 5, 2004, Dr. Mahajan documented "Came [with] grandmother. Doing fine, school ok, doing better @ school & home. Sleep & appetite ok. No side effects. Med compliance is good." Dr. Mahajan noted the diagnosis "314.01" and prescribed "Concerta 36 mg [two tablets] AM" and "Zyprexa 5 mg qhs." He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good with respect to medication compliance and support system, and fair with respect to impulse control, stress management, and problem solving. (St. Ex. 2 at 109)

May 6, 2004, visit

96. On May 6, 2004, Dr. Mahajan documented "In counseling," "No trouble in school," and "attitude bad." Dr. Mahajan recorded his diagnosis of "Bipolar D/O" and prescribed "Concerta 72 mg AM" and "Zyprexa 5 mg qhs." He checked boxes indicating that

Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good across all categories. (St. Ex. 2 at 107)

May 17 through 21, 2004, hospitalization at UVMC

97. Patient 2 was again hospitalized on May 17, 2004. Dr. Mahajan documented the history of the present illness:

> The patient got into physical confrontation with his stepfather and then put a knife to his own stomach threatening suicide. He [shoved] mother and he also promised to kick his stepfather in the genitals. The patient has been on a plan at school and has done well for the past four weeks. He did not complete some late assignments so he was not given the reward that had been offered. The patient was mad about it. After school, he allegedly put car oil onto the lawn mower by mistake. The parents did not make a big issue. The patient became belligerent, cussing parents and refusing to accept the directions. He persisted in screaming, cussing and tried to follow stepfather out of the room. His stepfather slapped him two or three times with an open hand. Then he put a knife to his stomach threatening suicide.

(St. Ex. 2 at 165) Patient 2 was also noted to have been "in court on the day of admission and was remanded to get a probation officer. The patient has had some incidents of biting at school." (St. Ex. 2 at 165) Further, Dr. Mahajan documented the following mental status examination:

> A cooperative male who was not able to sit still in the crisis center. He appeared disinterested. Eye contact here is poor. He feels bad about what he did. Affect is angry. Mood is angry. Associations are coherent. He denies any delusions or hallucinations. Judgment is poor. Impulse control is poor. Insight is absent. Intellectual functions are in average range clinically.

(St. Ex. 2 at 165)

98. On May 21, 2004, Dr. Mahajan discharged Patient 2 with diagnoses of bipolar disorder, mixed, moderate, recurrent, and ADHD. His discharge instructions were to meet with an outpatient therapist on June 1, and he recommended that Patient 2 and his family would benefit from "Further outpatient work on coping skills, anger management, and communication," and for Patient 2 to "[p]articipate in age appropriate, positive, peer group activities." Dr. Mahajan prescribed "Concerta 72 mg every morning," "Paxil CR 25 mg every morning," and "Zyprexa 5 mg every night." (St. Ex. 2 at 163)

June 21, 2004, visit

99. Patient 2 next visited Dr. Mahajan's office on June 21, 2004. Dr. Mahajan's progress note states: "Released from hospital on May 21st – was admitted for 4 days. Mom c/o of [Patient 2's] beh. continues to be oppositional. He has been living [with] Dad due to his not able to get along with Mom. Taking meds regularly. Poor attitude." Dr. Mahajan noted a diagnosis of "Bipolar D/O," and his plan was to continue medication management and counseling. He prescribed Concerta 72 mg with 1 tablet to be taken in the morning, Zyprexa 5 mg to be taken at bedtime, and Paxil CR 25 mg with 1 tablet to be taken in the morning. He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal except for mood which was noted to be "oppositional," and that Patient 2's limitations and strengths were fair with respect to medication compliance, impulse control, and support system, and poor with respect to stress management and problem solving. (St. Ex. 2 at 105)

July 19, 2004, visit

100. Dr. Mahajan's progress note for July 19, 2004, states that Patient 2 "came in with Mom. Has been doing fine. Had <u>one</u> incident last night where he had an anger outburst. Got upset when told not to go to a friend's home & became very frustrated. Mom not sure if medications are being given to him while at Dad's place." (Emphasis in original) The diagnosis is "Bipolar D/O." Dr. Mahajan again prescribed Concerta 72 mg, Zyprexa 5 mg, and Paxil CR 25 mg. He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good with respect to support system, fair with respect to medication compliance and impulse control, and poor with respect to stress management and problem solving. It was also noted that the patient left without making an appointment. (St. Ex. 2 at 103)

October 13, 2004, visit

101. Patient 2 did not visit Dr. Mahajan again until October 13, 2004. Dr. Mahajan's progress note for that visit states "Doubtful progress in school," "good compliance [with] meds,"[14] and "threatened to hurt Mom." Dr. Mahajan documented the diagnosis "Bipolar D/O." He prescribed "↑ Concerta 108 mg AM," "Zyprexa 7.5 mg 8 PM,"[15] and "Paxil CR 25 mg

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[14] The medical records do not state the quantity and number of refills provided for any medication Dr. Mahajan prescribed since November 17, 2003. Therefore, it cannot be determined if Patient 2 had had enough medication to carry him through between July and October 2004. There is nothing documented to indicate that Dr. Mahajan had provided any prescriptions to Patient 2 during the interim. (St. Ex. 2)

[15] This is also an increased dose over the previous prescription for Zyprexa 5 mg, but was not documented as such. (St. Ex. 2 at 101-103)

AM." He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal (although "passive" was written next to "Judgment/Insight") and that Patient 2's limitations and strengths were good across all categories. (St. Ex. 2 at 101)

November 10, 2004, visit

102. Dr. Mahajan's November 10, 2004, progress note states: "Came in [with] mother. Mom states he is stable. Moods are stable. School is going well, behavior at school improved, grades still not improving – working on it." Dr. Mahajan noted his diagnosis of bipolar disorder and prescribed Concerta 108 mg to be taken in the morning, and Zyprexa 7.5 mg to be taken at 8:00 p.m. Dr. Mahajan noted that he discontinued Paxil. He checked boxes indicating that Patient 2 was not a danger to himself or others, that he had no substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." He indicated that the mental status exam was normal and that Patient 2's limitations and strengths were good with respect to medication compliance and support system, fair with respect to impulse control, stress management, and problem solving. Dr. Mahajan instructed Patient 2 to return in two months. (St. Ex. 2 at 99)

January 7, 2005, visit and subsequent visits

103. From January 7, 2005, through the last visit on April 26, 2006, Dr. Mahajan maintained Patient 2 on Concerta 108 mg to be taken in the morning (which he changed to two Concerta 54 mg in the morning beginning on June 13, 2005), and Zyprexa 7.5 mg to be taken at 8:00 p.m. Patient 2 also continued with therapy to address anger, self-esteem, and anxiety issues. Documentation from later visits make clear that Patient 2's behavior at home and school improved, although one note dated February 6, 2006, states that Patient 2 "experience[s] hallucinations sometimes." (St. Ex. 2 at 53-95)

Opinion of Dr. Karp

104. Dr. Karp testified that he had found many of Dr. Mahajan's notes concerning Patient 2 to be illegible or very difficult to read. (Tr. at 77)

105. Dr. Karp testified that Dr. Mahajan's documentation of diagnostic criteria in Patient 2's medical record was sufficient to meet the minimal standard of care, but that it was not sufficient to support the DSM-IV code identified. (Tr. at 80-81)

Opinion of Dr. Mahajan

106. With respect to the allegation that he had failed to maintain lab results in his medical record for Patient 2, Dr. Mahajan responded that, if patients were the way they are "in books," he would have done so. However, in what Dr. Mahajan referred to as "real world psychiatry,"

things do not work that way, and he did the best he could do. Dr. Mahajan opined that it had not been necessary to obtain lab work on Patient 2. (Tr. at 431) Dr. Mahajan further opined that the question of when to do bloodwork is a matter of clinical judgment: "Especially in the medicines that you can watch them clinically. It becomes more important in lithium. It becomes more important in Tegretol. It becomes more important in Digoxin hard medicines. But there are certain conditions when we use it, but there is no clinical correlation." (Tr. at 432)

107. Dr. Mahajan denied that he had failed to document DSM-IV criteria for his diagnoses. Dr. Mahajan testified that his working diagnoses for Patient 2 had been ADHD and oppositional defiant disorder. Dr. Mahajan further testified that he had made diagnoses of 314.01 ADHD and (later on according to the medical record) 296 bipolar disorder. (Resp. Ex. B; Resp. Ex. AA; Tr. at 432-434)

108. With respect to documenting informed consent concerning diagnoses and medication, Dr. Mahajan wrote in his report:

> In all progress notes, there is a section to document discussions, which are done at each visit, of consent regarding diagnosis and medications in regard to their intended benefits, side effects, reason for recommending a certain medication, duration of usage, and alternative. This section has been documented and discussed in all visits. A form signed by the patient, dated 4-25-03, is present in the chart.

(Resp. Ex. AA at 5; Tr. at 435)

109. With respect to the allegation that he had failed to follow up on medication changes, Dr. Mahajan wrote in his report:

> This is absolutely untrue. I have used sound clinical judgment and, when needed, requested tests from psychologists. This patient was stabilized and made functional at home and school. After one year of struggling, patient became, and remained, very stable for a period of 2 ½ years, after which he did not return.

(Resp. Ex. AA at 5)

110. Dr. Mahajan testified that Patient 2 had improved under his care. (Tr. at 437)

111. With respect to the issue of tardive dyskinesia and AIMS testing, Dr. Mahajan testified that the newer types of antipsychotic medication carry far less risk of tardive dyskinesia than the older drugs because of their lesser effect on dopamine receptors. Dr. Mahajan testified that, because the risk of tardive dyskinesia is so low with the newer drugs, AIMS testing is no longer required "for acute cases except Risperdal." Dr. Mahajan likened AIMS testing on patients using the newer drugs to noting in younger patients' files that they are not yet showing signs of dementia. Dr. Mahajan testified that, accordingly, he does not believe that AIMS testing had been necessary in Patient 2's case. (Tr. at 438-442)

112. Dr. Mahajan testified that, in his opinion, his care and treatment of Patient 2 complied with the standard of care. Dr. Mahajan further testified that, in his care and treatment of Patient 2, he had maintained the minimal standard of care and employed acceptable scientific methods in the selection of drugs. (Tr. at 451)

Opinion of Dr. Gutheil

113. Dr. Gutheil acknowledged with respect to several of Patient 2's early visits that neither the quantity of medication prescribed nor the dosing instructions are documented. (Tr. at 770-774; St. Ex. 2 at 125-131)

114. In his report, Dr. Gutheil stated as follows concerning Dr. Mahajan's care of Patient 2:

> The alleged failure to obtain depakote levels apparently was rendered unnecessary by the fact that the visit on which they would be ordered was preempted by hospitalization, and depakote was discontinued.[16] While not all progress notes record detailed informed consent discussions, many but not all progress notes contain a check box as to the patient's understanding (the goal of informed consent) and a completed form from 4/28/03 is included. The puzzling claim of "inappropriate medication prescribing" is refuted by the use of fully standard medications for the assessments and the restoration of function in the patient. * * *

(Resp. Ex. EE at 3) In addition, Dr. Gutheil indicated that AIMS testing was unnecessary because the only antipsychotics prescribed were of the newer variety. (Resp. Ex. EE at 2-3)

115. Dr. Gutheil testified that Patient 2 remained stable for two and one-half years under Dr. Mahajan's care, which "suggests at least that the total care was functioning in the right direction." (Tr. at 718)

Opinion of Dr. Polster

116. As previously mentioned, Dr. Polster had submitted written questions to Dr. Mahajan concerning his care of Patients 1 through 10 and received Dr. Mahajan's written responses. Among the questions Dr. Polster asked Dr. Mahajan with respect to his review of Patient 2, question 2 asked: "5/29/03 patient's Adderall is stopped and instead he is started on Lexapro and Zyprexa. Why that choice/combination?" (St. Ex. 16A) Dr. Mahajan responded, "On 5/29, parents insisted no improvement on Adderall, on Bipolar diagnosis, but apparently not setting structure and not giving Adderall as prescribed." (St. Ex. 16B)

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[16] Dr. Gutheil testified that "the moment of getting the [Depakote] levels was about to approach when the patient was hospitalized * * * and the Depakote was discontinued. So arguably levels would have been relevant, but the situation was basically bypassed because of other intervening events." (Tr. at 717)

Dr. Polster testified that Dr. Mahajan's response answered the question in part, but did not address why Dr. Mahajan chose Lexapro and Zyprexa. However, Dr. Polster testified that, rather than being concerned that those medications were inappropriate, he had really just been curious why Dr. Mahajan had chosen those particular medications. (Tr. at 852)

117. Dr. Polster's question 3 asked: "Yet, 6/03 (next appt) he is BACK on Adderall. What happened here? When/why was Lexapro stopped?" (St. Ex. 16A) (Emphasis in original) Dr. Mahajan responded, "Parents gave Adderall from previous month." (St. Ex. 16B)

Dr. Polster testified that he had been unable to determine from Dr. Mahajan's June 3, 2003, progress note why Lexapro was discontinued. Dr. Polster agreed that, taking into consideration Dr. Mahajan's response to his question, he is still unable to determine why Lexapro was discontinued. (Tr. at 855-856; St. Ex. 2 at 123)

118. Dr. Polster's question 4 asked:

> Events between 10/27/03 appointment and patient's hospitalization are confusing. At October appointment was on Adderall and Zyprexa still. By November someone wanted him to try Concerta. At the 12/12/03 appointment he's indeed on Concerta, but now there is mention of Depakote and clonidine. Was he ON them at that point or were they started at that appointment?

(St. Ex. 16A) (Emphasis in original)

Dr. Mahajan responded: "In 7/03, disagreement over the diagnosis, all meds discontinued, psych. evaluation advised. Evaluation done on 10/8. On 10/27, mom wanted him back on Adderall. Family is crisis oriented. Grandmother (hospital employee) felt Concerta will help." (St. Ex. 16B)

A handwritten note next to Dr. Mahajan's response was written by Dr. Polster, which Dr. Polster testified says, "Still confusing." Dr. Polster indicated that he was still unsure whether Dr. Mahajan had started Patient 2 on Depakote and clonidine at that visit. (Tr. at 874; St. Ex. 16B)

119. Dr. Polster's question 8 asked: "Mental Status Exams in these notes do not seem to include an assessment for abnormal movements. Are these being done?" (St. Ex. 16A) Dr. Mahajan responded: "Since most of the patients are not chronic, abnormal movements when present were assessed. Now a formal Aims test and documentation is being instituted." (St. Ex. 16B)

Dr. Polster testified that his question did not necessarily concern a formal AIMS test, "but just a visual observation for any abnormal movements that might be happening." (Tr. at 876)

120. In his report, Dr. Polster made the following statement concerning his review of Patient 2's records: "Dr. Mahajan could do a better job documenting the difficulties he had with this

family as well as the ongoing discussion of medications and a more thorough Mental Status Examination that would include a formal AIMS test." (Resp. Ex. GG at 2)

When asked if it is his opinion that Patient 2 warranted formal AIMS testing, Dr. Polster first indicated that tardive dyskinesia is less common using the new atypical antipsychotics, but also testified that "either a formal AIMS test or documentation of a visual monitoring of abnormal movements" had been warranted. (Tr. at 884-886)

121. Dr. Cordell, the psychologist who evaluated Patient 2, wrote a letter of support for Dr. Mahajan. (Resp. Ex. LL at 5)

Patient 3

122. Patient 3, an adult male born in 1963, first saw Dr. Mahajan on January 14, 2004. The last progress note included in State's Exhibit 3 is dated July 21, 2006. (St. Ex. 3)

January 14, 2004, visit

123. During his initial visit on January 14, 2004, Patient 3 completed an Adult Information questionnaire in which he indicated among other things that the purpose of the visit concerned focus problems, sleeping problems, and comprehension difficulties. He also indicated that he was currently taking Strattera 40 mg[17] and Zyprexa 2.5 mg. (St. Ex. 3 at 77)

124. In his progress note concerning Patient 3's initial visit, Dr. Mahajan documented Patient 3's presenting problem as "Strattera didn't help. did not sleep." The mental status exam indicates that Patient 3's hygiene, speech, thought process, judgment/insight, mood, and affect were within normal limits. Dr. Mahajan further found that Patient 3's impulse control, stress management, problem solving, and support system were all good. Dr. Mahajan listed as diagnoses "314.01" and "296.2."[18] He prescribed "Adderall XR 20 mg" (with no quantity or instruction noted), and "Remeron 15 mg qhs" (no quantity noted).[19] There is no note to continue or discontinue Strattera and Zyprexa. Dr. Mahajan did not indicate whether Patient 3 understood or consented to the medications prescribed. (St. Ex. 3 at 75)

125. Dr. Karp testified that he was unable to determine from the medical record whether Dr. Mahajan had advised Patient 3 at his initial visit to discontinue taking Zyprexa or Strattera, or whether the patient had continued taking those medications during his treatment with Dr. Mahajan. (Tr. at 91-92)

126. Dr. Mahajan testified that he would never prescribe Strattera and Adderall together. Dr. Mahajan further testified that he had instructed Patient 3 to discontinue taking Strattera; however, the medical record does not document that instruction. When asked how he

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[17] Dr. Karp further testified that Strattera is approved for the treatment of ADHD. (Tr. at 91)
[18] Dr. Karp testified that DSM-IV code 296.2 refers to "major depressive disorder, single episode." (Tr. at 88-89)
[19] Dr. Mahajan testified that Remeron is an antidepressant that also can cause sedation. (Tr. at 444)

knows that he had so instructed Patient 3, Dr. Mahajan replied, "I don't have to prove everything for somebody. I'm not documenting it for anyone. I'm treating my patient." When asked again how he knows he told Patient 3 to discontinue Strattera, Dr. Mahajan replied, "Because I have a system." Dr. Mahajan testified that his system is that he "will never give Strattera and Adderall together." (Tr. at 616) Pressed further, Dr. Mahajan testified that he made a note, under Presenting Problem, that states, "Strattera did not help." (Tr. at 616-617; St. Ex. 3 at 75)

127. Dr. Mahajan testified that Patient 3 had a daughter who was also Dr. Mahajan's patient. Dr. Mahajan further testified that Patient 3 or his wife traveled 80 miles to take their daughter to see him. During one visit with Patient 3's daughter, Patient 3 asked Dr. Mahajan if Dr. Mahajan would see him as a patient. Dr. Mahajan testified that, even though it was late in the day, and he had a six-week waiting list, he decided to stay late and see Patient 3. Dr. Mahajan noted that, at that time, Patient 3 was taking Strattera and Zyprexa. Dr. Mahajan acknowledged that his documentation or possibly the situation was not ideal because he had not been able to contact Patient 3's physician that late in the day. (Tr. at 443-444)

128. Dr. Mahajan testified concerning his prescribing of Remeron:

> Remeron is antidepressant, but all antidepressants are not the same. There are some functions. Remeron, he's a travelling guy, so later on I find out that he was using it as a sleeper.
>
> Now, for travelling person who reaches the room at 11:00 o'clock, has to go for a meeting in the morning, early in the morning, Remeron intermittently is going to cause sedation. And if the person doesn't sleep well, they end up feeling depressed, tired, whatever you call it, that tiredness. So this was the problem and he was made to believe, what his wife thought.
>
> So there were medicine changes made. ADD was definitely a factor. Sleep deprivation contributed to depression. Appearance, not chemical depression. And in terms of him taking the drug—because everybody knows more than the psychiatrist, it was—but I have to still work with them knowing that deficit. And it may not look ideal from the way it is on the chart, but, believe me, I did everything considering the patient variation.

(Tr. at 444-445)

129. With respect to the allegation that he had failed to complete or document completion of a psychiatric evaluation for Patient 3, Dr. Mahajan testified: "I did not fail to do the documentation. I still had the questionnaire. I used my head. I used the judgment. Plus, I had seen him over a number of visits, too, with his daughter." (Tr. at 445)

February 20, 2004, visit

130. At Patient 3's second visit on February 20, 2004, Dr. Mahajan documented "Some changes," followed by illegible notations. He maintained Patient 3 on Adderall XR 20 mg but increased the dose of Remeron to 30 mg. Dr. Mahajan checked a box indicating that Patient 3 understood and consented to the medications. (St. Ex. 3 at 73)

131. When asked if he knows why Dr. Mahajan doubled Patient 3's dose of Remeron, Dr. Polster responded that he does not, based on what was documented under the heading, Symptoms or Complaints. Dr. Polster further testified, however, that "it would appear that lack of efficacy on the 15 milligrams resulted in increase to 30 milligrams and, given the diagnosis, continued presence of depressive symptoms." (Tr. at 883)

July 8, 2004, visit

132. Dr. Karp noted that, on July 8, 2004, Dr. Mahajan documented, without further explanation, "Irregular [with] Remeron" and "feels good." Dr. Karp testified that he is uncertain what "Irregular [with] Remeron" had meant because Dr. Mahajan prescribed only Adderall XR at that visit. However, Dr. Karp testified that Remeron was prescribed again at the next visit on August 4, 2004. After that, there is no further documentation concerning Remeron. Dr. Karp testified that it is not clear from the record if or why Remeron was no longer prescribed. (St. Ex. 3; Tr. at 85-86)

133. Dr. Mahajan testified that "Irregular with Remeron" meant that Patient 3 was not taking his Remeron regularly. Dr. Mahajan further testified that he discontinued prescribing Remeron to Patient 3 at the July 8, 2004, visit.[20] (Tr. at 620)

Subsequent visits

134. For Patient 3's visit on November 19, 2004, Dr. Mahajan noted, among other things, "sleeping poorly." He prescribed Adderall XR and "↑ Ambien 20 mg qhs > doesn't take." (St. Ex. 3 at 61)

135. At the next visit on January 12, 2005,[21] Dr. Mahajan noted, among other things, "NOT taking Ambien regularly," "sleep sporadic," and indicated that Patient 3 did not need a new prescription for Ambien. In addition, Dr. Mahajan prescribed Adderall XR and Xanax 0.25 mg to be taken three times per day. (St. Ex. 3 at 59)

136. Next, in his progress note for February 11, 2005, Dr. Mahajan noted that Patient 3 was having trouble sleeping and was not taking his Ambien. In addition to prescribing Adderall XR, it appears from Dr. Mahajan's note that he again prescribed Ambien 20 mg.

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[20] However, the progress note for the next visit on August 4, 2004, indicates that Remeron was prescribed again at that visit. (St. Ex. 3 at 65)

[21] The note actually states "2004," but that is clearly a typo. (St. Ex. 3 at 59)

Nothing was noted concerning the previous Xanax prescription, and Dr. Mahajan did not prescribe Xanax to Patient 3 again. (St. Ex. 3 at 57)

137. At the next visit, March 9, 2005, Dr. Mahajan noted that Patient 3 was eating and sleeping okay. He prescribed only Adderall XR at that visit. (St. Ex. 3 at 55)

138. Three visits later, on August 24, 2005, Dr. Mahajan noted, among other things, that Patient 3 was having difficulty sleeping. He prescribed Adderall XR and started Patient 3 on Lunesta 3 mg at bedtime. (St. Ex. 3 at 49)

139. At the following visit, on October 24, 2005, Dr. Mahajan noted that no prescription for Lunesta was given; however, for the next two visits, December 12, 2005, and April 4, 2006, it appears that Dr. Mahajan prescribed Lunesta 3 mg to Patient 3 while noting that Patient 3 was not taking it. (St. Ex. 3 at 43-47)

140. In his notes for Patient 3's visit on July 12, 2006, visit Dr. Mahajan stated, with respect to Symptoms/Complaints: "Sleep – ↑↓"; decreased appetite, "doesn't take time to eat," decreased focus, "mind still wanders," depressed mood, increased anxiety, and "Stable." The diagnosis code listed is "314.01." A note above the medication section appears to say "down on life." Dr. Mahajan discontinued Adderall and started Lexapro 20 mg. No legible quantity, number of refills, or patient instructions can be discerned from the note. (St. Ex. 3 at 37)

    Dr. Karp testified that Adderall is used to treat ADHD while Lexapro is an antidepressant. Dr. Karp further testified that Lexapro is not used to treat ADHD; however, the only diagnosis noted for that visit was 314.01, the DSM-IV code for ADHD. (Tr. at 84-95)

141. At Patient 3's next visit on July 21, 2006, Dr. Mahajan noted, among other things: "Stopped taking Adderall on 7/13 – 7/15 → had noticed a difference before the meeting – poor attention." Dr. Mahajan noted diagnoses of 296.2 and 314.01. He discontinued Lexapro and reinstituted Adderall XR. (St. Ex. 3 at 33)

Documentation of Consent to Diagnoses and Medications

142. Dr. Karp testified with regard to a document in Patient 3's medical record labeled Informed Consent to Treatment with Medication:

    > On this form are mentioned eight different classes of medications. For example, antipsychotics, antidepressants. The form says, "My physician has discussed with me the nature of my psychiatric behavioral problems for which medication has been prescribed." However, no medications are checked, no class of medications are checked, nor can I find any reference, at least in the written record, as to whether or not informed consent was actually accomplished.

    (Tr. at 89-90; St. Ex. 3 at 31)

In addition, the document was signed by Dr. Mahajan on February 20, 2004, and, although the document references Patient 3, it appears to have been signed by a female relative of Patient 3's on April 19, 2004. (St. Ex. 3 at 31)

143. Dr. Mahajan acknowledged that Patient 3's wife had signed the Informed Consent to Treatment with Medication, and not Patient 3 himself. Dr. Mahajan added that, despite the technical mistake, Patient 3 had understood why Dr. Mahajan gave him the medications and consented to being treated with those medications. Dr. Mahajan further testified that he would not have given Patient 3 the medication otherwise. (Tr. at 449-451)

144. For most of Patient 3's visits, the initial visit being one notable exception, Dr. Mahajan checked a box on his progress notes indicating that Patient 3 understood and consented to the medications prescribed. (St. Ex. 3) Curiously, however, Dr. Mahajan checked the "no" box at a few visits indicating that Patient 3 did *not* understand or consent to the medications. This was noted on the progress notes for Patient 3's visits on June 14, 2004, January 12, 2005, and February 11, 2005. (St. Ex. 3 at 57, 59, 69)

Dr. Gutheil testified concerning the progress notes where boxes were checked "no" with respect to the patient's understanding of the medication:

> And the one thing I raised a question is that there were a number of no's in terms of the understanding. I'm not absolutely clear about what weight to give that. Obviously, if the family or parents or even patient says they don't understand what this is for, they make some statement that indicates that they may not have the relevant information, then you could, of course, check no. But then it is assumed that you would then give them the information they don't have, whatever that might be.

(Tr. at 718-719)

Laboratory Studies

145. Dr. Mahajan testified that the medications he prescribed to Patient 3 did not require any baseline or follow-up lab studies. (Tr. at 452-453)

Diagnostic Codes

146. Dr. Mahajan's progress notes for most of Patient 3's visits through February 11, 2005, list only a diagnosis of "296.2" and prescriptions for Adderall XR and a sleep aid such as Remeron (which Dr. Mahajan evidently prescribed as a sleep aid), Ambien, or Lunesta. (St. Ex. 3 at 57-65, 69-73) For later visits, his notes usually identify only "314.01" as the diagnosis along with the same medication regimen: Adderall XR and a sleep aid. (St. Ex. 3 at 37-51)

147. Dr. Karp criticized Dr. Mahajan for documenting no descriptive term for Patient 3's diagnoses, only the DSM-IV codes. For example, Dr. Mahajan's progress note for

Patient 3's July 8, 2004, visit identifies the diagnosis as "314.01." Dr. Karp testified that 314.01 is the DSM code for ADHD. Dr. Karp further testified that the record for that visit contains "a few" criteria or characteristics to support that diagnosis.[22] However, Dr. Karp said that a problem occurs when in later visits the code "is supplanted by another code and then another code."[23] For example, Dr. Mahajan's progress note for Patient 3's next visit, on August 4, 2004, states as the diagnosis only "296.2," indicating "major depressive disorder, single episode." Moreover, Dr. Karp testified that "there is no explanation for the change in diagnosis or diagnostic code; thus, it makes it very difficult to assess the meaning and the context of the treatment because one should link a diagnosis with a specific intervention or medication." (St. Ex. 3 at 65-67; Tr. at 82-81, 89)

148. Dr. Mahajan responded to Dr. Karp's criticism that, on August 4, 2004, Dr. Mahajan had used the DSM-IV code 296.02, major depressive episode, instead of 314.01, ADHD, with no explanation. Dr. Mahajan testified:

> ADD was the etiological diagnosis. Depression was off and on. I wasn't sure what he was going to respond to chemically, and there was no way to know. But I needed to give him the benefit of the doubt and treat it when it became prominent. My diagnosis is the focus at that time. That's why it was important. Both diagnoses are there. He carried those and you can see at the end.[24]

(Tr. at 447-448; see also Dr. Mahajan's testimony at 619-620)

Patient 4

149. Patient 4, an adult female born in 1974, first saw Dr. Mahajan as a patient on June 26, 2003. Her last visit was February 23, 2005. (St. Ex. 4 at 3-15)

150. At her initial visit, Dr. Mahajan documented that Patient 4 had a history of ADHD as a child and "difficulty functioning [or possibly "focusing"] at work and paying attention." He checked boxes indicating that Patient 4 was not a danger to herself or others, that she had no substance abuse problem, that no tests were ordered, and that no samples were given. He listed an Axis I diagnosis of "314.01" and prescribed Adderall XR 20 mg #60 with instructions to take two tablets each morning. "Yes" and "No" checkboxes next to a

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[22] The Hearing Examiner is uncertain what criteria Dr. Karp is referring to. Aside from the name and date, Dr. Mahajan's July 8, 2004, note states, "Irregular [with] Remeron," "feels good," "314.01," "Adderall XR 40 mg AM," and "See 2 m." Dr. Mahajan also drew a line through all the normal boxes under Mental Status Exam, and similarly indicated that all Patient 3's Limitations and Strengths were "Good." He also checked boxes indicating that Patient 3 was not a threat to himself or others, that he did not have a substance abuse problem, that no tests were ordered, that no sample were given, and that Patient 3 understood and consented to the medications prescribed. (St. Ex. 3 at 67)

[23] The Hearing Examiner's review of State's Exhibit 3 revealed only the codes 296.2 and 314.02. At most visits, only one is used. On two occasions—the initial visit and the last visit in the record—both are used. (St. Ex. 3 at 33-75)

[24] Dr. Mahajan referred to his progress note for Patient 3's last visit on July 21, 2006, where he recorded both 296.02 and 314.01 as his diagnoses. (Resp. Ex. C at 41)

statement that "Patient/Guardian understands and consents to medication" were left blank. Dr. Mahajan instructed Patient 4 to see him again in one month. (St. Ex. 4 at 3)

Nothing else was documented by Dr. Mahajan or his staff at Patient 4's initial visit except for patient registration information. (St. Ex. 4; Resp. Ex. D)

151. At Patient 4's next visit on August 22, 2003, Dr. Mahajan documented "better but not enough attention span problem." No diagnosis was noted. He increased the dose to Adderall XR 30 mg with instructions to take two in the morning. (St. Ex. 4 at 4)

Dr. Mahajan maintained Patient 4 on that medication and dosage for the remainder of his treatment of Patient 4. (St. Ex. 4 at 3-8)

Testimony of Dr. Mahajan

152. Dr. Mahajan testified that Patient 4 was a drug company representative who had approached him seeking treatment. Dr. Mahajan testified, "She had seen me work with the kids and adults, accuracy of my diagnoses, so she approached me." (Tr. at 455)

153. Dr. Mahajan testified that he does not believe that laboratory studies were clinically indicated for Patient 4. (Tr. at 459)

154. Dr. Mahajan testified that his DSM-IV diagnosis for Patient 4 had been 314.01. (Tr. at 460-461)

155. Dr. Mahajan testified that he had discussed the prescribed medication with Patient 4 and that she had understood the side effects and consented. (Tr. at 461-462) However, the medical record indicates that Dr. Mahajan had documented that Patient 4 "understands and consents to medications" only at her last two visits. (St. Ex. 4)

156. Dr. Mahajan testified that Patient 4 had exhibited a side effect of Adderall, weight loss. Dr. Mahajan testified: "But to say to a female that you're losing weight, it can be very boundary issue. So watch that. If there was a problem, I would have somehow managed to get it across."[25] (Tr. at 465)

157. Dr. Mahajan testified that his care and treatment of Patient 4 had complied with the minimal standard of care. (Tr. at 463-465)

Opinion of Dr. Gutheil

158. In his report, Dr. Gutheil stated with respect to Patient 4:

> This chart is noteworthy by being a "bare bones" chart (apparently some data were discovered missing), but the patient is a drug rep and thus likely to be far

[25] No weight information or documentation of weight loss is documented in the medical record. (St. Ex. 4)

> higher on the scale of competence to consent to pharmacologic treatment and report problems than the average patient. An initial evaluation is recorded with hand-written follow up progress notes as well as filled out forms.

(Resp. Ex. EE at 3)

Opinion of Dr. Polster

159. Dr. Polster stated in his report, "The patient herself has provided a glowing letter of recommendation on behalf of Dr. Mahajan expressing that he DID thoroughly discuss medication options, changes, etc." (Resp. Ex. GG at 3) (Emphasis in original)

Patient 4's letter of support may be found at Respondent's Exhibit K, page 1.

Patient 5

160. Patient 5 is a male born in 1990. He first visited Dr. Mahajan on or around April 26, 2005 (Dr. Mahajan did not document the date on his initial visit form). (St. Ex. 5 at 63-67) The last visit documented in State's Exhibit 5 was July 27, 2006. (St. Ex. 5 at 29)

161. At Patient 5's initial visit, Dr. Mahajan rendered a diagnosis of "296.2" and prescribed Lexapro 20 mg in the morning and Geodon 40 mg at 6:00 p.m.[26] (St. Ex. 5 at 63-65)

162. At Patient 5's next visit on May 18, 2005, Dr. Mahajan documented: "Mom notices remarked improvement in sleep, attitude. [Decreased] anger; lot more friendly & fun to be around. Taking meds regularly. No complaints. School is going well." Dr. Mahajan documented "296.2" as the diagnosis and maintained Patient 5 on Lexapro and Geodon. (St. Ex. 5 at 61)

163. At Patient 5's next visit on June 15, 2005, Dr. Mahajan noted that summer school was not going well for Patient 5 "because he is skipped ahead of himself & [illegible] essential assignment. Overall moods are ok." Medication compliance and appetite were noted to be okay. Dr. Mahajan documented a diagnosis of "296.2," continued Lexapro and Geodon, and added Adderall XR 10 mg in the morning. (St. Ex. 5 at 59)

164. At the following visit on July 13, 2005, Dr. Mahajan documented, among other things, "Trouble falling asleep," "OCD more pronounced,"[27] increased irritability, agitation, frustration, anger, and "grinding teeth." The diagnosis is noted to be "296.2." Dr. Mahajan increased Lexapro to 30 mg in the morning, maintained Geodon at 40 mg at 6:00 p.m., and discontinued Adderall XR.

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[26] MedlinePlus describes Geodon as an atypical antipsychotic. (MedlinePlus website, March 15, 2010 <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a699062.html>)
[27] Dr. Mahajan did not document a diagnosis of OCD. (St. Ex. 5)

165. On August 15, 2005, Dr. Mahajan noted, among other things, that Patient 5 was stable and "OCD under control." Dr. Mahajan noted the diagnosis as "296.2" and maintained Lexapro and Geodon. (St. Ex. 5 at 55)

166. At Patient 5's next visit on October 5, 2005, Dr. Mahajan noted that Patient 5's social skills were improving, he was involved in volunteer work, he was less angry and more cooperative, his mood was stable, and he was sleeping well. Dr. Mahajan also noted that "Adderall did not [either help or hold]." He noted a diagnosis of "296.2," maintained Lexapro and Geodon, and added Focalin XR 20 mg in the morning. (St. Ex. 5 at 51)

167. At the following visit, October 31, 2005, Dr. Mahajan noted, among other things, "Better focus" and increased memory. He documents a diagnosis of 296.2 and maintained Patient 5 on Lexapro, Geodon, and Focalin XR. (St. Ex. 5 at 49)

168. Dr. Mahajan maintained Patient 5 on this regimen through the last visit documented in the hearing record. (St. Ex. 5 at 29-47)

In addition, Dr. Mahajan documented a diagnosis of "296.2" until the January 31, 2006, visit, at which time he began documenting bipolar disorder as the diagnosis. (St. Ex. 5 at 29-61) However, Dr. Mahajan's documentation does not provide a rationale for the change or indicate that there *was* a change. (St. Ex. 5 at 43) At the prior visit, on January 3, 2006, Dr. Mahajan had documented: "Came [with] mom," "stable moods," increased focus, appetite and sleep okay, "med compliance ok," and either "stable with meds" or "stable with moods." (St. Ex. 5 at 45)

Psychiatric/Psychological Evaluation

169. Dr. Mahajan's medical record for Patient 5 includes an eight-page report of a psychological evaluation, dated May 19, 2005, performed by Dr. Cordell, a Ph.D. psychologist. (St. Ex. 5 at 81-95) Dr. Cordell rendered the following diagnoses:

Axis I:	300.02 Generalized Anxiety Disorder
	400.04 Dysthymic Disorder
	314.00 ADHD, Inattentive Type
Axis II:	Avoidant and Schizoid Personality Traits with Depressive and Negativistic Features

(St. Ex. 5 at 93)

170. Dr. Mahajan denied that he had failed to complete or document a psychological evaluation of Patient 5. He testified that a psychological evaluation was performed on Patient 5 by Dr. Cordell, a psychologist with whom he had worked and had trusted for more than 25 years. (St. Ex. 5 at 81-95; Resp. Ex. E at 22-30; Tr. at 469-470, 473)

However, Dr. Mahajan's progress note for the visit following Dr. Cordell's report, June 15, 2005, does not mention Dr. Cordell's report, nor does any subsequent progress note. (St. Ex. 5 at 29-59)

171. Dr. Mahajan testified that laboratory studies had not been indicated for Patient 5. (Tr. at 473-474)

Diagnostic Codes

172. Dr. Mahajan testified that he had written the diagnostic code for "depressive disorder based on [Patient 5's] obsessiveness," and diagnosed "bipolar disorder, based on the symptoms, but that was not the focus of the treatment." (Tr. at 473-474)

Dr. Mahajan further testified to the effect that Patient 5's mother had pushed for a diagnosis of bipolar disorder. Moreover, Dr. Mahajan testified, "I cannot deny it because he meets the symptoms of DSM-IV * * *." When asked to clarify how he had arrived at the diagnosis of bipolar disorder, Dr. Mahajan replied: "Sir, he—if I followed DSM-IV? I just followed pure symptoms. You or I, everybody's bipolar. If you insist on it, I'll diagnose you bipolar, but I actually won't treat it." Dr. Mahajan further testified that he changed only the diagnosis but that he did not believe that the treatment needed to be changed. Finally, Dr. Mahajan testified that he had used his own independent judgment regardless of what the parent said. (Tr. at 477-478)

Documentation of Informed Consent

173. Dr. Mahajan did not document that Patient 5 or his guardian understood or consented to the medication prescribed at Patient 5's initial visit. (St. Ex. 5 at 63-65) At the next visit on May 18, 2005, Dr. Mahajan checked the "no" box next to "Patient/Guardian understands and consents to medications." (St. Ex. 5 at 61) For subsequent visits, Dr. Mahajan checked the "yes" box next to that statement." (St. Ex. 5 at 29-59)

AIMS Testing

174. Dr. Mahajan denied that he had failed to document AIMS testing, for reasons previously discussed. (Tr. at 480)

Patient 6

175. Patient 6 is a male born in 1998. He first visited Dr. Mahajan on March 7, 2005. The last visit documented in State's Exhibit 6 occurred on March 8, 2006. (St. Ex. 6 at 23-65)

176. At Patient 6's first visit on March 7, 2005, a psychiatric initial evaluation visit form that was completed the same day indicates that Patient 6 had been seen by a psychologist who had tested Patient 6 for ADHD, that Patient 6 had been in counseling for three or four months, and that his teachers believed he had ADHD. The section concerning the presenting problems lists a number of issues: "Wets the bed," hyperactivity, "aggressive

towards other children – hits & kicks other children," "easily distracted," "can't focus or complete work," and restlessness. (St. Ex. 6 at 51) The mental status exam section documents normal results across most categories, although speech is documented as "quiet." The diagnosis documented is:

Axis I:	314.01
Axis III:	Allergies/asthma
Axis IV:	Psychosocial – relationships
Axis V:	65

(St. Ex. 6 at 53) That form also indicates that the side effects of the medication were explained and that the "Patient/Guardian understands and consents to medications." (St. Ex. 6 at 53)

Dr. Mahajan's progress note for the initial visit states "school & parents indicate ADHD – behavior here hyper." Mental status exam and Patient 6's limitations and strengths were documented as normal across all categories. Dr. Mahajan diagnosed Axis I "314.01" and prescribed Ritalin LA 10 mg in the morning. He checked boxes indicating that Patient 6 was not a danger to himself or others, that he did not have a substance abuse problem, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." Dr. Mahajan instructed Patient 6 to return in three weeks. (St. Ex. 6 at 49)

177. A note dated March 18, 2005, indicates that the parents had called, concerned about side effects from Ritalin. When Patient 6 was picked up at school that day he had complained of aching all over for two days and of being tired all day. He was doing better in school, but was hyperactive in the evening. Dr. Mahajan signed below that part of the note. Below Dr. Mahajan's signature the note states: "Symptoms will diminish. Parents decision if wants to stop Ritalin. [Mother] notified. Verbalized understanding." That part of the note appears to have been signed by a nurse. (St. Ex. 6 at 47)

178. Dr. Mahajan maintained Patient 6 on Ritalin LA 10 mg in the morning through August 11, 2005. Dr. Mahajan's progress note for the August 11 visit states, among other things "Ritalin LA not working," "Hyperactive," "Suspended from daycare – sexual act," problems going to sleep, wetting bed, and "can get out of control physically." Dr. Mahajan discontinued Ritalin and prescribed Focalin XR 20 mg in the morning, added Tenex 1 mg at bedtime,[28] and added DDAVP 0.2 mg at bedtime.[29] He documented the patient/guardian's understanding of side effects and consent to medications by checking "yes" next to that statement, but left blank the checkboxes next to a similar statement that is directed specifically toward newly-prescribed medications. (St. Ex. 6 at 35)

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[28] Tenex is a brand name of guanfacine, a blood pressure medication that is also used to treat ADHD. (MedlinePlus website, March 15, 2010, <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601059.html>) Dr. Mahajan testified that he had prescribed Tenex 1 mg to Patient 6 to help him settle down to sleep. (Tr. at 491-492)

[29] DDAVP is desmopressin acetate and can be used to treat bedwetting. (PDRHealth.com, March 10, 2010, <http://www.pdrhealth.com/drugs/rx/rx-mono.aspx?contentFileName=dda1117.html&contentName=DDAVP&contentId=226>)

Dr. Mahajan testified that he had switched Patient 6 from Ritalin to Focalin in August 2005 "[b]ecause [of] insurance." However, this factor was not documented in the progress note for that visit. (Resp. Ex. F at 35; Resp. Ex. AA at 10; Tr. at 491)

179. At the next visit on September 6, 2005, Dr. Mahajan documented "excellent" and that Patient 6 was eating and sleeping okay. He continued Patient 6 on Focalin XR and Tenex. DDAVP was not mentioned. Dr. Mahajan checked "yes" next to both statements concerning patient/guardian consent, including the statement that specifically relates to new medications, although no new medications were prescribed at that visit. (St. Ex. 6 at 33)

180. Dr. Mahajan maintained Patient 6 on a regimen of Focalin XR and Tenex until Patient 6's visit on December 19, 2005. On that date, Dr. Mahajan documented that Patient 6 had "good focus and grades" but "fair appetite" and "sensitive in evening" with the Focalin wearing off around 5:00 p.m. In addition, Dr. Mahajan noted that Patient 6 had stopped taking Tenex but was sleeping okay and staying dry. Dr. Mahajan discontinued Focalin and Tenex and prescribed Concerta 54 mg in the morning. He checked a box indicating that "Patient/ Guardian understands/side effects and consents to medication." (St. Ex. 6 at 29-31)

181. At the next visit, January 11, 2006, Dr. Mahajan noted "overall good, "parents divorcing," and "father feels Focalin XR 20 [nothing further written]." Dr. Mahajan discontinued Concerta and reinstated Focalin XR 20 mg in the morning. He checked "yes" to both questions relating to understanding and consenting to medications. Also, there is a notation that Dr. Patel had reviewed this progress note on January 17, 2006.[30] (St. Ex. 6 at 27)

Dr. Mahajan maintained Patient 6 on Focalin XR 20 mg in the morning through the last visit documented in State's Exhibit 6, March 8, 2006. (St. Ex. 6 at 23-25)

Diagnostic Code

182. Dr. Mahajan documented "314.01" as the diagnosis at every visit. (St. Ex. 6 at 23-49)

183. Dr. Mahajan testified that he had treated Patient 6 for the provisional diagnosis of DSM-IV 314.01, ADHD, which he documented in the chart. (Tr. at 489-490)

Documentation of Informed Consent

184. Dr. Mahajan's medical record for Patient 6 indicates that, at each visit, he checked the box or boxes indicating that Patient 6 or his guardian understood and consented to the medication. (St. Ex. 6 at 23-53)

In addition, there is a consent form signed by Patient 6's mother dated March 30, 2005, the date of Patient 6's second visit. (St. Ex. 6 at 79)

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[30] Amita R. Patel, M.D., is Dr. Mahajan's monitoring physician pursuant to Dr. Mahajan's October 2005, consent agreement with the Board. (Resp. Ex. CC) Dr. Mahajan's consent agreement is addressed later in this report.

Testimony of Dr. Mahajan

185. Dr. Mahajan testified that Patient 6 was a male who was six years old when he first came to see Dr. Mahajan. He had previously been evaluated and counseled by a psychologist and medicated with low doses of stimulant by his family physician.[31] (Resp. Ex. F; Tr. at 483-484)

    Dr. Mahajan testified that his treatment of Patient 6 was complicated by the parents' disagreement on how to treat the child—father thought Patient 6 should be medicated, mother did not. Dr. Mahajan testified that they eventually divorced and "Mother had her say" and removed Patient 6 from medication. Dr. Mahajan testified that she instead took Patient 6 to a Neuro Feedback Clinic, which Dr. Mahajan did not believe would be helpful. (Tr. at 484-485)

186. Dr. Mahajan denied the allegation that he had failed to complete or document a psychiatric evaluation of Patient 6, and referred to several documents in his medical records, including a two-page document entitled "Psychiatric INITIAL Evaluation Visit." (St. Ex. 6 at 51-53; Resp. Ex. F at 3-4; Tr. at 485-487) (Emphasis in original) In addition, the medical record includes questionnaires filled out by Patient 6's school and parents prior to Patient 6's initial visit on March 7, 2005. (St. Ex. 6 at 55-71[32]; Resp. Ex. F at 5-9, 17-26; Tr. at 487-488)

187. Dr. Mahajan testified that baseline and follow-up lab studies were not indicated for Patient 6. (Tr. at 489)

188. Dr. Mahajan testified that, in his opinion, Patient 6 improved under his care. (Tr. at 502)

Patient 7

189. Patient 7, a female born in 1990, first visited Dr. Mahajan on July 25, 2005. The last visit included in State's Exhibit 7 occurred on March 14, 2006. (St. Ex. 7 at 33-49)

190. Prior to her initial visit, on July 14, 2005, a Child/Adolescent Intake Interview form was filled out by Dr. Mahajan or a staff member. Under Presenting Problem, the note states: "Referred by Dr. Willoby * * * for [symptoms?] of extreme anxiety. She has been worrying a lot for past two years. [Increased] heart rates and fear of dying.[33] Needs constant reassurance. Picks arms & legs and face when nervous. Nausea, sweating, very fearful of new situations." (St. Ex. 7 at 51) Another entry further indicates that she had been prescribed Zoloft for about one year until May 2005, which "did not do much for her." She had also been tried on Metadate and Dexedrine which made her hyper.

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[31] The Hearing Examiner was unable to find documentation in the medical record that Patient 6 had previously been treated with a stimulant. (St. Ex. 6)

[32] Some of the copies in State's Exhibit 6 are very difficult to read. Copies of the same documents in Respondent's Exhibit F are far more legible.

[33] The parent questionnaire indicates that Patient 7 suffers from anxiety and "extreme fear of dying; lost classmate to cancer in 4th grade * * *." (St. Ex. 7 at 61)

(St. Ex. 7 at 51) The Mental Status Examination documented indicates abnormal results for Description of Thought (obsessions), Mood (anxiety), and Affect (constricted). (St. Ex. 7 at 55)

191. Dr. Mahajan's medical record for Patient 7 includes a report of a psychological evaluation by a psychologist. (St. Ex. 7 at 71-79)

192. Dr. Mahajan's progress note for Patient 7's initial visit on July 25, 2005, stated, among other things, that Patient 7 has a hard time getting to sleep, worries about dying, "picks @ school & makes sores," "OCD," "on IEP at school – doesn't like school – people make fun of her compulsive behaviors – doesn't like bare feet, etc.," good appetite, stable mood, difficulty making friends, "rapid speech," and "not depressed." Dr. Mahajan documented Axis I as "anxiety" and "OCD," Axis IV as psychosocial, and Axis V as 60. Dr. Mahajan checked "yes" indicating "Patient/Guardian understands and consents to medications." He prescribed Adderall XR 10 mg in the morning and at noon, and Zyprexa 5 mg at 8:00 p.m. (St. Ex. 7 at 49)

193. At Patient 7's next visit on August 11, 2005, Dr. Mahajan documented, among other things that Patient 7 was sick every morning, focusing better, sleeping okay, "appetite," "mood stable most of time," "anxious sometimes," "picking at skin," and "nervous habit- wiping mouth [with] shirt." Dr. Mahajan noted a diagnosis of "anxiety" and maintained Patient 7 on Adderall XR and Zyprexa. (St. Ex. 7 at 47)

    Dr. Mahajan maintained Patient 7 on that regimen through November 9, 2005, at which time he decreased the Adderall XR to 20 mg in the morning. He continued Zyprexa 5 mg at 8:00 p.m. Dr. Mahajan's progress note for that visit indicates among other things that Patient 7 was experiencing increased anger and frustration, increase in compulsive behaviors such as cracking knuckles, and "inappropriate acting out in public places." Dr. Mahajan noted diagnoses of 300.02 and 314.01. (St. Ex. 7 at 41)

194. A notation on the progress note for the November 9, 2005, visit indicates that it had been reviewed by Dr. Patel. (St. Ex. 7 at 41)

195. At the following visit on December 7, 2005, Dr. Mahajan noted: "Came [with] father. Overall anxiety is under control <u>except</u> social situations. In class peers tease her for her reactions to sneezing & inadvertently [Patient 7] gets more anxious. Parents are working [with Patient 7] to empower her with recognizing the anxiety triggers." (Emphasis in original) Dr. Mahajan noted diagnoses of "300.02" and "314.05." He increased Patient 7's Adderall XR from 20 mg in the morning to 30 mg in the morning. Zyprexa was maintained at 5 mg at 8:00 p.m. (St. Ex. 7 at 39)

196. At Patient 7's next visit on January 12, 2006, Dr. Mahajan documented: "Mom would like to ↓ Zyprexa due to ↑ appetite," "night terrors," "picking @ legs & forehead," "[expressive?] sometimes," and "mood stable most of time." Dr. Mahajan noted diagnoses of "300.02" and "314.05." He prescribed Adderall XR 30 mg in the morning, "Zyprexa 5 mg HS," and added "Klonopin 0.25 mg qhs." (St. Ex. 7 at 37)

At the following visit, Dr. Mahajan continued Patient 7 on Adderall and Zyprexa, and noted "Klonopin 0.25 mg HS – never filled per mom." (St. Ex. 7 at 35) At the next visit, the Klonopin is lined out. (St. Ex. 7 at 33)

197. Dr. Mahajan continued Patient 7 on Adderall and Zyprexa through the last visit documented in State's Exhibit 7, May 18, 2006. The progress note for that visit indicates that Patient 7's parents wanted to try counseling. Dr. Mahajan prescribed a one-month supply of Adderall XR 30 mg and discontinued Zyprexa. Patient 7 was to see him again on August 17, 2006. (St. Ex. 7 at 25-27)

Psychiatric Evaluation

198. With respect to the allegation that he had failed to complete or document a psychiatric evaluation of Patient 7, Dr. Mahajan stated in his report: "A complete evaluation was done on 7-25-05 based upon a psychiatric diagnostic interview with the patient and mother. An evaluation by a psychologist was enclosed." (Resp. Ex. AA at 11; Tr. at 497)

Diagnostic Codes

199. Dr. Mahajan's documentation of diagnoses for Patient 7 is particularly confusing. His initial diagnoses were anxiety disorder (DSM-IV 300.2) and obsessive-compulsive disorder [OCD]. (Resp. Ex. G at 23) Later in the chart, one of the following additional diagnostic codes is also used at different visits: "314.07" (Resp. Ex. G at 29), "314.05" (Resp. Ex. G at 34-36), and "314.01" (ADHD) (Resp. Ex. G at 37-40).

Laboratory Studies

200. Dr. Mahajan stated in his report that laboratory studies were not indicated for the medications he prescribed to Patient 7. (Resp. Ex. AA at 11)

Documentation of Adverse Effects of Medications Prescribed

201. Dr. Mahajan denied the allegation that he had failed to document the presence or absence of adverse effects for the medications he prescribed to Patient 7. Dr. Mahajan testified that, at every office visit with Patient 7, he had paid attention to possible adverse effects from medication. (Tr. at 498-501)

AIMS Testing

202. Dr. Mahajan testified that AIMS testing was unnecessary in Patient 7's case because he had prescribed a modern antipsychotic medication, Zyprexa. (Tr. at 501; Resp. Ex. G)

Additional testimony by Dr. Mahajan

203. Dr. Mahajan testified that, in his opinion, Patient 7 improved under his care. (Tr. at 502)

204. Dr. Mahajan testified that his treatment of Patient 7 had complied with the minimal standard of care. (Tr. at 502-503)

Patient 8

205. Patient 8 is a male born in 1992. He first visited Dr. Mahajan on May 29, 1997.[34] The last visit documented in State's Exhibit 8 occurred on July 20, 2006. (St. Ex. 8 at 47-231)

206. For Patient 8's December 3, 1999, visit,[35] Dr. Mahajan documented diagnoses of "314.01" and "309.28," and prescribed Dexedrine SP 10 mg to be taken three times per day; Tenex 1.0 mg, one-half pill to be taken twice per day; and Risperdal 1 mg to be taken in the morning and at bedtime. (St. Ex. 8 at 183) According to the medical record, Dr. Mahajan prescribed the following regimen:

Dexedrine SP 10 mg three times per day
Tenex 1.0 mg, ½ tablet twice per day
Risperdal 1 mg in the morning and at bedtime

207. Subsequently, Dr. Mahajan made the following changes to that regimen:

a. On May 18, 2000, Dr. Mahajan documented "Trouble in AM – on the [bus?] in PM. Good med. compliance. No side effects." The diagnosis is "314.01." He increased Tenex to 1.0 mg twice per day. (St. Ex. 8 at 175) Thus, the new regimen consisted of:

Dexedrine SP 10 mg three times per day
Tenex 1.0 mg twice per day
Risperdal 1 mg in the morning and at bedtime

b. Patient 8 remained on that regimen until November 3, 2000. At that visit, Dr. Mahajan documented "Not sleeping at night, otherwise doing well," and a diagnosis of "314.01." He increased Risperdal to 1 mg in the morning and 1.5 mg at bedtime. (St. Ex. 8 at 165) Accordingly, the medications then prescribed were:

Dexedrine SP 10 mg three times per day
Tenex 1.0 mg twice per day
Risperdal 1 mg in the morning and 1.5 mg at bedtime

c. About ten months and several visits later, on September 20, 2001, Dr. Mahajan documented "Overall doing well," eating and sleeping okay, no new medical problems, and "Major trouble in school." He documented a diagnosis of "314.01." Dr. Mahajan discontinued Dexedrine and prescribed Effexor XR 37.5 mg in the

[34] The date of the Patient 8's initial visit with Dr. Mahajan is outside the scope of the Notice, which concerns a period "[f]rom in or about 2000 to in or about 2006 * * *." (St. Ex. 14A)
[35] The Hearing Examiner considers December 1999 to be "in or about 2000" as stated in the Notice. (St. Ex. 14A)

morning, along with Tenex 1.0 mg twice per day and Risperdal 1 mg in the morning and 1.5 mg at bedtime. (St. Ex. 8 at 151)

New regimen: Effexor XR 37.5 mg in the morning
Tenex 1.0 mg twice per day
Risperdal 1 mg in the morning and 1.5 mg at bedtime

d. At the following visit, October 5, 2001, Dr. Mahajan documented "Beh. worse" and "attention worse."[36] He documented a diagnosis of "314.01." Dr. Mahajan discontinued Effexor and reinstituted Dexedrine SP 10 mg in its place. (St. Ex. 8 at 149)

New regimen: Dexedrine SP 10 mg three times per day
Tenex 1.0 mg twice per day
Risperdal 1 mg in the morning and 1.5 mg at bedtime

e. Patient 8's next visit occurred on November 30, 2001. Dr. Mahajan documented "O.D.D. [illegible] bad" and "school ok," along with the diagnoses "296.2" and "314.01." Dr. Mahajan discontinued Risperdal and Tenex and prescribed Seroquel 25 mg,[37] to take one in the morning and two at bedtime. (St. Ex. 8 at 145)

New regimen: Dexedrine SP 10 mg three times per day
Seroquel 25 mg in the morning and 50 mg at bedtime

f. At the next visit on December 28, 2001, Dr. Mahajan documented (and this is very difficult to read) "not sleeping," "beh. during the day – ok," and "restless[?] during the day." The diagnosis is "314.01." Dr. Mahajan discontinued Dexedrine and Seroquel and prescribed Adderall XR 10 mg in the morning and Zyprexa 2.5 mg at bedtime. He also reinstituted Tenex 1 mg twice per day, (although he wrote it on the same line as "D/C Dexedrine," which makes it very confusing). (St. Ex. 8 at 143)

New regimen: Adderall XR 10 mg in the morning
Tenex 1.0 mg twice per day
Zyprexa 2.5 mg at bedtime

g. For the following visit, on January 21, 2002, Dr. Mahajan documented "argumentative," "school – disorganized," "grades ↓," and "no tics."[38] Dr. Mahajan documented a diagnosis of "314.01." He discontinued Adderall and reinstituted Dexedrine SP 10 mg three times per day. (St. Ex. 8 at 141)

New regimen: Dexedrine SP 10 mg three times per day
Tenex 1.0 mg twice per day

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[36] This is the Hearing Examiner's best interpretation of the note, which is barely legible. (St. Ex. 8 at 149)
[37] MedlinePlus states that Seroquel is an atypical antipsychotic. (MedlinePlus website, March 15, 2010, <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a698019.html>)
[38] Tics had not been mentioned previously in Patient 8's medical record. (St. Ex. 8)

Zyprexa 2.5 mg at bedtime

h. At the next visit, February 18, 2002, Dr. Mahajan documented "Still aggressive" but "Ok at school." He documented a diagnosis of "314.01" and added to the regimen Effexor XR 75 mg in the morning. (St. Ex. 8 at 139)

New regimen: Effexor XR 75 mg in the morning
Dexedrine SP 10 mg three times per day
Tenex 1.0 mg twice per day
Zyprexa 2.5 mg at bedtime

i. On March 3, 2002, Patient 8 was admitted to UVMC. Dr. Mahajan's History of Present Illness states:

> The patient has been seen at the office for a couple of years. Intermittently, he has improved. He has also been seeing Kevin for counseling. She [sic] has been Dexedrine, Zyprexa, Tenex, and Effexor with intermittent benefit. In the last three weeks, however, he has become very bizarre. He has been urinating in clothes and spitting in inappropriately. He has been having mood swings. He has been very disruptive. He has become withdrawn and has been using foul names without any provocation. He has a history of worrying, crying often, racing thoughts, restlessness, irritability, lying, truancy, and fighting.

(St. Ex. 8 at 288) Under Mental Status, Dr. Mahajan stated:

> Mental status examination shows a cooperative male with flat affect, labile moods, anger, and not wanting to be here. He is in denial. Judgment is poor. Impulse control is poor. Insight is absent. Intellectual functions are in average range clinically. He does not know why he has shown inappropriate behaviors. He denies hearing any voices.

(St. Ex. 8 at 288) Dr. Mahajan's Diagnostic Impression was:

Axis I: Psychotic disorder, NOS; rule out bipolar disorder, mixed, moderate, recurrent; rule out ADHD.
Axis II: None.
Axis III None.
Axis IV 2.
Axis V: Global Assessment of Functioning – 20.

(St. Ex. 8 at 287)

Patient 8 was discharged on March 8, 2002. Dr. Mahajan diagnosed bipolar disorder, mixed, moderate, recurrent; and ADHD. Under Treatments Rendered, he wrote: "During

his stay in the unit, he participated in individual and group therapies. Medications of Depakote and Adderall were given with benefit. His affect improved. Mood improved. No side effects were reported." (St. Ex. 8 at 290) Dr. Mahajan prescribed Adderall 5 mg three times per day, and Depakote 250 mg with instructions to take one in the morning and two at night. He prescribed a two-month supply of each. (St. Ex. 8 at 289)

In addition, under the heading Laboratory Data, Dr. Mahajan stated: "Depakote level was in 70s. Otherwise the laboratory examination were within normal limits." (St. Ex. 8 at 290) There is no indication whether Tenex and/or Zyprexa were to be continued or discontinued. (St. Ex. 8 at 289-290)

New regimen: Adderall 5 mg three times per day
Depakote 250 mg in the morning and 500 mg at night
Tenex 1.0 mg twice per day? (Presumed discontinued)
Zyprexa 2.5 mg at bedtime?

j. Patient 8 next visited Dr. Mahajan on March 11, 2002, a few days after his discharge from UVMC. Dr. Mahajan documented diagnoses of "314.01" and "Bipolar D/O." No symptoms or side effects were noted. Dr. Mahajan documented increasing Patient 8's Adderall to 10 mg three times per day, and maintaining Patient 8 on Depakote 250 mg one in the morning and two at night. (St. Ex. 8 at 135)

New regimen: Adderall 10 mg three times per day
Depakote 250 mg in the morning and 500 mg at night
Zyprexa 2.5 mg at bedtime? (not documented)

k. At Patient 8's next visit, March 22, 2002, Dr. Mahajan noted "on Zyprexa 2.5 mg qhs as usual complaints." Dr. Mahajan documented diagnoses of "314.01" and bipolar disorder. He prescribed Adderall 10 mg three times per day, Depakote 250 mg one in the morning and two at night, and Zyprexa 2.5 mg at bedtime. (St. Ex. 8 at 133)

New regimen: Adderall 10 mg three times per day
Depakote 250 mg in the morning and 500 mg at night
Zyprexa 2.5 mg at bedtime

l. Several visits later, on September 5, 2002, Dr. Mahajan documented "Not staying on task" and "cooperative but impulsive stealing." He documented "314.01" as the only diagnosis. He changed Adderall 10 mg to Adderall XR 10 mg three times per day, continued Depakote 250 mg one in the morning and two at night, and increased Zyprexa to 5 mg at bedtime. (St. Ex. 8 at 125)

New regimen: Adderall XR 10 mg three times per day
Depakote 250 mg in the morning and 500 mg at night
Zyprexa 5 mg at bedtime

m. At the next visit, October 3, 2002, Dr. Mahajan documented "overall doing well" and "some problems with grades." He documented "314.01" as the only diagnosis. He increased Adderall XR to 15 mg three times per day and maintained the Depakote and Zyprexa. He instructed Patient 8 to return in one month. (St. Ex. 8 at 123)

New regimen: Adderall XR 15 mg three times per day
Depakote 250 mg in the morning and 500 mg at night
Zyprexa 5 mg at bedtime

n. At the next visit, which was two months later on December 2, 2002, Dr. Mahajan wrote "minimal change" and "good meds compliance." He documented a diagnosis of "314.01" only. He prescribed Adderall XR 30 mg in the morning and 10 mg at noon (a decrease of 5 mg per day), Depakote 250 mg two in the morning and two at bedtime (an increase of 250 mg per day), and Zyprexa 7.5 mg at bedtime (an increase of 2.5 mg per day). Dr. Mahajan did not document those medication changes as changes. (It is possible that there had been an intervening appointment in November, but neither State's Exhibit 8 nor Respondent's Exhibit H includes a progress note from that visit, if there had been such a visit.) (St. Ex. 8 at 121)

New regimen: Adderall XR 30 mg in the morning and 10 mg at noon
Depakote 500 mg in the morning and 500 mg at night
Zyprexa 7.5 mg at bedtime

o. On April 25, 2003, Dr. Mahajan that Patient 8 had been seen in the ER, "argumentative," "grades ↓↓," and "Adderall works." He documented a diagnosis of "314.01" only. Dr. Mahajan further documented that he was increasing Adderall XR to 20 mg two in the morning and, although it is hard to read, probably 10 mg at noon.[39] (Depakote and Zyprexa are not mentioned.) (St. Ex. 8 at 115)

New regimen: Adderall XR 40 mg in the morning and 10 mg (possibly 20 mg) at noon
Depakote 500 mg in the morning and 500 mg at night?
Zyprexa 7.5 mg at bedtime?

p. At the following visit on May 8, 2003, Dr. Mahajan documented "Better" and that Patient 8's eating, sleeping, and school were all okay. He documented a diagnosis of "314.01" only and prescribed Adderall XR 20 mg two in the morning and 20 mg at noon, Depakote 250 mg two in the morning and two at bedtime, and Zyprexa 7.5 mg at bedtime. (St. Ex. 8 at 113)

New regimen: Adderall XR 40 mg in the morning and 20 mg at noon
Depakote 500 mg in the morning and 500 mg at night
Zyprexa 7.5 mg at bedtime

[39] It might say 20 mg but the "2" in 20 appears to have been scratched out. (St. Ex. 8 at 115)

q. A note dated May 23, 2003, indicates that Patient 8 had been seen in the ER. It appears that Dr. Mahajan had been consulted, or possibly had seen Patient 8 at the ER. Dr. Mahajan's note says, "[illegible] – stole – paranoid – talking to self – impulse control poor – violent – screaming things – add Risperdal 1 mg AM. See as scheduled." (St. Ex. 8 at 111)

New regimen: Adderall XR 40 mg in the morning and 20 mg at noon
Depakote 500 mg in the morning and 500 mg at night
Zyprexa 7.5 mg at bedtime
Risperdal 1 mg in the morning

r. Patient 8's next visit was June 5, 2003. Dr. Mahajan documented "Doing well," eating okay, "strange behavior," and "[illegible (possibly "bugging")] – [illegible (possibly "pulling")] mom." Dr. Mahajan documented a diagnosis of "314.01" only. He discontinued Adderall and Zyprexa, continued Depakote, and increased Risperdal to 1 mg in the morning and 2 mg at bedtime. (St. Ex. 8 at 109)

New regimen: Depakote 500 mg in the morning and 500 mg at night
Risperdal 1 mg in the morning and 2 mg at bedtime

s. Patient 8 was again admitted to UVMC on June 10, 2003. Dr. Mahajan noted the following History of Present Illness:

> The patient was brought to the crisis center. The patient was hearing voices, seeing things. Mother stated he was very paranoid. He stated people were out to get him. The patient was pointing to people who were really not doing anything. He has been cussing, going after family members for no reason. He tried to break mother's fingers. He tried to get out of the car while moving. He chased his brother with a shovel. Mother is worried about family safety. Outpatient management was not working. Many medicines have been changed.

(St. Ex. 8 at 247) Dr. Mahajan also documented, among other things, "The patient has been seen in my office for counseling and medicines. Presently, he is on Depakote and Risperdal. He was taken off the Adderall because he was not responding." (St. Ex. 8 at 247) In addition, Dr. Mahajan noted the following under Mental Status Exam:

> A cooperative male who appeared stated age. He was internally preoccupied. Eye contact was good. Facial expressions were appropriate. He was oriented to person, place and time. However, there was inappropriate laughter. Mood was anxious to depressed. Thought patterns had paranoid ideations. He talked about hearing voices and seeing things. Associations were coherent. Judgment is poor. Impulse control is poor. Insight is absent. Intellectual functions are in average range clinically.

(St. Ex. 8 at 249)

Patient 8 was discharged on June 17, 2003. Dr. Mahajan's discharge diagnoses were bipolar disorder and ADHD. He prescribed Zyprexa 2.5 mg with instruction to take one-half tablet in the morning and one whole tablet at 8:00 p.m., Tegretol Chewable 100 mg three time per day, Adderall XR 15 mg twice per day, and Lexapro 10 mg one at 6:00 p.m. (St. Ex. 8 at 243)

New regimen: Adderall XR 15 mg in the morning and at noon
Tegretol Chewable 100 mg three times per day
Zyprexa 1.25 mg in the morning and 2.5 mg at bedtime
Lexapro 10 mg at 6:00 p.m.

Patient 8 next saw Dr. Mahajan at Dr. Mahajan's office on June 20, 2003. He documented a diagnosis of bipolar disorder only. He continued the medications prescribed at discharge. (St. Ex. 8 at 103)

New regimen: Adderall XR 15 mg in the morning and at noon
Tegretol Chewable 100 mg three times per day
Zyprexa 1.25 mg in the morning and 2.5 mg at bedtime
Lexapro 10 mg at 6:00 p.m.

t. Two visits later, on July 28, 2003, Dr. Mahajan noted "very hyper," "constantly hyper," and "denies." He documented a diagnosis of bipolar disorder, and discontinued Tegretol, Zyprexa, and Lexapro. Dr. Mahajan also added a new medication, "Mellaril 10 mg BID $ qhs."[40] Adderall XR was not mentioned. (St. Ex. 8 at 99)

New regimen: Adderall XR 15 mg in the morning and at noon?
"Mellaril 10 mg BID $ qhs"

u. Patient 8 next visited Dr. Mahajan on September 8, 2003. Dr. Mahajan documented that Patient 8 was doing "reasonably well" and was eating and sleeping okay. His documented diagnosis was "314.01." He prescribed Mellaril 10 mg one tablet twice per day, two at bedtime, and Adderall XR 15 mg twice per day. (St. Ex. 8 at 97)

New regimen: Adderall XR 15 mg in the morning and at noon
Mellaril 10 mg twice per day plus 20 mg at bedtime

v. At the following visit on October 6, 2003, Dr. Mahajan documented "Super unorganized" "No [illegible]," "hyper," "difficult to wake up," and "anger [illegible (outbursts?)]. Dr. Mahajan further documented that Patient 8 was not receiving his noon dose of Adderall XR. The diagnosis is "314.01," and Dr. Mahajan increased

[40] MedlinePlus describes Mellaril as a conventional antipsychotic medication. (MedlinePlus website, March 15, 2010, <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682119.html>)

Adderall XR to 20 mg in the morning and at noon, and continued Mellaril. (St. Ex. 8 at 95)

New regimen: Adderall XR 20 mg in the morning and at noon
Mellaril 10 mg twice per day plus 20 mg at bedtime

w. Two visits later, on January 26, 2004, Dr. Mahajan documented "No [illegible] – disorganized" and "Adderall not working." Dr. Mahajan noted a diagnosis of "314.01" and prescribed Strattera 40 mg in the morning and Mellaril 10 mg one tablet twice per day, two at bedtime. (St. Ex. 8 at 91)

New regimen: Strattera 40 mg in the morning
Mellaril 10 mg twice per day plus 20 mg at bedtime

x. Dr. Mahajan's progress note for the following visit on February 23, 2004, states, "Tics are improved.[41] Disruptive behavior, [less] focused, hyperactive. More aggressive [circled] @ home/school. Complaints from school. Poor @ school. More demanding. Gets into fight. Appetite better, sleep WNL. Med compliance is good." Dr. Mahajan's diagnosis was "314.01." He discontinued Strattera and Mellaril, reinstated Adderall XR 20 mg in the morning and at noon, and added Geodon 20 mg one in the morning and two at bedtime. (St. Ex. 8 at 89)

New regimen: Adderall XR 20 mg in the morning and at noon
Geodon 20 mg in the morning and 40 mg at bedtime

y. Two visits later on April 5, 2004, Dr. Mahajan noted "obsessed – a lot but doing well" and "scared to go to bed." Dr. Mahajan documented a diagnosis of bipolar disorder. He discontinued Geodon and prescribed Adderall XR 20 mg to be taken in the morning and at noon, and "Symbyax 6/25."[42] (No instructions for Symbyax were documented). (St. Ex. 8 at 85)

New regimen: Adderall XR 20 mg in the morning and at noon
Symbyax 6/25

Dr. Mahajan next saw Patient 8 on April 26, 2004. Dr. Mahajan noted: "Came [with] mother. Fearless. Getting into fight @ school. Getting worse. Very moody. Does not listen. Defiant. Sleep & appetite ok. [Patient 8] says brother bother him. picking up [illegible] kids." Dr. Mahajan documented a diagnosis of bipolar disorder and prescribed Adderall XR 20 mg in the morning and at noon, and Symbyax 6/25 at bedtime. (St. Ex. 8 at 83)

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[41] This is the first progress note since January 21, 2002, to mention tics. Since then, until February 23, 2004, there had been no documentation that Patient 8 had suffered from tics or that tics had been a problem. (St. Ex. 8)

[42] "Symbyax contains two medicines, olanzapine [Zyprexa] and fluoxetine [Prozac]." (*PDRHealth.com* March 8, 2010, <http://www.pdrhealth.com/drugs/rx/rx-mono.aspx?contentFileName=sym1686.html&contentName=Symbyax&contentId=726>)

Regimen: Adderall XR 20 mg in the morning and at noon
Symbyax 6/25 at bedtime

z. Patient 8 next visited Dr. Mahajan on May 3, 2004. Dr. Mahajan documented "irritable," "not caring," and "Symbyax not working." He documented a diagnosis of "314.01." Dr. Mahajan discontinued Symbyax and added Risperdal 0.5 mg twice per day and 1 mg at bedtime. (St. Ex. 8 at 81)

New regimen: Adderall XR 20 mg in the morning and at noon
Risperdal 0.5 mg twice per day and 1 mg at bedtime

Dr. Mahajan maintained Patient 8 on this regimen for a little over one year. (St. Ex. 8 at 65-75)

aa. On July 6, 2005, Dr. Mahajan documented that Patient 8 had not been taking the mid-day Risperdal or Adderall, and "Mom thinking ↓ meds." Dr. Mahajan noted that Patient 8 was sleeping okay, "argumentative," and "wants to know if he still needs meds." He noted a diagnosis of bipolar disorder. Dr. Mahajan discontinued Risperdal, noted that Patient 8 had 15 Adderall left, and instructed him to take one tablet per day in the morning, presumably until gone. (St. Ex. 8 at 63)

New regimen: Adderall XR 20 mg in the morning for 15 days, then discontinue

bb. At Patient 8's next visit, which occurred August 29, 2005, Dr. Mahajan documented "states very [illegible] hyper," "argumentative," and "goes [illegible]." Dr. Mahajan noted the diagnosis as bipolar disorder and prescribed Adderall XR 20 mg to be taken in the morning (which was corrected a few days later to one in the morning and one at 11:00 a.m.), and Risperdal 0.5 mg, one in the morning, one at 11:00 a.m., and two at bedtime. (St. Ex. 8 at 61)

New regimen: Adderall XR 20 mg in the morning and at 11:00 a.m.
Risperdal 0.5 mg twice per day and 1 mg at bedtime

Dr. Mahajan maintained Patient 8 on this regimen through May 2006. (St. Ex. 8 at 49-59)

cc. Dr. Mahajan's progress note for Patient 8's May 17, 2006, visit states, "Hasn't changed behavior, motivation ↑, grades up, some behavior problems, sleep is good, appetite ↑ and argumentative." Dr. Mahajan's diagnosis was "314.01." He continued the Risperdal as before but decreased Adderall XR 20 mg to one in the morning, although it is not noted as a decrease. (St. Ex. 8 at 49)

New regimen: Adderall XR 20 mg in the morning
Risperdal 0.5 mg twice per day and 1 mg at bedtime

> Dr. Mahajan continued Patient 8 on that regimen at his next visit on July 20, 2006, the last visit documented in State's Exhibit 8. (St. Ex. 8 at 47)

Documentation of Informed Consent

208. For the majority of Patient 8's visits between September 2000 and the last visit documented in July 2006, Dr. Mahajan documented "Patient/Guardian understands and consents to medications." (St. Ex. 8 at 47-167)

Opinion of Dr. Mahajan

209. Dr. Mahajan testified concerning Patient 8:

> I knew this patient would get me in trouble somewhere if the chart was looked at. He saw me until last year since 1997. Since '97. And I hung with them for different reasons. I did not want an ideal patient. I wanted to grow with them. So in the charting you can find a lot of things, but I did everything right.

(Tr. at 503)

Dr. Mahajan further testified that the mother's primary focus had been Patient 8's aggressive behavior. Dr. Mahajan further stated, "Complaints were inconsistent. Compliance was inconsistent. She said she was giving it, but I have no right to question them because that's practice of psychiatry." Dr. Mahajan noted that he was not practicing forensic psychiatry where he can doubt his patient. (Tr. at 504)

Moreover, Dr. Mahajan testified that, of the ten patients at issue in this matter, Patient 8 was by far the most difficult and unresponsive to treatment. (Tr. at 510-511)

210. Dr. Mahajan testified that Patient 8's Depakote levels were low during his stay in the hospital because he was started on Depakote at the hospital, and it takes about five days before the Depakote starts working. Dr. Mahajan acknowledged that he then continued prescribing Depakote to Patient 8 for more than one year. (Tr. at 635-636)

211. When asked what DSM-IV diagnoses he had treated Patient 8 for, Dr. Mahajan replied: "My working diagnosis, still, etiological working diagnosis still was attention deficit. DSM-IV, according to symptoms, was bipolar. But as DSM says, you don't have to treat axis 1. And it is—it makes sense that how can you treat cluster of symptoms?" (Tr. at 525)

212. Dr. Mahajan denied that he had failed to obtain patient/guardian consent for the medications he prescribed for Patient 8. With respect to educating the patients concerning side effects, Dr. Mahajan testified that all patients/guardians are instructed to call him personally with questions concerning any new effect that the patient experiences. Dr. Mahajan further testified that he answers patients' questions at no charge to improve the quality of their care. (Tr. at 526-527)

213. With respect to Dr. Mahajan's reason for briefly changing Patient 8's medication from Adderall and Mellaril to Strattera and Mellaril in January 2004, the following exchange took place:

Q. [By Mr. Subashi] Now, tell us about placing him on Mellaril ten milligrams. Tell us about that, in the last paragraph on page 12 [of Respondent's Exhibit AA].

A. [By Dr. Mahajan] Okay. Now, this would have been the ideal medicine combination for him. Low dose of Mellaril and Adderall. When the environment at home would be good, he took the medicine. He did well on this. And for a short time, if you looked at the notes, he did well. But these TV commercials, insurance company irritations, they have messed up the treatment.

Strattera was being advertised, and it is a non-addicting medicine. What they say is wrong. So what do you do? Yeah, it is non-stimulant. But do they know that it takes three months first and you have to keep increasing? Because drug company's saying it. Liver side effects. And in kids, it doesn't work. In adults, it works, because adults have already adjusted to their past.

Q. Okay. So, Doctor, why then on January 26th, 2004, 1-26-04, why did you change to Strattera?

* * *

A. On 11-3 [2003], he has been given medicines for three months. Christmas coming and all. From 11-21, it is two months. Second, 80 pound weight, 79. He has taken the medicine. But Mom's report is Adderall is not working and why not Strattera? How do you argue? So give Strattera a try.

Q. Okay. Did you consider the use of Strattera to be the right thing at that point in time?

A. No, sir. I cannot practice ideal psychiatry in clinical settings all the time.

Q. Okay. So why did you—why did you diagnose this—or prescribe this Strattera, then?

A. Because of all the outside influences. I don't know if it was also on the formulary. That part I cannot tell you. But there has to be a reason because even I know I don't agree.

Q. Is the use of Strattera for ADHD—

A. Yes.

Q. —a recognized use?

A. And it's a very low dose [40 mg in the morning]. 120 [mg] is the maximum.

Q. Were you giving the Strattera, then, on January 26th, 2004, and—

A. I wrote it, so I—

Q. Okay. Doctor, remember, we can't talk at the same time. Okay?

A. No, no, no. Sorry.

Q. My question to you was, were you giving the Strattera on an experimental basis to see how it worked with this patient?

A. Yes, sir.

(Tr. at 518-521)

214. As stated previously, at Patient 8's February 23, 2004, visit, Dr. Mahajan documented, among other things, "Tics are improved." Dr. Mahajan acknowledged that, at Patient 8's previous visit on January 26, 2004, there was no mention of tics. January 26, 2004, was also the visit where Dr. Mahajan changed Patient 8 to Strattera. (Tr. at 631-632; St. Ex. 8 at 89, 91)

When asked if he had made any medication adjustment to address a problem with tics prior to the February 23, 2004, visit, Dr. Mahajan replied:

> Okay. They—this Strattera was changed in response to the tics complaints, because that's how they were market—it was marketed, that Strattera does not cause tics. Adderall, Concerta can cause tics. Tics or Tourette's—it's due to excessive Dopamine. And Concerta and Adderall can cause that, so does Strattera, but marketed as Strattera does not cause tics.[43]

(Tr. at 633) However, in Dr. Mahajan's notes for Patient 8's January 26, 2004, visit, when Dr. Mahajan discontinued Adderall and added Strattera, the only reason documented for that change was "Adderall not working." (St. Ex. 8 at 91)

215. Dr. Mahajan denied that tics are a symptom of tardive dyskinesia. (Tr. at 633)

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[43] Dr. Mahajan seemed to be saying that, in order to address Patient 8's complaint of tics, he changed Patient 8's psychostimulant from Adderall, which can cause tics, to Strattera, which can also cause tics but which is marketed as not causing tics. (Tr. at 633)

216. Dr. Mahajan opined that his care and treatment of Patient 8 complied with the minimal standard of care. (Tr. at 527-528)

217. Dr. Mahajan testified that Patient 8 had improved under his care. (Tr. at 528)

Opinion of Dr. Gutheil

218. Dr. Gutheil testified that "Tegretol has a blood risk factor and Depakote has a liver risk factor" and that the standard of care requires that levels be done. Dr. Gutheil further testified that there was a comment in the chart that the patient had been noncompliant by failing to have the lab work done;[44] however, "[t]he appropriate response would have been to further emphasize the importance and/or discontinue the medication, which of course is risky because then the patient has the untreated symptoms." (Tr. at 721) Dr. Gutheil testified concerning the failure to have lab work done: "The failure to do that in this one case would in my view be below the standard of care. Probably maybe even not below the minimum standard of care, but certainly enough to make me uncomfortable with that as a practice." (Tr. at 722)

219. Dr. Gutheil testified that Dr. Mahajan's "[c]are of Patient 8 shows some deficiencies which, although not resulting in harm, would be deviations from the standard of care." (Tr. at 723)

Opinion of Dr. Polster

220. In his report, Dr. Polster stated:

> Recommendations for monitoring levels of Depakote and Tegretol can be vague and the actual practice varies between different physicians. This may be especially true in children who may be wary of needle sticks. In this particular case, this patient was on Tegretol for a short period of time only. Depakote had been monitored during the patient's hospitalizations. During some lengthier periods of time in which it appeared Depakote levels were not monitored, Dr. Mahajan reports that the family was non-compliant with recommendations and would tell him that the pediatrician was monitoring the patient. He SHOULD have documented that, or otherwise stopped the medication in favor of a different agent.

(Resp. Ex. GG at 5) (Emphasis in original)

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[44] The Hearing Examiner was unable to find documentation that, after he began prescribing Depakote or Tegretol to Patient 8, Dr. Mahajan had ordered a blood test and Patient 8 had been noncompliant. Much earlier, beginning with Patient 8's first visit in May 1997 and the next two visits through August 1997, Dr. Mahajan *had* documented ordering liver function tests and Patient 8's noncompliance; however, Dr. Mahajan did not prescribe Depakote or Tegretol to Patient 8 until Patient 8's March 2002 hospitalization. Moreover, beginning with Patient 8's August 8, 2002, visit, Dr. Mahajan had changed his progress note form to add a notation that said "Test Ordered" with "yes" and "no" checkboxes next to it. For that visit and each subsequent visit, Dr. Mahajan either checked the "no" box or left both checkboxes blank. (St. Ex. 8 at 47-133, 231-232)

221. When asked to describe the purpose of obtaining Depakote levels on a patient who is taking Depakote for an extended period of time, Dr. Polster replied:

> There are several things you're looking for when—if and when you document the Depakote level—when you get the blood test. One is to document a Depakote level, either to see if it falls within a therapeutic change of Depakote or to see how compliant the patient is being with the medication.
>
> There are also some parameters that you want to watch to see if the Depakote can be affecting the body in any way. Liver panel, to see how it might affect the liver; platelets, to see if there are might be a reduction in the amount of platelets; something called a PT and PTT which has to do with blood clotting times, things like that. And those are usually what I will measure if * * * I have a patient on Depakote, I'll usually send them for those four things.

(Tr. at 896-897)

Dr. Polster further testified that, once he has a patient established on what he considers to be a stable dosage of Depakote, he has the patient tested every six months. (Tr. at 897) However, Dr. Polster testified: "I would say that I would at least like to monitor those parameters once a year, and I know practitioners that will monitor them once a year. So I would want those things checked at least yearly." (Tr. at 898)

222. Patient 8's mother wrote a letter of support for Dr. Mahajan. (Resp. Ex. K at 2-3)

Patient 9

223. Patient 9 is a male born in 1999. He first saw Dr. Mahajan on March 3, 2005. The last visit documented in State's Exhibit 9 occurred on December 22, 2005. (St. Ex. 9 at 19-47)

224. Prior to his initial visit, on or around March 1, 2005, Dr. Mahajan or a member of his staff completed a Child/Adolescent Intake Interview form. Under Presenting Problems, the writer stated:

> Mom complains of [increased] moodiness; quick change in moods; In December, he stated he hears voices; aggression; oppositional [illegible]; very angry when asked not to do something; screams, temper tantrums, [very] hyper, low self esteem. Up late at night – up at 5:30 – sleeps restless.

(St. Ex. 9 at 49) Symptoms were identified as poor sleep, irritability, hyper and disruptive energy level, anxiety, anger, and very poor concentration. His primary care physician had tried him on Adderall XR 5 mg from October 2003 through February 2004. Under the Behavioral Disorders and Assessment, all boxes except one were checked in the ADHD category, and all boxes were checked in the ODD category. (St. Ex. 9 at 49-51, 63)

225. At Patient 9's initial visit on March 3, 2005, Dr. Mahajan reiterated the symptoms noted above and further noted that Patient 9 hears "voices in his head * * * makes him do bad things" and has a hard time getting along with other children. He diagnosed Axis I "314.01," Axis IV psychosocial, and Axis V 65. Dr. Mahajan prescribed Adderall XR 10 mg in the morning and Seroquel 25 mg at bedtime. He checked boxes indicating that Patient 9 was not a danger to himself or others, that he had no substance abuse issue, that no tests were ordered, that no samples were given, and that "Patient/Guardian understands and consents to medications." (St. Ex. 9 at 47)

226. Dr. Mahajan's progress note for Patient 9's next visit on April 7, 2005, states "sleeping good," "verbal and physical aggression remains but has [decreased], "anger problems," "stable at school," and "better focus." Dr. Mahajan documented a diagnosis of "314.01." He prescribed Adderall XR 15 mg in the morning (an increase of 5 mg) and Seroquel 25 mg at bedtime. (St. Ex. 9 at 45)

    A "post-it" note attached to the April 7, 2005, progress note says, among other things "should she up the dose on Seroquel?" and "↑ 50 mg qhs." The note is dated "4/15" and was signed by Dr. Mahajan. (St. Ex. 9 at 43)

227. At Patient 9's next visit on May 4, 2005, Dr. Mahajan noted that Patient 9's focus and grades were good, he was less moody and irritable, and "no voices," but that he was argumentative and "aggressive [with] parents & yelling." He documented a diagnosis of "314.01." Dr. Mahajan prescribed Adderall XR 15 mg in the morning and Seroquel 25 mg to take two at bedtime. (St. Ex. 9 at 41)

228. Patient 9's next visit took place June 8, 2005. Dr. Mahajan noted increasing improvement in Patient 9's behavior. He further noted that Patient 9 was going to Florida to visit his grandmother for two months. He documented a diagnosis of "314.01" and prescribed Adderall 15 mg in the morning and increased Seroquel 25 mg to one at 4:00 p.m. and two at bedtime. (St. Ex. 9 at 39)

229. A note from Patient 9's grandmother dated July 29, 2005, indicates that Patient 9 misbehaved during his stay with her. She further indicated that he had "received his med's at the right time." (St. Ex. 9 at 37)

230. Dr. Mahajan progress note for Patient 9's next visit on August 3, 2005, indicates that Patient 9's parents were experiencing the same problems with Patient 9's behavior as his grandmother had. Dr. Mahajan documented a diagnosis of "314.01" and prescribed Adderall 15 mg in the morning and Seroquel 50 mg at bedtime. (St. Ex. 9 at 35)

231. At the following visit on August 29, 2005, Dr. Mahajan noted that Patient 9's bad behavior had continued, as well as "Adderall not helping much," and a diagnosis of "314.01." He maintained Seroquel 50 mg at bedtime, discontinued Adderall, and added Strattera 25 mg in the morning. (St. Ex. 9 at 33)

232. Dr. Mahajan's progress note for the next visit on October 12, 2005, indicated that Patient 9's behavior deteriorated on Strattera. The diagnosis is "314.01." Dr. Mahajan reinstated Adderall XR 15 mg in the morning and maintained Seroquel 50 mg at bedtime. (St. Ex. 9 at 31)

233. A note dated October 20, 2005, appears to describe a telephone call from Patient 9's mother. The noted stated that Patient 9 had been "[s]tarted on Focalin XR 10 mg 1 wk" and that his hitting and anger had increased. Another note stated, "Make sure Pt is taking Seroquel as prescribed per Dr. Mahajan." The next note stated: "Spoke [with] dad & [Patient 9] is taking Seroquel as prescribed. Pt. really has never stopped [with] hitting & anger. [Dad's] father beat him as a child & he doesn't want to discipline [Patient 9]." The last note stated, "Encourage to bring Pt. in as needed. Call for earlier appt as needed. Has only been on Focalin 1 wk." (St. Ex. 9 at 27)

234. Dr. Mahajan's progress note for Patient 9's November 10, 2005, visit indicated that his behavior had improved somewhat. The diagnosis is "314.01." Dr. Mahajan continued Seroquel 50 mg at bedtime and prescribed Focalin XE 10 mg in the morning and at noon, an increase over the amount referenced in the October 20 note. (St. Ex. 9 at 25)

235. Dr. Mahajan's progress note for Patient 9's last visit stated, among other things, "Focalin not working," "kicking, screaming, hitting, destructive," and argumentative. The diagnosis is "314.01." Dr. Mahajan discontinued Seroquel, and may also have discontinued Focalin—his note is a little difficult to understand. In addition, he prescribed Zyprexa 5 mg at 8:00 p.m. (St. Ex. 9 at 19)

236. At each visit, Dr. Mahajan checked a box on the progress note indicating that Patient 9/Patient 9's guardian understood and consented to the medications prescribed. (St. Ex. 9 at 19-47)

237. Dr. Mahajan record does not document the ordering of any laboratory studies for Patient 9. (St. Ex. 9)

Opinion of Dr. Mahajan

238. Dr. Mahajan testified that a psychiatric evaluation of Patient 9 had been documented in the chart. (Tr. at 541-542)

239. Dr. Mahajan testified that laboratory studies had not been indicated for Patient 9. (Resp. Ex. AA; Tr. at 542-543)

240. Dr. Mahajan testified that he had had discussions with Patient 9 and his guardian at every visit. Dr. Mahajan further testified that he had a consent letter signed by the guardian dated May 4, 2005.[45] (Resp. Ex. I at 22; Tr. at 543-544)

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[45] The consent form does not mention the name or type of medication consented to which Patient 9's parent consented. (Resp. Ex. I at 22)

241. With respect to the allegation that he had failed to document the presence or absence of adverse side effects of prescribed medication, Dr. Mahajan wrote in his report:

> Monitoring the side effects is a standard part of each visit and is always discussed. To ensure its documentation, there is a section on the progress note which states "Patient/guardian understands side effects and consents to medications ___yes ___ no." An honest attempt is made to check this while doing the documentation process. This is documented during each visit in this chart.

(Resp. Ex. AA at 15; Tr. at 545)

242. Dr. Mahajan denied that he had prescribed medications to Patient 9 on an ad hoc basis. (Tr. at 544-545)

243. Dr. Mahajan testified that AIMS testing was unnecessary in Patient 9's case. (Tr. at 545)

244. Dr. Mahajan testified that his care and treatment of Patient 9 had complied with the minimal standard of care. (Tr. at 546)

Patient 10

245. Patient 10 is a male born in 1994. He first visited Dr. Mahajan on May 8, 2002. The last visit documented in State's Exhibit 10 occurred on July 20, 2006. (St. Ex. 10 at 47-115)

246. In the Child Information questionnaire completed by Patient 10's parent, the parent indicated that the purpose for Patient 10's visit was:

> ADHD; also has oppositional issues; very headstrong & uncooperative at times; concerned about his temper outbursts & tendency to strike out very quickly; seems to have built up frustration and anger; psychologist suggested intervention/exam by psychiatrist for possible behavioral meds.

(St. Ex. 10 at 117)

247. At Patient 10's initial visit on May 8, 2002, Dr. Mahajan noted "on Adderall XR 20 mg AM – able to stay on task," "sleep good [with] melatonin 1 mg," appetite poor, and "anger – still but at home." The mental status examination as documented says "hyper." Dr. Mahajan diagnosed Axis I "314.01," prescribed Adderall XR 20 and Zyprexa 1.25 mg at bedtime, and recommended counseling. Dr. Mahajan checked boxes indicating that Patient 10 was not a danger to himself or others, that no samples were given, and that "Patient/Guardian understands and consents to medications." (St. Ex. 10 at 115)

248. At the next visit, May 30, 2002, Dr. Mahajan noted "Sleeping better but still wakes up." and "Adderall works." Dr. Mahajan documented a diagnosis of "314.01." He prescribed

Adderall 20 mg in the morning and increased Zyprexa to 2.5 mg at bedtime. He further noted that Patient 10 had not been to counseling as recommended. (St. Ex. 10 at 111)

249. On June 27, 2002, Dr. Mahajan noted that Patient 10 "still not sleeping" and that "mom would like to change to concerta." He noted a diagnosis of "314.01," discontinued Adderall, and prescribed Concerta 36 mg in the morning and Zyprexa 2.5 mg at bedtime. Counseling was not mentioned. (St. Ex. 10 at 109)

250. Dr. Mahajan maintained Patient 10 on a regimen of Concerta 36 mg in the morning and Zyprexa 2.5 mg at bedtime through October 27, 2003, except for a brief period when Strattera was substituted for Concerta, evidently due to the wishes of the patient or parent.[46] (St. Ex. 10 at 83-109)

251. On October 27, 2003, Dr. Mahajan documented "overall good," eating and sleeping okay, and "no side effects." Dr. Mahajan increased Concerta to 54 mg in the morning and maintained Zyprexa at 2.5 mg at bedtime. (St. Ex. 10 at 83)

252. Dr. Mahajan maintained Patient 10 on the regimen of Concerta 54 mg in the morning and Zyprexa 2.5 mg at bedtime through May 28, 2004. Dr. Mahajan's notes from that visit indicate that "Mother would like to [discontinue] meds for summer." Dr. Mahajan noted that Patient 10's medications were discontinued. (St. Ex. 10 at 75)

253. Patient 10 next visited Dr. Mahajan on July 22, 2004. Dr. Mahajan documented "very hyper," aggressive, and "trouble – name calling." He documented a diagnosis of "314.01." Dr. Mahajan's prescription documentation for that visit is very hard to read, but it appears he prescribed Concerta 36 mg (possibly 54 mg) in the morning and Zyprexa 2.5 mg at bedtime; however, next to Zyprexa he wrote, "Wants [discontinued]." (St. Ex. 10 at 73)

254. At the next visit, August 18, 2004, Dr. Mahajan noted that Patient 10's sleep was irregular and "mom wants Zyprexa." Dr. Mahajan prescribed Concerta 36 mg in the morning and Zyprexa 2.5 mg at bedtime. (St. Ex. 10 at 71)

255. Subsequently, Dr. Mahajan prescribed Concerta 36 mg in the morning and Zyprexa 2.5 mg at bedtime through at least March 24, 2005. At that visit, Dr. Mahajan noted "Not taking Zyprexa – does not think it helps," "appetite good," "focusing at school & getting good grades," "sleeping," "a little more mature," and "stable." Dr. Mahajan prescribed Concerta 36 mg in the morning and, apparently, Zyprexa 2.5 mg at bedtime. Next to the Zyprexa notation he (or a staff member) wrote a ">" symbol. (St. Ex. 10 at 63-69)

At the following visit on June 23, 2005, next to the Zyprexa notation, someone wrote "> not taking." It is not clear if Dr. Mahajan prescribed Zyprexa at that visit. (St. Ex. 10 at 61) However, at the next visit on August 18, 2005, Dr. Mahajan noted, among other things, "Mom does not want Zyprexa." Dr. Mahajan prescribed only Concerta 36 mg

[46] See St. Ex. 10 at 87-93

at bedtime. (St. Ex. 10 at 59) He also prescribed Concerta 36 mg at bedtime at the following visit on October 27, 2005. (St. Ex. 10 at 57)

256. On December 22, 2005, Dr. Mahajan noted that Patient 10's appetite and sleeping was okay, but "[t]eachers wondering if needs ↑ Concerta," "difficult to sit still & focus," "sometimes irritable," and "not following directions." Dr. Mahajan increased Concerta to 54 mg in the morning. (St. Ex. 10 at 55)

257. Dr. Mahajan maintained Patient 10 on Concerta 54 mg in the morning until May 15, 2006. At that time, Dr. Mahajan noted that Patient 10 was focusing better, his appetite and sleeping were okay, his mood was stable, and that he was "sometimes disorganized." Dr. Mahajan prescribed Concerta 54 mg in the morning for one month, and following that, Concerta 36 mg in the morning. (St. Ex. 10 at 49) Dr. Mahajan continued this regimen at the next visit on July 20, 2006, which is the last visit included in State's Exhibit 10. (St. Ex. 10 at 47)

258. Dr. Mahajan noted, among other things, "No side effects," on his progress notes for the visits on September 27, 2002, October 27, 2003, February 6 and December 6, 2004, and "No S.E." on his progress notes for Patient 10's visits on June 23 and August 18, 2005. (St. Ex. 10 at 59, 61, 67, 79, 83, 103)

259. Dr. Mahajan denied that he had failed to complete or document a psychiatric evaluation of Patient 10. Dr. Mahajan testified that on May 8, 2001,[47] a complete evaluation was performed, and that there is a nine-page report from a psychologist in the medical record. Moreover, Dr. Mahajan testified that it is customary and appropriate for a psychiatrist such as him to rely upon a report from a psychologist. (Tr. at 547-548)

    Dr. Mahajan made the same reference to a "nine-page report from a psychologist" in his expert witness report. (Resp. Ex. AA at 15) However, the Hearing Examiner was unable to find such a report in either the State's copy or the Respondent's copy of Dr. Mahajan's medical record for Patient 10. There *is* a one-page letter to Dr. Mahajan from a psychologist with a single-page attachment containing a WISC-III report. (St. Ex. 10 at 37, 39, 45; Resp. Ex. J at 4-6) The Hearing Examiner believes that Dr. Mahajan is confusing Patient 10's record with his record for Patient 5, which *does* have a nine-page psychological evaluation report (counting the cover page). (St. Ex. 5 at 79-95)

260. Dr. Mahajan testified that his DSM-IV diagnosis for Patient 10 was ADHD. (Tr. at 548)

261. Dr. Mahajan testified that he has ongoing discussions of informed consent with patients concerning their diagnoses and medications. Dr. Mahajan further testified that, in Patient 10's case, he obtained a signed consent on May 2, 2003. (St. Ex. 10 at 41; Resp. Ex. J at 25; Tr. at 548-549)

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[47] Dr. Mahajan actually testified that the year was 2001, but his medical records make clear that Patient 10's first visit took place May 8, 2002. (St. Ex. 10 at 115)

262. With respect to following up on medication changes, additions, and deletions, Dr. Mahajan stated in his report:

> I have not neglected follow up on medication changes. Medications have been discussed and followed up at each medication monitoring visit once each month, or as needed. I have not prescribed on an ad hoc basis. All treatment has been based upon sound clinical judgment derived and based upon information and symptoms provided by the patient or guardian.

(Resp. Ex. AA at 16; Tr. at 549)

263. Dr. Mahajan denied that he had failed to perform AIMS examinations, and said that that accusation is not even applicable to Patient 10 because he had not prescribed the kind of medication that would cause tardive dyskinesia.[48] (Tr. at 550-551)

264. Dr. Mahajan noted that Patient 10 is still an active patient. (Tr. at 547)

Allegation 1(a): Dr. Mahajan "failed to complete and/or document a psychiatric evaluation of Patients 1, 3, 4, 5, 6, 7, 9 and 10."

Opinion of Dr. Karp

265. Dr. Karp stated in his report that there are no indications that Dr. Mahajan completed a psychiatric evaluation on Patients 1, 3, 4, 5, 6, 7, 9 and 10. (St. Ex. 12 at 3)

266. Dr. Karp stated that a psychiatric evaluation should include the following elements:

- A chief complaint "that is clearly understandable and is reflective of why the patient is there";
- A history of the presenting illness [HPI], "[t]hat is some kind of elucidation of the origin of the patient's symptoms in time and their development over time as well as the presence or absence of associated symptoms or signs as observed by others[,] in the case of a child";
- A medical history;
- A developmental history in the case of a child or adolescent;
- The presence or absence of a substance abuse history if a teen or adult; and
- A comprehensive mental status examination.

(Tr. at 67-68; St. Ex. 12)

267. In his report, Dr. Karp indicated that Dr. Mahajan's medical records for Patients 1, 3, 4, and 10 lacked each of the elements of a psychiatric evaluation as listed above. Further, Dr. Karp found that Dr. Mahajan's records for Patients 5 and 6 include substance abuse

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[48] Note however, that Dr. Mahajan had prescribed Zyprexa to Patient 10 from May 8, 2002, through June 23, 2005. (Resp. Ex. J at 7-53)

histories but lack all other elements of a psychiatric evaluation. Moreover, Dr. Karp indicated that Dr. Mahajan's record for Patient 7 includes a chief complaint and substance abuse history but lacks an HPI, medical history, developmental history, and mental status examination. Finally, Dr. Karp stated that Dr. Mahajan's medical record for Patient 9 includes a chief complaint, developmental history, substance abuse history, and a mental status examination, but lacks an HPI and past medical history. (St. Ex. 12 at 9)

268. In some patient records, such as the records for Patients 5 and 7, a report of an evaluation by a psychologist is included. With respect to these records, Dr. Karp stated, "I do not find any indication that Dr. Mahajan reviewed those records. He did not initial or date the records and did not specify in any notes that he reviewed them." (St. Ex. 5 at 81-95; St. Ex. 7 at 71-79; St. Ex. 12 at 2)

269. Dr. Karp stated that Dr. Mahajan's medical records for Patients 2 and 8 include psychiatric evaluations that were obtained during hospital admissions. Those patients were not included in allegation 1(a). (Tr. at 74-77; St. Ex. 12 at 9; St. Ex. 14A)

Opinion of Dr. Gutheil

270. Dr. Gutheil testified that the allegation that Dr. Mahajan failed to do thorough or complete psychiatric examinations "is pretty much globally refuted by the fact that, although the information is not in some of the more faculty standard forms of examination, the data are there in various different inputs, including checklists, reports from families, psychological testing, the doctor's own written observations, and the like." (Tr. at 713-714)

271. Dr. Gutheil testified that, in an outpatient setting, he typically does not perform an initial mental status examination "if the patient is speaking clearly about their situation and it's not crazy * * *." Dr. Gutheil testified that, in such cases, he allows "the mental status to develop over time." Dr. Gutheil testified that such an approach is common, "especially with patients who don't particularly show mental status type disturbances but are coming for life problems." (Tr. at 758-759)

Opinion of Dr. Polster

272. Dr. Polster stated in his report: "Dr. Mahajan pulled together information from parents, the school, a psychologist and other sources to compile a thorough understanding of the patient, rather than documenting a traditional initial evaluation." (Resp. Ex. GG at 1)

273. Dr. Polster described what he means by the term, "traditional initial evaluation"

> What I mean by that is the patient comes into the office, sits down in front of you, and for whatever a length of time the psychiatrist starts asking questions about what's going on here, what the complaints are, what the symptoms are, gets a background in terms of a medical history, psychiatric history, performs a mental status exam. All of those elements that when we think of a traditional initial evaluation would be transcribed onto the chart.

(Tr. at 849-850)

Allegation 1(b): Dr. Mahajan "failed to order, review and/or document baseline and/or follow-up laboratory evaluations of patients 1, 3, 4, 5, 6, 7 and 9. Further, [Dr. Mahajan] failed to maintain any laboratory results in [his] patient record for Patients 2 and 8."

Opinion of Dr. Karp

274. Dr. Karp testified concerning the importance of baseline and follow-up laboratory evaluations in the treatment of psychiatric patients:

> We are taught as physicians to never assume upon the first meeting of a patient, especially one who has not previously been treated, that their presentation is psychiatrically based; that is, we are taught to think about the possibility that their presentation was caused by or in some way worsened by a medical illness or other—or psychiatric or non-psychiatric medication that they came into our office on.
>
> In order to evaluate the presence of such an illness, as well as to document a baseline that is prior to the introduction of psychiatric medications or taking over the management of these medications, that the patient is medically well. If not medically well, that we understand the nature and medical risks associated with any current medical problem.
>
> For example, if an adult patient was on a blood thinner such as Coumadin and the doctor had diagnosed major depression, it would be important to understand that there were certain psychiatric medications that it could interact with their Coumadin, thus increasing the risk of bleeding. Many of us would obtain a medical history as well as perhaps documenting bleeding time or what we call pro time or PTT at the time—just before we began treatment. I'm not sure we would do so afterwards unless there was a problem, but at least at baseline.
>
> The same is true for a patient—a young patient who, for example, we are about for the first time to place on a psychostimulant. And we know and have known for many years that stimulants can contribute to a rhythm disturbance of the heart. For many years, many of my colleagues and myself have obtained an EKG before we began treatment and periodically thereafter to ensure that the medication we were prescribing was not causing a rhythm disturbance.

(Tr. at 100-101)

275. Dr. Karp stated in his report that Dr. Mahajan had included lab reports in only one patient's medical record, Patient 10, and that "consisted of a single set." Dr. Karp further stated with

respect to two patients, Patients 2 and 8, that lab reports were mentioned in hospital-based records but that Dr. Mahajan failed to include the lab reports in his outpatient records. (St. Ex. 12 at 3)

Opinion of Dr. Gutheil

276. Dr. Gutheil testified that, for the majority of the medications Dr. Mahajan prescribed, there are no established clinical levels. Accordingly, the standard of care does not require baseline or follow-up lab tests. (Tr. at 714-716)

Opinion of Dr. Polster

277. Dr. Polster wrote in his report: "[Dr. Karp] shares the State's concern that Dr. Mahajan did not order baseline [or] follow-up labs in these cases. As I have stated [elsewhere in my report], there was no need to do so in most of these cases!" (Resp. Ex. GG at 7) With respect to that statement, Dr. Polster testified:

> In most of these cases, I believe eight out of the ten were children or adolescents. I did not see any need to draw any baseline labs on these patients. The medications that were being prescribed in many cases do not require monitoring with labs, so to draw something at baseline did not seem necessary.

(Tr. at 829-830)

Allegation 1(c): Dr. Mahajan "failed to order and/or document therapeutic levels of Depakote for Patients 2 and 8 and of Tegretol for Patient 8."

278. During his treatment of Patient 2, Dr. Mahajan had prescribed Depakote, among other medications, to Patient 2 from December 12, 2003, until early March 2004, when Patient 2 was hospitalized at UVMC in Troy, Ohio. During this time, Dr. Mahajan did not document ordering blood tests to check Patient 2's Depakote levels. (St. Ex. 2 at 113-115)

279. In addition, Dr. Mahajan had prescribed Depakote, among other medications, to Patient 8 beginning around March 8, 2002, when Patient 8 was discharged from UVMC. While Patient 8 was at UVMC, Dr. Mahajan noted that Patient 8's Depakote level "was in the 70s." (St. Ex. 8 at 288-290) Dr. Mahajan continued to prescribe Depakote to Patient 8 through around June 10, 2003, when Patient 8 was again admitted to UVMC. On June 17, 2003, when Patient 8 was discharged from UVMC, Dr. Mahajan prescribed Tegretol. Dr. Mahajan discontinued Tegretol on July 23, 2003. Aside from the initial Depakote level obtained during Patient 8's first UVMC hospitalization, Dr. Mahajan did not document obtaining further levels of Depakote, or Tegretol, during the period he prescribed those medications to Patient 8. (St. Ex. 8 at 109-135, 243-247, 289-290)

Opinion of Dr. Karp

280. In his report, Dr. Karp stated:

> There are **no indications**: Dr. Mahajan ordered a follow-up laboratory evaluation or any therapeutic concentration (following hospital discharge) for several patients for whom he was prescribing a mood-stabilizer. These were receiving Depakote ([Patients 2 and 8]) (a primary mood-stabilizer – associated with agranulocytosis, aplastic anemia, hepatic toxicity, urea cycle disorders, pancreatitis), or Tegretol ([Patient 8]) (another mood stabilizer and AED, associated with severe anemia, fatal rash, liver toxicity).

(St. Ex. 12 at 3) (Emphasis in original)

281. Dr. Karp testified concerning the importance of laboratory monitoring for patients who receive Depakote or Tegretol. First, it is necessary to ensure the patient's safety. Dr. Karp testified, "Each of these medications when given in an amount exceeding a therapeutic target in the blood can cause significant if not life-threatening side effects." Second, laboratory monitoring is necessary to ensure that the patient is receiving a dose that results in a blood level that falls within a therapeutic range: too low, and the medication is ineffective; too high, and the patient risks serious side effects. In addition, Dr. Karp testified that laboratory monitoring is necessary to ensure that the patient is taking the medication. (Tr. at 102-103) Dr. Karp testified:

> In our business, 60 to 65 percent of patients are not compliant, at least in part, with the medications. And, thus, for example, if a patient comes into our office reporting various symptoms attributable to their primary illness, most of us will first—will quickly obtain a blood level to ensure that the patient is indeed taking the treatment.

(Tr. at 104)

282. Dr. Karp further testified that a Depakote level should be obtained about one week after initiating the medication, after it has had a chance to stabilize in the patient's system. Dr. Karp further testified that follow-up levels should be obtained every month to four months afterward. (Tr. at 106)

Opinion of Dr. Gutheil

283. As referenced above, Dr. Gutheil testified that "Tegretol has a blood risk factor and Depakote has a liver risk factor" and that the standard of care requires that levels be done. Dr. Gutheil further testified that there was a comment in the chart that the patient had been

noncompliant by failing to have the lab work done;[49] however, "[t]he appropriate response would have been to further emphasize the importance and/or discontinue the medication, which of course is risky because then the patient has the untreated symptoms." (Tr. at 721) Dr. Gutheil testified concerning the failure to have lab work done: "The failure to do that in this one case would in my view be below the standard of care. Probably maybe even not below the minimum standard of care, but certainly enough to make me uncomfortable with that as a practice." (Tr. at 722)

284. Dr. Gutheil testified that Dr. Mahajan's "[c]are of Patient 8 shows some deficiencies which, although not resulting in harm, would be deviations from the standard of care." (Tr. at 723)

Opinion of Dr. Polster

285. Dr. Polster wrote in his report:

> Dr. Karp points out that Dr. Mahajan should have ordered follow-up labs to those patients getting mood stabilizers. In some of these cases, patients were on the drugs for short periods of time such that the drugs were stopped before routine labs would have been drawn. Although in one case, [Patient 8], I would share the concern that Depakote levels and associated labs were not documented, Dr. Mahajan has stated that the family would not comply with this recommendation.[50] Indeed, he should have documented that problem given the potential risks of the drug, or looked at other options in treating the patient.

(Resp. Ex. GG at 7)

Allegation 1(d): Dr. Mahajan "failed to document DSM-IV or DSM-IV-TR criteria having been met for any psychiatric diagnoses."

Opinion of Dr. Karp

286. Dr. Karp testified that DSM stands for Diagnostic and Statistical Manual, introduced by the American Psychiatric Association [APA] in the early 1950s. Dr. Karp noted that it has been revised a number of times and that the current version, in place since the early 2000s, is the

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[49] The Hearing Examiner was unable to find documentation that, after he began prescribing Depakote or Tegretol to Patient 8, Dr. Mahajan had ordered a blood test and Patient 8 had been noncompliant. Much earlier, beginning with Patient 8's first visit in May 1997 and the next two visits through August 1997, Dr. Mahajan *had* documented ordering liver function tests and Patient 8's noncompliance; however, Dr. Mahajan did not prescribe Depakote or Tegretol to Patient 8 until Patient 8's March 2002 hospitalization. Moreover, beginning with Patient 8's August 8, 2002, visit, Dr. Mahajan had changed his progress note form to add a notation that said "Test Ordered" with "yes" and "no" checkboxes next to it. For that visit and each subsequent visit, Dr. Mahajan either checked the "no" box or left both checkboxes blank. (St. Ex. 8 at 47-133, 231-232)

[50] As stated in the previous footnote, the Hearing Examiner was unable to find documentation that Patient 8 and/or his family had been non-compliant with orders for testing <u>after</u> Dr. Mahajan began prescribing Depakote and Tegretol. (St. Ex. 8 at 47-133, 231-232)

DSM-IV-TR. Dr. Karp testified that the objective for the DSM has been to standardize diagnoses made by psychiatrists across the U.S., and its developers have sought to "extract the most critical questions or criteria that are truly reflective of" psychiatric diagnoses. Dr. Karp further testified that, although the APA and the American Academy of Child and Adolescent Psychiatry [AACAP] recommend that psychiatrists comply with the DSM standards in making their diagnoses, "[f]ew psychiatrists outside of academia conform to that recommendation." Nevertheless, Dr. Karp testified that psychiatrists typically document sufficient DSM criteria to reasonably reflect their diagnoses. (Tr. at 77-79)

287. Dr. Karp testified that it is important for a psychiatrist to render an accurate diagnosis because the success of the treatment depends on the diagnosis. He gave an example of a patient who presents with hyperactivity. If the patient is simply treated as having attention deficit/hyperactivity disorder [ADHD] "when, in fact, [the patient's] hyperactivity is part of another diagnosis such as bipolar disorder, yet we prescribe a [psychostimulant] medication for ADHD * * * like Adderall, Metadate, Ritalin, we can make them dramatically worse." (Tr. at 79-80)

288. Dr. Karp stated in his report: "The majority of diagnoses are specified as numbers, presumably from the Diagnostic and Statistical Manual. In no case are criteria described matching the designated code and fulfilling [the] criteria for the disorder." (Resp. Ex. 12 at 2) However, the Hearing Examiner finds this statement confusing because, elsewhere in his report, Dr. Karp indicates that he found DSM-IV diagnoses in Dr. Mahajan's medical records for Patients 2 and 8. (St. Ex. 12 at 9)

289. Dr. Karp testified that "it is customary to place the descriptive terms for the diagnosis in the record" and that Dr. Mahajan's medical records for Patients 1 through 10 are the first that he can recall reviewing "where consistently it was simply the code for the diagnosis that was recorded." (Tr. at 82)

Opinion of Dr. Mahajan

290. With respect to the allegation that he had failed to document DSM-IV criteria for his diagnoses, Dr. Mahajan testified, among other things, that the DSM-IV does not carry the force of law, and that he made the diagnoses based on etiology. (Tr. at 407, 345-346, 648-652)

Opinion of Dr. Gutheil

291. In his report, Dr. Gutheil stated: "[F]ull listing of DSM-IV criteria for diagnosis are rarely done in office practice since the initial working diagnosis guides the care until there is a basis for changing it; of course, many initial diagnoses do not change." (Resp. Ex. EE at 2) Dr. Gutheil testified:

> [Y]ou form a tentative diagnosis the first time you see the patient. And since all—I would say all treatment in psychiatry is largely empirical, you work with that diagnosis until something causes you to change it.

> So a person may come in with hyperactivity, let's say, and your initial diagnosis may be attention deficit hyperactivity disorder. And then as time evolves, you may decide, well, this is possibly also mania, because they're very hard to tell apart initially. So then you then might modify the diagnosis at that point.
>
> But private office practice has too much going on to list all the, you know, different criteria. You are given the benefit of the doubt of your initial diagnosis unless there's serious reason to change it.

(Tr. at 701-702)

292. Referring to the diagnoses of Patients 1 through 10 made by Dr. Mahajan, Dr. Gutheil testified:

> The diagnoses appeared clinically consistent with the symptoms and observations that were made not only by Dr. Mahajan face to face but also the patients' responses to various checklists, psychological testing, parental information stuff, and basically the total input. So that consistency was clear throughout the record.

(Tr. at 803)

Allegation 1(e): Dr. Mahajan "failed to properly document the performance of initial or ongoing discussion of informed consent regarding diagnoses, why a specific medication was recommended, the medication's intended benefits, potential medication side effects, and/or recommended duration of use or alternative medications for Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10."

Opinion of Dr. Karp

293. In his report, Dr. Karp stated:

> There are **no indications**: Dr. Mahajan documented an initial, or ongoing, informed consent discussion regarding any of the ten patient's diagnoses, why a specific medication was recommended (beyond a generic "Medication consent" form), it's intended benefits, or its potential side effects, recommended duration of use, or alternatives.

(St. Ex. 12 at 3) (Emphasis in original)

294. Dr. Karp testified concerning the importance of having an informed consent discussion with a patient:

> Informed consent draws the patient into the treatment as a collaborator. Through informed consent, patients are made aware of the treatment that is recommended, the benefits, common, serious, expected side effects of the

> treatment that is recommended, the alternatives, including no treatment, and the rationale for the specific treatment that is identified.
>
> For example, if the major diagnosis is major depressive disorder, then one would assume that if medications were used to treat the major depressive disorder, that the classification would be antidepressants and, thus, the doctor's rationale for introducing such medication would be I am recommending the use of this specific antidepressant to treat major depressive disorder.

(Tr. at 98)

When asked when such a discussion should take place, Dr. Karp replied:

> Ethically and legally, informed consent is thought of as evolving from the first contact through the end of treatment; that is, it is repeated throughout the course of treatment in various ways and is certainly introduced at a time that the treatment is modified or changed any significant degree.
>
> For example, if a diagnosis changes from major depression to bipolar disorder, or ADHD due to depression, it is incumbent upon each of us to discuss with the patient the rationale for those proposed changes. Of course, it is virtually impossible to include in a medical record comprehensively the content of all informed consent discussions.
>
> The average physician will document something like I discussed with the patient their change in diagnosis and the rationale proposed for this change in treatment.

(Tr. at 98-99)

295. With one exception, Dr. Karp did not specifically address, in his testimony or in his report, the statements found on many of Dr. Mahajan's progress notes to the effect that the patient and/or his or her guardian understood and consented to the medication prescribed. The one exception concerns Dr. Mahajan's progress note for Patient 7's visit on November 9, 2005, on which Dr. Mahajan did not check the box indicating that Patient 7 or her guardian understood and consented to new medication added. However, Dr. Mahajan had not added any new medication at that visit. (Tr. at 308; St. Ex. 7 at 41-43; Resp. Ex. G at 28-29)

Testimony of Dr. Mahajan

296. Dr. Mahajan testified that he discusses with the patient/guardian the diagnoses he renders and the medications he prescribes at every visit, and answers all of their questions. (Tr. at 435, 454-455, 499, 543, 545; Resp. Ex. AA)

Opinion of Dr. Gutheil

297. Dr. Gutheil stated that Dr. Mahajan's assertion that he discusses medication effects and reactions at every patient visit should be taken seriously. (Tr. at 706-708; Resp. Ex. EE at 2)

Allegation 1(f): Dr. Mahajan "failed to consistently follow up on medication changes, additions and deletions in Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. [Dr. Mahajan] inappropriately prescribed to Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 on an ad hoc basis."

Opinion of Dr. Karp

298. In his report, Dr. Karp made the following statement:

> There are **no indications**: Dr. Mahajan consistently followed-up when he changed, added, deleted medications. The number and combination of medications, how and when they were prescribed, and in what amounts, suggests an ad hoc basis (one patient, [Patient 8], had, through the course of seven years, been placed on 18 different medications!).

(St. Ex. 3 at 12; emphasis in original)

299. With reference to that statement, Dr. Karp testified as follows:

> One of the most challenging problems I had in this case review as an expert is attempting to ascertain the rationale for the use and modification of the medication regime. There certainly were a number of instances that I could read between the lines and understand the doctor's actions, but in the majority of encounters it was virtually impossible for me to do that as I couldn't place the medication change, deletion, elimination, substitution, or modification in any clinical context as reflected in the record.

(Tr. at 110)

300. In his report, Dr. Karp stated, "Dr. Mahajan provides no rationale for his medications (other than the DSM code number), or for his polypharmacy, numerous terminations, resumptions, and additions of medications." (St. Ex. 12 at 2)

Opinion of Dr. Gutheil

301. Dr. Gutheil stated in his report: "[T]he curious claim of 'inappropriate prescribing' appears challenged by the physician's use of standard medications for the conditions diagnosed; similarly, <u>all</u> prescribing is in a sense 'ad hoc,' that is, it is empirical and driven by the presentation of the patient coupled with trial and error adjustments." (Resp. Ex. EE at 2; emphasis in original) Dr. Gutheil testified that Dr. Mahajan had used common medications for the conditions he diagnosed. (Tr. at 703-704)

Dr. Gutheil went on to testify that, when a patient is started on a particular medication to treat a psychiatric condition, it is essentially an experiment. The psychiatrist cannot know in advance what the patient's reaction will be—will the medication be effective or will the patient have an abnormal reaction? On subsequent visits the psychiatrist may have to consider another medication or adjust the dose of the first medication. (704-705) Dr. Gutheil further testified:

> [Y]ou will never know in advance * * * who is what kind of responder. You do an ad hoc trial of an average dose or average starting dose and literally follow what happens. And there's no other way to prescribe. I mean, * * * this aspect of the field [of psychiatry] is very empirical.

(Tr. at 705)

Opinion of Dr. Polster

302. Dr. Polster stated in his report:

> Dr. Karp supports the State's belief that Dr. Mahajan prescribed medications inappropriately and on an "ad hoc" basis. He cites one patient treated with 18 different medications over a seven-year period. However, this in NOT unheard of in psychiatry or in medicine in general. Treatment-refractory cases of Major Depression, Bipolar Disorder, or even hypertension might see a similar number of medication changes in order to control symptoms! Again, the problem arises when the reasons and logic for the changes are not always documented.

(Resp. Ex. GG at 7; emphasis in original)

303. Dr. Polster testified that the medications utilized by Dr. Mahajan were consistent with the diagnoses he had made and with good medical practice. (Tr. at 829)

Allegation 1(g): Dr. Mahajan "failed to document the presence or absence of adverse effects for medications prescribed by [him] to Patients 1, 2, 3, 4, 5, 6, 7, 8 and 9."

Opinion of Dr. Karp

304. In his report, Dr. Karp stated: "No mention is made, in Dr. Mahajan's notes, regarding the presence or absence of adverse effects, except with a single patient (Patient 10) and in several notes for that patient. Those notes simply specify 'no side effects.'" (St. Ex. 12 at 3)

With reference to that statement, Dr. Karp testified:

> Well, as we all are aware, medications can contribute to adverse effects. It was hard for me as an expert to determine whether or not the doctor had considered whether or not some of the patient's complaints, for example, of racing thoughts

> by one patient, of sleep disturbance in a number of patients, were a result of the treatment or associated with their illness; that is, there was no clinical context as documented in the record that allowed me to determine this.

(Tr. at 110-111)

Medical Records

305. In his progress notes for Patient 10's visits on September 27, 2002, October 27, 2003, February 6 and December 6, 2004, June 23 and August 18, 2005, Dr. Mahajan note, among other things, "No side effects" or "No S.E." (St. Ex. 10 at 59, 61, 67, 79, 83, 103)

    In addition, Dr. Mahajan also noted "No side effects," "No S.E.," or similar notation on his progress notes with respect to these other patients' visits:

    - **Patient 1**: June 21, 2002, September 11, 2003, May 20 and July 15, 2004, and February 17, April 14, June 9, July 28, September 16, and November 4, 2005. (St. Ex. 1 at 43, 45, 47, 49, 51, 53, 63, 65, 73, 97)
    - **Patient 2**: March 8 and April 5, 2004, and December 5, 2005. (St. Ex. 2 at 79, 109, 111)
    - **Patient 3**: April 19, 2004, January 12, March 9, June 30, and December 12, 2005. (St. Ex. 3 at 45, 51, 55, 59, 71)
    - **Patient 4**: June 17, 2004, and January 25, 2005, (St. Ex. 4 at 8, 13)
    - **Patient 5**: October 31, 2005, and January 31, 2006. (St. Ex. 5 at 43, 49)
    - **Patient 7**: September 12 and October 12, 2005. (St. Ex. 7 at 43, 45)
    - **Patient 8**: May 18, 2000, June 7, 2001, August 8, 2002, August 20 and December 27, 2004, and December 16, 2005. (St. Ex. 8 at 55, 71, 75, 127, 155, 175)

306. There were no such notations in the medical records for Patients 6 and 9. (St. Exs. 6, 9)

Opinion of Dr. Mahajan

307. In his written report, Dr. Mahajan stated that, at every visit, he monitors the side effects of prescribed medication and ensures that the patient or guardian understands the side effects and consents to the medication prescribed. Dr. Mahajan further stated that this is documented at each visit. (Resp. Ex. AA at 7; Tr. at 454-455)

Allegation 1(h): Dr. Mahajan "failed to discuss and/or document the discussion, either initially or in follow-up, of Tardive Dyskinesia for Patients 2, 5, 7, 8, 9 and 10 who were prescribed anti-psychotic medications by [Dr. Mahajan]. Further, despite the fact that [he]

prescribed anti-psychotic medications to Patients 2, 5, 7, 8, 9 and 10, [Dr. Mahajan] failed to perform and/or document Abnormal Involuntary Movement examinations at baseline or during treatment."

Opinion of Dr. Karp

308. With respect to Dr. Mahajan's patients who received antipsychotic medication, Dr. Karp testified that such medications can cause tardive dyskinesia as a side effect. Dr. Karp further testified that tardive dyskinesia means involuntary twitches or jerks Dr. Karp further testified that an examination referred to as an "abnormal involuntary movement scale or AIMS" should be performed and documented annually for patients who receive such medication. Dr. Karp found no such documentation of a base exam or annual exam in the patient records for patients who received antipsychotic medication; namely, Patients 2, 5, and 7 through 10, with respect to documentation of the base AIMS exam, and Patients 2, 5, 7, 8, and 10 with respect to documentation of annual AIMS exams.[51] (Tr. at 70, 118; St. Ex. 12 at 9)

309. In his report, Dr. Karp stated:

> No initial or follow-up discussions about Tardive Dyskinesia are documented of any patient placed on an anti-psychotic [Patients 2, 5, 7, 8, 9, and 10]. No [AIMS] examinations are documented at baseline or at any other point in treatment for these patients. One of the patients [Patient 8], had been prescribed various antipsychotics for approximately seven years. No mental status examination specifically note[d] the presence or absence of AIMS, with the exception of a single patient who Dr. Mahajan describes as having a "tic," but does not describe its content, frequency, location, onset, duration, or intensity.

(St. Ex. 12 at 3-4; emphasis in original)

With respect to discussing tardive dyskinesia with patients receiving antipsychotic medications, Dr. Karp testified:

> There are basically several viewpoints that suggest the importance of such a discussion. First, while the modern agents such as Zyprexa, Risperdal, and other similar newer antipsychotics have less risk of causing twitches or jerks, which technical name for is tardive dyskinesia, about a one percent risk or two percent risk, that risk was found in adults upon which these drugs were initially tested on.
>
> Tardive dyskinesia when present can be as bad as you can imagine involving twitches or jerks. For example, I've had patients through the years twist their head from side to side. In the old days when we had telephone operators, I

[51] Patient 9's medical records cover less than one year; accordingly, the annual exam was not applicable. (St. Ex. 12 at 9)

had one operator lose her job because she had developed tardive dyskinesia and developed such significant motions of her tongue that she couldn't perform as an operator and so lost her job.

So from one context, one perspective, it's important to have the discussion regarding twitches or jerks and to observe * * * for these, the inception of treatment as well as periodically thereafter, because of the risk.

In the case of children, we know they are likely to remain on these medicines for many years and we know that the risk escalates with the longer you are exposed to a drug. So it is particularly important to have this discussion with parents and with the child themselves, if they're above the age of 5 or 6, especially, so that they know what to look for, they know what to report and when to report it.

We do know that early intervention, which would normally mean the termination of such treatment, can lead to the resolution of most or all twitches or jerks.

The second reason or the second perspective that suggests the importance of this discussion is a legal one. Perhaps a lot of people don't like to think of the legal view in the scientific prescription of treatment by physicians, but the truth is before modern medications the risk of tardive dyskinesia was substantial, I mean, as high as 60 to 65 percent of patients in the old days who over the course of years would develop such symptoms and they were not benign. In the old days, they constituted among the top three reasons doctors were sued for malpractice. Today, I don't think that's as much of a problem; that is, legally. But it certainly is from the view of the patient and the possible development of such a side effect.

(Tr. at 111-114)

Opinion of Dr. Mahajan

310. Referencing Dr. Mahajan's new AIMS form (Resp. Ex. X), Dr. Mahajan was asked when it is appropriate to administer the AIMS test. He replied:

There are—have been some instances where patients—adult patients who have been treated for a long time and they have gotten—the insurance or their family got concerned and they brought them to me and they said change the medicine, he's on—he's overmedicated. Now, in those cases, I had to reduce the antipsychotics. They were already tremorous.

So I would fill this out, tell them this is what has happened. How will it resolve? I may not be—they have to be willing when I change the medications around because there is psychological addiction to the medicine,

> too, and they end up going back on those medicines many times. But that's when this is to be filled out.

(Tr. at 645)

Opinion of Dr. Gutheil

311. Dr. Gutheil testified that tardive dyskinesia was a significant risk for patients taking the first-generation antipsychotic medications that came out in the late 1950s and 1960s. However, Dr. Gutheil testified that, with the newer antipsychotics: "The occurrence of tardive dyskinesia is so rare as to not require AIMS testing unless the person begins to develop some particular symptoms. So since none of the original antipsychotics are used [by Dr. Mahajan], AIMS testing as a requirement is not applicable here." (Tr. at 695-696)

Opinion of Dr. Polster

312. Dr. Polster's testimony concerning Patient 2 indicates that, although tardive dyskinesia is mush less of a problem today than it used to be, the medical records for patients receiving antipsychotic medication should still include "either a formal AIMS test or documentation of a visual monitoring of abnormal movements." (Tr. at 884-886)

Testimony Concerning the Principle that, If It Isn't Documented in the Medical Record, It Wasn't Done

Testimony of Dr. Karp

313. Dr. Karp testified that he is familiar with the principle that, if something is not documented in the medical record, it didn't happen. He further testified that he teaches that to his medical students and residents. (Tr. at 60) When asked the reason for that principle, Dr. Karp replied:

> Physicians are licensed and credentialed by many different organizations representing the public interest, public trust; whether or not, for example, we performed a service that we said we performed. From a legal, from an ethical, and from a medical view, all we have to base our assessment on a doctor's practice is what is contained in the record.
>
> Classically, we physicians are taught that the record does reflect the reality of our practice in that, for example, if we die, if we are ill, if we go on vacation, if we change cities, if we are sued, if our credentials are called into practice, the Medical Board, a plaintiff's jury, a magistrate, an insurance company will demand of us that we prove that we documented the service that we delivered.
>
> Among the difficulty of the medical record is that it is not really for us clinicians. The medical record is for everybody, including the patient. This is so because if a patient has complex medical issues or psychiatric issues and an

> emergency arises or they change clinicians, it is critical for their well-being and their care that the interventions that were made are understood in a rational and clear way so that they could either be continued or changed.
>
> The bottom line about documentation is that we are taught that we should—our documents, our records should allow a colleague or supervisor to be able to step in and to immediately take over the care of that patient. In that sense, [Dr. Mahajan's] records do not provide the framework within which care could be continued in a reasonable, responsible way.

(Tr. at 64-65) Dr. Karp testified that his opinion applies to Dr. Mahajan's records for each of the ten patients in this matter. (Tr. at 65-66)

314. Moreover, with respect to the importance of medical documentation, Dr. Karp testified:

> I would add this. We physicians must maintain clinical lives of integrity, of service, and of excellence. We cannot do this if we do not have the trust of the public. The public is—I'm using this as an inclusive term to include magistrates at hearings like this, insurance companies, and other payors.
>
> How we maintain that trust is based on how we conduct our clinical practice, to include what we include in our medical records. Because, after all, the only record that appears in court without having to raise its right arm and swear an oath is the medical record. That's all we have. That's all we have to demonstrate our integrity, our excellence, and the service that we provide.
>
> The absence of such documentation makes it very hard for triers of fact, whether they be malpractice juries or other magistrates, to determine the basis of the treatment that was given. All of us know these things. We are all taught from the first day of medical school the importance of the archival record. It's important in preserving integrity of the treatment, maintaining continuity for a specific patient over time—that is, making understandable what we're doing for ourselves, as well as to provide a framework within which credentialing bodies, insurance companies and, for example, plaintiff's attorneys or juries can render a verdict or assessment about the nature of what we do.
>
> When the record is absent, when the record is incomplete, it makes it very difficult for credentialing bodies to assess the service that we provide. * * *

(Tr. at 127-128)

315. Dr. Karp agreed that he had not been present during Dr. Mahajan's visits with Patients 1 through 10 and did not in any way participate in their care. Therefore, all that he knows and can opine upon with respect to Dr. Mahajan's care of those patients is based upon Dr. Mahajan's documentation in the patients' medical records. (Tr. at 118)

Testimony of Dr. Polster

316. Dr. Polster testified:

> Well, my response is that that's an adage that has had its root in the medical/legal world, where we as physicians are constantly on the defensive in terms of malpractice cases and practicing defensive medicine.
>
> I certainly would say that there are many things that occur in doctor/patient relationships that do occur and are not necessarily charted, but it doesn't make it any less real that they happen.

(Tr. at 824)

Dr. Karp's Testimony Concerning his Agreement or Disagreement with Dr. Gutheil's Report

317. During cross-examination, Dr. Karp was asked whether he agrees with statements made by Dr. Gutheil in Dr. Gutheil's written report:

- Dr. Karp agreed with Dr. Gutheil's opinion that there is a difference between the levels of charting required in a hospital setting versus a private practice setting, and that outpatient records are shorter and the standard of care for documentation is less rigorous. (Tr. at 275-276)

- Dr. Karp disagreed with Dr. Gutheil's opinion that, with newer antipsychotic medications, the standard of care does not require AIMS examinations. (Tr. at 282-283)

- Dr. Karp disagreed with Dr. Gutheil's opinion that listing only positive symptoms, or noting "stable" when there are no noteworthy findings, is common practice in office psychiatry. (Tr. at 283)

- Dr. Karp disagreed that Dr. Gutheil knows more about the standard practice of office psychiatry than he does. (Tr. at 283)

- Dr. Karp agreed with Dr. Gutheil's opinion that competent patients are capable of alerting the physician if new "findings" develop. (Tr. at 283; Resp. Ex. EE at 2)

- Dr. Karp agreed with Dr. Gutheil's opinion that repeat mental status examinations are rarely performed in private office practice unless new symptoms are discovered on examination or reported by the patient or his or her family. (Tr. at 283-284)

- Dr. Karp agreed with Dr. Gutheil's opinion that "full listing of DSM criteria for diagnosis are rarely done in office practice since the initial working diagnosis guides

the care until there is a basis for changing it; of course, many initial diagnoses do not change." (Resp. Ex. EE at 2; Tr. at 284; Resp. Ex. EE at 2)

- Dr. Karp disagreed with Dr. Gutheil's opinion that many of Dr. Mahajan's medical records for Patients 1 through 10 show clear improvement of the patient. (Tr. at 285)

- Dr. Karp agreed with the following statement by Dr. Gutheil:

> [T]he curious claim of " inappropriate prescribing" appears challenged by the physician's use of standard medications for the conditions diagnosed; similarly, <u>all</u> prescribing is in a sense "ad hoc," that is, it is empirical and driven by the presentation of the patient coupled with trial and error adjustments.

(Resp. Ex. EE at 2 [emphasis in original]; Tr. at 285-286)

- Dr. Karp also agreed with the following statement by Dr. Gutheil:

> [T]he physician's claim, that discussion of medication effects and reactions is done on each visit, should be accepted barring evidence to the contrary, which might come [from] interviewing the patients themselves; in this context, informed consent is a longitudinal process: it is not a single discussion nor a single form, and [Dr. Mahajan's] claim that he explores this every session should be taken seriously.

(Resp. Ex. EE at 2; Tr. at 286)

- Dr. Karp agreed with Dr. Gutheil's opinion that all treatment records are summaries of treatment, and not all material is recorded; thus, the doctor's attestation that he addressed certain points without noting them may be given some benefit of the doubt, since that is universal practice." (Tr. at 286-287; Resp. Ex. EE at 2)

Conclusions of the Expert Witnesses

Opinion of Dr. Karp

318. After being given an opportunity to review the allegations set forth in the Notice, Dr. Karp testified that he agreed with those allegations. Dr. Karp further testified that he believes that Dr. Mahajan's lack of documentation as described in the Notice violated Sections 4731.22(B)(2) and (6) of the Ohio Revised Code. (St. Ex. 14-A; Tr. at 119-126)

Opinion of Dr. Gutheil

319. Dr. Gutheil took issue with the fact that the 10 patient charts at issue in this matter were not selected at random. (Tr. at 685-686)

320. Dr. Gutheil testified with respect to Dr. Mahajan's treatment and documentation for Patients 1 through 10: "[I]n general, they did meet the standard of care, the minimum standard of care as required, and a number of—I would also suggest that a number of the complaint bases appear to me without foundation in the materials presented to me." (Tr. at 724) Dr. Gutheil further testified that Dr. Mahajan met the standard required for the selection or administration of drugs and acceptable scientific methods in the selection of drugs or other modalities for treatment of Patients 1 through 10. (Tr. at 724-725)

Opinion of Dr. Polster

321. Dr. Polster believes that Dr. Mahajan's documentation as reflected in the medical records for Patients 1 through 10 met the minimal standard of care. Further, Dr. Polster opined that Dr. Mahajan's care and management of Patients 1 through 10 met the minimal standard of care. Moreover, Dr. Polster testified that Dr. Mahajan maintained the minimal standards applicable to the selection of drugs, and that he employed acceptable scientific methods in the selection of drugs or other modalities in his treatment of Patients 1 through 10. (Tr. at 836-838)

Additional Expert Opinions

Opinion of Dr. Hawkins

322. James R. Hawkins, M.D., wrote a May 8, 2008, letter expressing his opinion concerning Dr. Mahajan's care and treatment of Patients 1 through 10.[52] Dr. Hawkins is a psychiatrist who practices in Cincinnati. His curriculum vitae was admitted to the record as Respondent's Exhibit JJ. (Resp. Ex. II)

Dr. Hawkins stated, in part:

> Progress notes are hand written and at times difficult to read. They span the years 2000 to 2007. In several instances, Dr. Mahajan's charting was deficient in terms of documenting mental status examinations, ongoing progress, presence or absence of adverse effects, and medication records. But, Dr. Mahajan did have a working diagnosis for every patient.
>
> All of these patients carried a diagnosis of ADHD; 2 patients were later diagnosed as Bipolar. His selection of medications is appropriate for the working diagnosis, thus his treatment of these 10 patients is appropriate for the diagnosis. He was able to keep the patients in treatment, respond to changes in their presentation/symptoms, and respond to family and school concerns. It is not unusual to try several medications to achieve emotional stability. Lack of "proper" documentation does not equate to poor clinical care.

[52] Dr. Mahajan's attorney represented that Dr. Hawkins had not reviewed anything other than the patient records for Patients 1 through 10. (Tr. at 920) Dr. Hawkins did not testify under oath and was not subject to cross-examination.

> In my opinion, to a reasonable medical certainty, Dr. Mahajan did maintain minimal standards of care in overall treatment of his patients. The only deficiencies I found were in documentation—not quality of care. Dr. Mahajan could benefit from a refresher course on the importance of charting, but he should be permitted to continue to practice psychiatry in the State of Ohio.

(Resp. Ex. II)

Opinion of Dr. Patel

323. Amita R. Patel, M.D., a psychiatrist who practices in Dayton, offered her opinion with respect to Dr. Mahajan in a May 6, 2008, letter. Dr. Patel has served as Dr. Mahajan's monitoring physician for Dr. Mahajan's 2005 consent agreement with the Board, which is addressed in detail below. Her curriculum vitae was admitted to the record as Respondent's Exhibit DD. (Resp. Ex. CC)

In her letter, Dr. Patel stated:

> I am a board-certified psychiatrist practicing in Dayton, Ohio. I have been in practice for over 15 years. I am very familiar with standards for care with Psychiatrists.
>
> From October 2005 until now I have been reviewing Dr. Mahajan's charts which have been chosen randomly as per the [Board's] consent agreement. I initially began reviewing ten charts per week and then it changed to ten charts per month. * * * Among other things, when I review Dr. Mahajan's charts I look for documentation of patient's chief complaints, signs and symptoms, mental status exam, medications, and refills documentation, side effect documentation and follow up documentation etc. I routinely report the results of my reviews to the Board. Since, October 2005, I have noticed a few examples of incomplete documentation in his charts. On those few occasions I have given him a call and mentioned my concerns to him. He has responded well to my suggestions and made the necessary documentation changes.
>
> Based upon my review of dozens of Dr. Mahajan's charts, it is my opinion, to a reasonable medical certainty, that Dr. Mahajan has, at all times, complied with the standard of care in the care, treatment, and management of his patients, and will continue to do so in the future.
>
> Currently in Dayton, Ohio we have a shortage of Psychiatrists who specialize in Child and Adolescent Psychiatry. If Dr. Mahajan were not permitted to keep practicing, patients in the Dayton area would suffer. In short, I believe that Dr. Mahajan is a good Psychiatrist and that the State Medical Board should permit Dr. Mahajan to continue the practice of psychiatry.[53]

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[53] Dr. Patel did not testify under oath and was not subject to cross-examination.

(Resp. Ex. CC)

Dr. Mahajan's 2005 Consent Agreement

Testimony of Dr. Mahajan

324. Effective September 14, 2005, Dr. Mahajan entered into a consent agreement with the Board based upon a violation of Section 4731.22(B)(12), Ohio Revised Code.[54] As set forth in the consent agreement, Dr. Mahajan admitted the following conduct:

> Dr. Mahajan admits that on repeated occasions in and prior to 2003, and in accordance with the practice of the mental health clinics at which he was working, he signed otherwise blank prescriptions that were to be kept in a double-locked system and used only to obtain patient medications in specified situations, including patient emergencies. Dr. Mahajan states that subsequent to the discovery that a nurse had completed one or more of these prescriptions to obtain medications for her own use, he cooperated with investigating authorities, including the Board, and ceased the practice of pre-signing otherwise blank prescriptions.

(St. Ex. 13) Dr. Mahajan further agreed to probationary terms and conditions including monitoring of his charts by a Board-approved physician, and continuing medical education courses concerning the prescribing of controlled substances. (St. Ex. 13)

325. Dr. Mahajan testified that Dr. Patel has served as his monitor and that she has reviewed approximately 900 of his files since October 2005. (Tr. at 371-373, 385; Resp. Ex. KK)

326. Dr. Mahajan testified that Dr. Patel had on a few occasions expressed concern to him with regard to incomplete documentation in his charts. (Tr. at 591-592) Dr. Mahajan testified:

> The concerns that were passed on were technical areas that were not checked or you didn't mention he was suicidal or homicidal but there was a box there. So I needed to check that. That was the thing. So it was a technical error, but I did check it and I told her on the phone I did check it.

(Tr. at 592)

Testimony of Dr. Karp

327. Dr. Karp testified that he had not been aware until the hearing that Dr. Patel had been conducting an ongoing review of Dr. Mahajan's patient charts. (Tr. at 239)

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[54] Section 4731.22(B)(12), Ohio Revised Code, proscribes the following conduct: "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."

328. Dr. Karp was asked at hearing to review several progress notes reviewed by Dr. Patel that are included in the medical records for Patients 1 through 10:

- Dr. Karp was asked to review a progress note dated June 29, 2006, from Patient 5's medical record. Dr. Karp opined that it was "a pretty fair note" except for the lack of documentation for the number of pills and number of refills prescribed. Dr. Karp acknowledged that a notation on that progress note indicates that Dr. Patel had reviewed that note and found that it complied with the standard of care. (Tr. at 248-249; St. Ex. 5 at 31; Resp. Ex. E at 45)

- A progress note from Patient 6's medical record dated January 11, 2006, bears a notation from Dr. Patel indicating that she had reviewed the note. Dr. Karp opined with respect to that progress note that it did not comply with the standard of care. Dr. Karp testified that he can read the medications but cannot determine how much was prescribed. Dr. Karp further testified that he could not read some of the progress note. Moreover, Dr. Karp testified that that progress note contains no information concerning the number of pills prescribed, dosing schedule, or number of refills. (Tr. at 250-252, 307-308; St. Ex. 6 at 27; Resp. Ex. F at 39)

- A progress note in Patient 7's medical record dated November 9, 2005, bears a notation from Dr. Patel indicating that she had reviewed it. Dr. Karp opined that that progress note does not comply with the standard of care. (Tr. at 254; St. Ex. 7 at 41; Resp. Ex. G at 29)

Further Testimony from Dr. Mahajan Concerning his Documentation

329. With respect to his medical documentation, Dr. Mahajan testified: "[D]ocumentation is for who? Am I trying to practice defensive medicine? I don't have—I get ten minutes in practice. Ten minutes. I'm not doing therapy. In ten minutes, I have to keep everything. It is like you are deciding about me. Can you decide about me in ten minutes?" (Tr. at 346)

Dr. Mahajan was then asked if he meant that he had ten minutes per follow-up visit with patients. Dr. Mahajan replied:

> Yes, sir. Evaluation is—insurance companies—the reality of psychiatry, one hour. We get paid $100. Out of that, $40, $30 is co-pay. And I have to pay all the expenses. I can choose to become a medical director in some places where I will have plenty of time and very few patients. I'm doing it because my son died.[55] I'm going to do that.

[55] Approximately two years prior to the hearing, Dr. Mahajan and his family were struck by tragedy. One of Dr. Mahajan's two sons, who was a medical student at the time, passed away on his birthday. (Tr. at 326-327)

(Tr. at 346) Following that, Dr. Mahajan was asked what he meant when he said that he stays in private outpatient practice because of his son's death. Dr. Mahajan replied:

> Hard to do it. See, my son—I got in trouble with the Board in October '05. I had nothing to say. Nobody heard me. This is the first time. I've been accused of many things. I don't know how I looked in anybody's eyes. I did the most ethical thing, that I reported the nurse.

(Tr. at 347) Dr. Mahajan went on to describe in detail the circumstances that led to his 2005 consent agreement with the Board and his selection of Dr. Patel as his monitoring physician. (Tr. at 348-354, 368-373)

Dr. Karp's Bias or Lack Thereof

330. In his written closing argument and reply brief, as redacted by the Hearing Examiner pursuant to a June 29, 2009, entry, Dr. Mahajan argued that Dr. Karp had been biased against Dr. Mahajan through Dr. Karp's contact with an Enforcement Attorney for the Board. (Resp. Ex. SS at 10-11)

331. During the hearing, Dr. Karp testified that no one influenced him concerning the medical opinions he rendered in his written report. Dr. Karp added:

> And just to help orient the court a little bit, when I first met with Mr. Katko in the early 2000s, and I do this with every attorney with whom I work, I set the framework of my expertise, which is I am hired solely for my time and not my opinion. * * *
>
> And I've made it clear with every attorney, and I believe this is true of Mr. Katko in the early 2000s, that as an expert I have to divorce my evaluation, my assessment with the outcome of any particular testimony that I give. I neither want to know nor do I want to be told of the outcome of that testifying—of that testimony.
>
> So, broadly speaking, on no case has Mr. Katko or anybody else, including Ms. Pfeiffer, shaped the substantive conclusions of the report. They are my own.

(Tr. at 192-193)

Dr. Mahajan's Updated Office Forms

332. Dr. Mahajan testified that he has continued to update the forms he uses in his practice in order to improve his documentation. (Tr. at 528-533)

333. Dr. Karp was asked to review some blank forms that Dr. Mahajan testified he now uses in his practice. Dr. Karp opined that those forms would be good practice tools for Dr. Mahajan to use in his practice. (Resp. Exs. L-1, M-1, O-1 through O-6, P-1 through

P-5, Q-1 through Q-4, R-1, Y-1 and Y-2, Z-1; Tr. at 228-229) Further, with respect to Respondent's Exhibits Q-1 through Q-4, Dr. Karp opined that if a physician required a patient or parent of a child patient to complete those forms, it would fall within the standard of care for medical documentation. Moreover, Dr. Karp agreed that the information sought on those forms is the type of information that a physician should obtain in order to comply with the standard of care. He testified similarly with respect to Respondent's Exhibits R-1, Y-1 and Y-2, and Z-1. (Tr. at 236-238)

Letters of Support

334. Dr. Mahajan presented a number of letters of support from patients and medical colleagues. These letters describe Dr. Mahajan as a compassionate and dedicated physician, and praise Dr. Mahajan's clinical abilities, professionalism, and integrity. (Resp. Exs. K and LL)

RELIABILITY OF WITNESSES

1. With respect to Dr. Karp's reliability as a witness, it is undeniable that some of Dr. Karp's testimony contradicts or otherwise appears inconsistent with information in the medical records, probably because he had difficulty reading Dr. Mahajan's handwriting. For example:

- At hearing, Dr. Karp misread the dosage of Concerta documented for one of Patient 1's visits. The correct dosage is, in the Hearing Examiner's opinion, legible.
- At another of Patient 1's visits, Dr. Mahajan changed Patient 1's medication from Metadate, which had first been prescribed at the previous visit, to Adderall XR. Dr. Karp testified that Dr. Mahajan documented no basis for that change, although the phrase "meds making him sick" is legible on the note. There was no testimony from Dr. Karp concerning that phrase or why it did not suffice.
- Dr. Karp criticized Dr. Mahajan for failing to document the presence or absence of medication side effects in his records for Patients 1 through 9. Dr. Karp specifically exempted Patient 10 from that criticism because Dr. Mahajan had documented "No side effects" in several progress notes for Patient 10. However, Dr. Mahajan had also documented the same statement, "No side effects" or "No S.E.," in progress notes for all but two of the patients in this matter. No evidence was presented why such documentation should suffice for one patient but not for others.

On the other hand, Dr. Karp has broad experience in psychiatry and, unlike Dr. Gutheil and Dr. Polster, also has experience treating both children and adults. In addition, Dr. Karp appeared to be very objective witness. The Hearing Examiner rejects the Respondent's strident accusations of bias as set forth in his closing arguments. Accordingly, the Hearing Examiner finds Dr. Karp to be a reliable witness in terms of his expertise. However, because of inaccuracies in Dr. Karp's reading of some of Dr. Mahajan's medical records, his opinions must be closely examined in conjunction with the medical records. The Board, as a panel of experts, can determine whether it agrees with Dr. Karp's opinions and can amend any Finding of Fact or Conclusion of Law accordingly.

2. With respect to the reliability of Dr. Gutheil and Dr. Polster, both are very well-qualified psychiatrists. However, Dr. Mahajan provided each of them with his written responses to the Board's allegations, which Dr. Gutheil and Dr. Polster reviewed along with the medical records. Further, even after being provided with Dr. Mahajan's written responses, Dr. Polster presented questions to Dr. Mahajan concerning Dr. Mahajan's treatment of his patients and received Dr. Mahajan's written answers. The fact that both of these experts were provided with and relied upon additional information from Dr. Mahajan in a matter that primarily concerns medical recordkeeping diminishes the reliability of their testimony.

   Another aspect of their review of Dr. Mahajan's responses is that both Dr. Gutheil and Dr. Polster appear to have unquestioningly accepted the accuracy of the additional information that Dr. Mahajan provided to them. However, despite Dr. Mahajan's insistence that he can remember details of patient visits years after they occurred, the Hearing Examiner highly doubts that Dr. Mahajan's memory is that accurate.

3. Dr. Mahajan testified and provided reports concerning his reasoning during patient visits that happened years ago, as long ago as 2000. It is true that some of the patient visits occurred as late as mid-2006, a little less than three years before the hearing, but the bulk of the visits happened before that. Moreover, Dr. Mahajan testified that his practice is extremely busy; he testified that he typically sees 30 to 35 patients per day and that he has 10 or 15 minutes to spend with each patient during follow-up visits. That Dr. Mahajan could, under such circumstances, accurately recall details of visits from years before strains credulity. The Hearing Examiner does not believe that Dr. Mahajan can accurately remember information that was not included in the medical records. Accordingly, Dr. Mahajan's testimony concerning his recollections of things that were not documented in the medical records is accorded little weight.

LEGAL ISSUES

1. Dr. Mahajan argued that the State's case is based upon patient records that were not randomly chosen. He argued that, because they were not randomly chosen, they have no value as evidence of the overall quality of Dr. Mahajan's recordkeeping or medical practice, and that it would violate Dr. Mahajan's right to due process to rely upon such evidence.

   Assuming for purposes of discussion that the medical records were not chosen at random, this argument has no merit. First, nothing in the Ohio Medical Practices Act or the rules promulgated thereunder requires the Board to select medical records on a random basis during an investigation. Second, and most important, it *would* violate Dr. Mahajan's right to due process if the Board were to randomly choose patient records, base its allegations upon those records, and then assume that its findings with respect to those records apply to Dr. Mahajan's practice as a whole.

   Dr. Mahajan received adequate notice of the allegations against him, which are limited to specified aspects of his care and treatment of the ten patients identified in the confidential

Patient Key, which was sent to Dr. Mahajan along with the notice of opportunity for hearing. Dr. Mahajan requested a hearing and a hearing was afforded to him. All requisites of due process have been given to Dr. Mahajan in the hearing process.

2. Dr. Mahajan argues that the Board disregarded the conclusions of its representative, Dr. Patel. This argument has no merit. First, even if one were to accept the assertion that Dr. Patel was the Board's "representative," (a) there is no evidence that the Board or its staff disregarded Dr. Patel's conclusions, and (b) the Board is under no obligation to accept the conclusions of a monitoring physician.

3. Dr. Mahajan argues that Dr. Karp's opinion should be disregarded because his practice differs from Dr. Mahajan's. While it is true that their practices are not identical, Dr. Karp has had broad experience as a psychiatrist, including working in private practice and at clinics treating outpatients. Furthermore, Dr. Karp has experience treating children and adolescents, although he is not certified in that subspecialty by the ABPN as is Dr. Mahajan.[56] Nevertheless, the Board should take into account the similarities and differences between Dr. Karp's and Dr. Mahajan's practices and may accept or reject Dr. Karp's opinions as it sees fit.

4. Dr. Mahajan argues that Dr. Karp's opinion should be disregarded because of his "consistent inability to see records and notes in the [patient] files that were plainly in front of him." (Resp. Ex. SS at 2) The Hearing Examiner disagrees with the characterization that Dr. Karp was "consistently" unable to read Dr. Mahajan's medical records. Nevertheless, as has been addressed elsewhere in this report, there were instances where Dr. Karp did not or could not read notes in the medical record that were discernible to others, including the Hearing Examiner. The Board is free to accept or reject this argument as it sees fit.

FINDINGS OF FACT

1. From in or about 2000 to in or about 2006, in the course of his psychiatric practice, Mahendra Kumar Mahajan, M.D., undertook the care of Patients 1 through 10, as identified on a confidential Patient Key.

   (a) Dr. Karp opined that the standard of care requires that a psychiatric medical record include documentation of the performance of a psychiatric evaluation. A psychiatric evaluation should consist of several elements, including the following: identification of the chief complaint, history of the presenting illness, medical history, developmental history if the patient is a child or adolescent, substance abuse history if the patient is a teen or adult, and a comprehensive mental status examination. Dr. Karp further opined that the documented psychiatric evaluation should reflect the physician's understanding of the patient's problem sufficient to support a reasonable diagnosis, which should in turn support a reasonable treatment plan. Dr. Karp indicated that he had found some or all of the elements of a

[56] Neither are Dr. Gutheil or Dr. Polster. In fact, neither Dr. Gutheil nor Dr. Polster treats children or adolescents.

psychiatric evaluation missing from the medical records of Patients 1, 3, 4, 5, 6, 7, 9 and 10. A review of those medical records supports Dr. Karp's conclusion.

Dr. Mahajan testified that he had performed psychiatric evaluations with every patient, but did not always document everything he did due to time constraints. Further, Dr. Gutheil and Dr. Polster opined that Dr. Mahajan's medical records include sufficient documentation in the form of reports from families, schools, and psychologists, in addition to Dr. Mahajan's notes. Moreover, both Dr. Gutheil and Dr. Polster opined that Dr. Mahajan's documentation was sufficient to comply with the *minimal* standard of care.

Dr. Karp testified in support of the principle that, if something was not documented in the medical record, then it did not happen. Dr. Karp further testified that medical records exist not just for the treating physician's benefit, but also for the benefit of patients, other healthcare providers, and third parties such as insurance companies, courts, and regulatory authorities. Moreover, Dr. Karp testified that physicians are taught that medical documentation should allow another physician to step in and immediately take over the care of a patient, and that Dr. Mahajan's medical records lacked the necessary documentation for that to occur.

From Dr. Karp's testimony, which the Hearing Examiner finds convincing, one can reasonably conclude that adequate medical documentation is itself an important element in the care of patients, and is necessary both for medico-legal purposes *and* for purposes of patient safety. Furthermore, it minimizes the risk of relying on the fallible memory of a treating physician. Therefore, the evidence supports a finding that Dr. Mahajan failed to perform and/or document a psychiatric evaluation of Patients 1, 3, 4, 5, 6, 7, 9 and 10.

(b) Dr. Mahajan did not document baseline and/or follow-up laboratory evaluations of Patients 1, 3, 4, 5, 6, 7, and 9, and he did not maintain any laboratory results in his patient records for Patients 2 and 8. This fact is uncontroverted; the question remains whether this constituted a departure from the minimal standard of care.

Dr. Karp opined that a psychiatrist should obtain and document laboratory evaluations of patients for two reasons:

- to ensure that a physical illness is not contributing to the patient's psychiatric symptoms; and/or
- to ensure that medications prescribed will not interfere with a patient's well-being, for example:
  - if a patient is receiving Coumadin for a non-psychiatric condition, it would be important for the psychiatrist to obtain the patient's medical history and perhaps a "pro time" as well, because some psychiatric medications interact with Coumadin; and/or
  - if a young patient is to be placed on a psychostimulant for the first time, the patient should be given an EKG before treatment begins and periodically

thereafter to ensure that the psychostimulant is not causing a heart rhythm disturbance.

On the other hand, Dr. Mahajan and his experts opined that there was no need to obtain laboratory evaluations on the patients who were not receiving mood-stabilizing medications such as Depakote or Tegretol. They further opined that the medications that Dr. Mahajan prescribed to Patients 1, 3, 4, 5, 6, 7, and 9 do not have established therapeutic levels, which obviates the reason for doing lab studies. Moreover, they testified that laboratory evaluations need not be obtained on every patient and are a matter for the psychiatrist's clinical judgment.

The Hearing Examiner finds that, in the evidentiary record, there is a lack of patient-specific evidence from the State on this issue, and the Hearing Examiner is unwilling to recommend that the Board make a blanket finding that the minimal standard of care requires psychiatrists to obtain laboratory evaluations on all of their patients.

The lack of patient-specific evidence and medical opinions from the State that Dr. Mahajan erred in his clinical judgment with respect to laboratory evaluations does not support a finding that Dr. Mahajan failed to order, review and/or document baseline and/or follow-up laboratory evaluations of Patients 1, 3, 4, 5, 6, 7 and 9, or failed to maintain laboratory results in his patient record for Patients 2 and 8.

(c)(i) Dr. Mahajan failed to order and/or document therapeutic levels of Depakote for Patient 2. He prescribed Depakote to Patient 2 from December 12, 2003, until early March 2004.

All expert witnesses agreed that it is important to obtain blood levels of Depakote for patients receiving that medication. Dr. Gutheil and Dr. Polster testified that Dr. Mahajan had discontinued prescribing Depakote to Patient 2 just before or at about the time when it would have been necessary for him to obtain such blood levels. Dr. Karp, on the other hand, testified that an initial blood level should be obtained approximately one week after initiation of the medication. Dr. Karp indicated that the initial level should be obtained to ensure that it is within the therapeutic range. If the level is too low, the patient receives no benefit from the drug; if the level is too high, the patient is at risk for developing significant and possibly life-threatening side effects. Dr. Karp added that is also important to obtain follow-up blood levels for the same reason, and to see if the patient is taking the medication.

Accordingly, the evidence is sufficient to support a finding that Dr. Mahajan failed to order and/or document therapeutic levels of Depakote for Patient 2.

(c)(ii) Patient 8 received Depakote from early March 2002 through mid-June 2003. In mid-June 2003, Dr. Mahajan prescribed Tegretol to Patient 8 and discontinued it on July 28, 2003.

Dr. Mahajan documented an initial Depakote level for Patient 8, but failed to order and/or document follow-up therapeutic levels of Depakote for Patients 8. Further, Dr. Mahajan failed to order and/or document therapeutic levels of Tegretol for Patient 8.

Both Dr. Gutheil and Dr. Polster disapproved of Dr. Mahajan's failure to obtain Depakote/Tegretol levels on Patient 8, although neither of them opined that he had violated the minimal standard of care by failing to do so.

Dr. Karp's testimony as set forth in Finding of Fact 1(c)(i) applies equally to Patient 8 and is incorporated herein by reference.

Accordingly, the evidence is sufficient to support a finding that Dr. Mahajan failed to order and/or document follow-up therapeutic levels of Depakote for Patient 8, and/or failed to order and/or document therapeutic levels of Tegretol for Patient 8.

(d) Convincing evidence was presented that it is not necessary for a psychiatrist to use the DSM as a diagnostic tool. Nevertheless, Dr. Mahajan chose to use DSM diagnostic codes for all patients in this matter, although he did not always use them for every visit. When Dr. Mahajan chose to use DSM codes to document his diagnoses, he was required to document the relevant DSM criteria to support those diagnoses, which he did not do. Accordingly, the evidence supports a finding that Dr. Mahajan failed to document that the relevant DSM-IV or DSM-IV-TR criteria had been met for any psychiatric diagnosis for which he documented a DSM code for Patients 1 through 10.

(e) Dr. Karp offered persuasive testimony that it is important for a psychiatrist to have informed-consent discussions with patients to educate them and to draw them in as active participants in their own treatment. Discussions regarding informed consent should concern diagnoses; the treatment recommended and the rationale for the treatment; the benefits of treatment; the common, serious, and/or expected side effects; and the available alternatives to the recommended treatment, including no treatment. Such discussions should begin at the first visit, and should be repeated throughout the course of treatment whenever the treatment is modified to any significant degree, or when the diagnosis changes. Dr. Mahajan's medical records for Patients 1 through 10 do not include documentation of such discussions.

In his defense, Dr. Mahajan offered testimony that he had actually had such discussions at every visit but simply did not document them. Dr. Gutheil opined that that testimony should be taken seriously by the Board, and Dr. Karp agreed. However, Dr. Mahajan's testimony concerning details of treatment that occurred long ago is unreliable. Moreover, Dr. Karp testified persuasively concerning the importance of medical documentation, and Dr. Karp's testimony in support of the principle that, if something was not documented, it was not done, was convincing and well-stated.

Accordingly, the evidence supports a finding that Dr. Mahajan did not properly document the performance of an initial or ongoing discussion of informed consent regarding diagnoses, why a specific medication was recommended, the medication's intended benefits, potential medication side effects, recommended duration of use and/or alternative medications for Patients 1 through 10.

In making this finding, it is further found that Dr. Mahajan's checking a box that the "Patient/Guardian understands and consents to medications" is insufficient documentation of the initial informed-consent discussion and of ongoing discussions concerning changes to diagnoses and/or treatment.

(f)(i) Evidence was presented by the State that Dr. Mahajan's lack of clear documentation made it difficult for Dr. Karp to ascertain Dr. Mahajan's rationale for the medications he prescribed and for modifications to the medication regimens. However, Dr. Mahajan was not charged with failing to document the reasons for *initiating or changing* prescriptions; he was charged with failing "to consistently *follow up* on medication changes, additions and deletions" for Patients 1 through 10. (Emphasis added.)

The Hearing Examiner finds that there is insufficient reliable evidence to support this allegation. In part, Dr. Karp was unable to read some of Dr. Mahajan's notes. In addition, evidence indicating deficiencies in documenting a rationale for initiating or changing medications in not probative with respect to an allegation limited to the failure to consistently "follow up" on medication changes, additions, and deletions. Accordingly, the evidence is insufficient to support a finding that Dr. Mahajan failed to consistently follow up on medication changes, additions and deletions for Patients 1 through 10.

(f)(ii) In his report, Dr. Karp stated that "[t]he number and amount of medications, how and when they were prescribed, and in what amounts, *suggests* an ad hoc basis * * *." (Emphasis added) Further, Dr. Karp testified that Dr. Mahajan's medication changes "*almost seem* ad hoc in the sense that they often follow statements that overall the patient is doing well, and then the medication disappears, is deleted, discontinued, modified, changed, or changed to another medication." (Emphasis added) Those statements, by themselves, do not support a finding that Dr. Mahajan actually prescribed to Patients 1 through 10 on an ad hoc basis.

Dr. Mahajan's experts testified convincingly that psychiatric treatment can necessitate trials of different medications until an effective medication or combination of medications is found. While that testimony is persuasive, there must nonetheless be adequate documentation of the effects of the trials and the reasons why they were discontinued and other medications substituted. Dr. Karp indicated that such documentation was lacking. However, while Dr. Karp is correct that many of Dr. Mahajan's notes say something like "overall doing well," these statements are often followed by other statements concerning some problem the patient is having, like sleep problems or problems in school. Further, Dr. Karp was unable to read some of Dr. Mahajan's notes, including a note that medications

were making a patient sick. The Hearing Examiner finds that there is insufficient reliable evidence to support a finding that Dr. Mahajan inappropriately prescribed to Patients 1 through 10 on an "ad hoc" basis.

(g)(i) Dr. Karp criticized Dr. Mahajan for failing to document the presence or absence of medication side effects in his records for Patients 1 through 9. Dr. Karp specifically exempted Patient 10 from that criticism because Dr. Mahajan had documented "No side effects" in several progress notes for Patient 10. However, the patient records demonstrate that Dr. Mahajan also documented "No side effects" or "No S.E." in progress notes for Patients 1 through 5, 7, and 8 as well. No evidence was presented why such documentation should suffice for one patient but not for others. Therefore, the evidence is insufficient to support a finding that Dr. Mahajan failed to document the presence or absence of adverse effects for medications he prescribed to Patients 1 through 5, 7, and 8.

(g)(ii) With respect to Patients 6 and 9, the evidence supports a finding that Dr. Mahajan failed to document the presence or absence of adverse effects for medications he prescribed to those patients.

(h) The evidence is uncontroverted that Dr. Mahajan prescribed antipsychotic medication to Patients 2, 5, and 7 through 10, all of whom were children or adolescents.

For the reasons set forth below, the evidence overwhelmingly supports a finding that Dr. Mahajan failed to discuss and/or document the discussion, either initially or in follow-up, of tardive dyskinesia for Patients 2, 5, and 7 through 10. Further, Dr. Mahajan failed to perform and/or document Abnormal Involuntary Movement examinations at baseline or during treatment for Patients 2, 5, and 7 through 10.

Dr. Karp offered persuasive testimony that antipsychotic medications carry a risk of a serious side effect called tardive dyskinesia, which involves involuntary twitches or movements that may not be reversible. Dr. Karp opined persuasively that the standard of care requires that a psychiatrist have discussions with the patient and the guardian before prescribing such medications so that the patient and guardian know what to look for and when to report problems. Further, the standard of care requires that a psychiatrist perform and document a baseline Abnormal Involuntary Movement Scale [AIMS] test, and perform and document follow up AIMS tests on a periodic basis.

Dr. Mahajan and Dr. Gutheil testified that the risk of tardive dyskinesia with the newer antipsychotic medications is so low that AIMS testing is not required by the standard of care.

Dr. Karp acknowledged that the newer antipsychotic medications carry far less risk of tardive dyskinesia developing—a one- or two-percent risk versus a 60 to 65 percent risk with the older drugs—however, it is still important to have discussions with patients and guardians and perform AIMS testing, particularly in the case of

children. The risk of tardive dyskinesia developing increases the longer a patient takes antipsychotic medication, and children may remain on such medicines for long periods of time. Accordingly, the evidence supports a finding that Dr. Mahajan failed to discuss and/or document the discussion, either initially or in follow-up, of tardive dyskinesia for Patients 2, 5, and 7 through 10, and failed to perform and/or document Abnormal Involuntary Movement examinations at baseline or during treatment for Patients 2, 5, and 7 through 10.

CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Dr. Mahajan as set forth in Findings of Fact 1(a), 1(c)(i), 1(c)(ii), 1(d), 1(e), 1(g)(ii), and 1(h), individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

2. The evidence is insufficient to support a conclusion that the acts, conduct, and/or omissions of Dr. Mahajan as set forth in Findings of Fact 1(b), 1(f)(i), 1(f)(ii), and 1(g)(i), individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

   Nevertheless, the Board was substantially justified in bringing those allegations because, at the time the allegations were made, the Board did not have before it all of the evidence produced at hearing. It is evident that the allegations were based upon the opinion of the State's expert witness. At hearing, however, the evidence indicated that the State's expert witness's reading of Dr. Mahajan's medical records was not entirely reliable, and certain allegations were not proven.

3. The Findings of Fact do not support a conclusion that Dr. Mahajan's acts, conduct, and/or omissions, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code. The Hearing Examiner is unaware of any previous case in which the Board found a violation of Section 4731.22(B)(2), Ohio Revised Code, without first making factual findings of inappropriate or excessive prescribing or dispensing of medications, or of a violation of an administrative rule that also constitutes violation of Section 4731.22(B)(2).

   If made, a finding that Dr. Mahajan prescribed on an "ad hoc" basis, as alleged, would constitute a violation of Section 4731.22(B)(2), Ohio Revised Code. That allegation in the Notice echoed the opinion set forth in the report of the State's expert witness. However, based upon the evidence produced at hearing, including evidence that the State's expert witness's reading of Dr. Mahajan's medical records was not entirely reliable, the allegation

that Dr. Mahajan had prescribed on an ad hoc basis was ultimately not proven. Nevertheless, the Board was substantially justified in bringing that allegation because, at the time the allegation was made, the Board did not have before it all of the evidence produced at hearing.

RATIONALE FOR THE PROPOSED ORDER

The Board has in the past affirmed the principle that, if something was not documented in the medical record, it was not done. Dr. Karp testified convincingly concerning the value of that principle as well as its acceptance by the medical community. Without appropriate documentation, the Board cannot be assured that important aspects of medical care are being performed. The evidentiary record makes clear that there is a pervasive lack of documentation in Dr. Mahajan's medical records for Patients 1 through 10, including lack of documentation of (a) psychiatric evaluations, (b) therapeutic levels of mood-stabilizing medications for two patients, (c) diagnostic criteria in support of DSM diagnoses, (d) informed-consent discussions with the patient and his or her guardian, and (e) discussions concerning tardive dyskinesia, and baseline and period AIMS testing, for several juvenile patients to whom he prescribed antipsychotic medication. Furthermore, there is a lack of credible evidence that these undocumented events actually occurred; Dr. Mahajan's testimony concerning details of treatment that occurred long ago was not persuasive.

In order to ensure that Dr. Mahajan is capable of practicing safely, the Proposed Order would suspend Dr. Mahajan's certificate until he completes an assessment program. He would then be subject to probation for at least three years, during which he would be required to complete any learning plan recommended following the assessment. He would also be subject to monitoring and be required to complete a medical recordkeeping course.

PROPOSED ORDER

It is hereby ORDERED that:

A. **SUSPENSION OF CERTIFICATE**: The certificate of Mahendra Kumar Mahajan, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time.

B. **CONDITIONS FOR REINSTATEMENT OR RESTORATION**: The Board shall not consider reinstatement or restoration of Dr. Mahajan's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration**: Dr. Mahajan shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Post-Licensure Assessment Program**: Prior to submitting his application for reinstatement or restoration, Dr. Mahajan shall have undergone an assessment and

completed the recommended educational activities, as developed for Dr. Mahajan by the Post-Licensure Assessment System [PLAS] sponsored by the Federation of State Medical Boards and the National Board of Medical Examiners. Dr. Mahajan's participation in the PLAS shall be at his own expense.

a. Prior to the initial assessment by the PLAS, Dr. Mahajan shall furnish to the PLAS copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions of Law, and any other documentation from the hearing record which the Board may deem appropriate or helpful to that assessment.

b. Should the PLAS request patient records maintained by Dr. Mahajan, Dr. Mahajan shall include in that submission copies of the patient records at issue in this matter. Dr. Mahajan shall further ensure that the PLAS maintains patient confidentiality in accordance with Section 4731.22(F)(5), Ohio Revised Code.

c. Dr. Mahajan shall ensure that, within ten days of its completion, the written Assessment Report compiled by the PLAS is submitted to the Board. Moreover, Dr. Mahajan shall ensure that the written Assessment Report includes the following:

- A detailed plan of recommended practice limitations, if any;
- Any recommended education;
- Any recommended mentorship or preceptorship;
- Any reports upon which the recommendation is based, including reports of physical examination and psychological or other testing.

d. Any Learning Plan recommended by PLAS shall have been developed subsequent to the issuance of a written Assessment Report, based on an assessment and evaluation of Dr. Mahajan by the PLAS. Dr. Mahajan shall successfully complete the educational activities as recommended in the Learning Plan, including any final assessment or evaluation.

e. At the time he submits his application for reinstatement or restoration, Dr. Mahajan shall submit to the Board satisfactory documentation from PLAS indicating that he has successfully completed the recommended educational activities.

3. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Mahajan has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.

C. **PROBATION**: Upon reinstatement or restoration, Dr. Mahajan's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:

1. **Obey the Law**: Dr. Mahajan shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance**: Dr. Mahajan shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Mahajan's certificate is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances**: Dr. Mahajan shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Mahajan's certificate is restored or reinstated, or as otherwise directed by the Board. Subsequent personal appearances shall occur every **six** months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. **Medical Records Course(s)**: Within the first year of his probation, or as otherwise determined by the Board, Dr. Mahajan shall provide acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. 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 course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

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

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

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

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

6. **Monitoring Physician**: Within 30 days of the date of Dr. Mahajan's reinstatement or restoration, or as otherwise determined by the Board, Dr. Mahajan shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Mahajan and who is engaged in the same or similar practice specialty.

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

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

   In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Mahajan shall immediately so notify the Board in writing. In addition, Dr. Mahajan shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Mahajan shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

   The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Mahajan's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Mahajan's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

7. **Absences from Ohio**: Dr. Mahajan shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the

Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have discretion to waive part or all of the monitoring terms set forth in this Order for occasional periods of absence of 14 days or less.

In the event that Dr. Mahajan resides and/or is employed at a location that is within 50 miles of the geographic border of Ohio and a contiguous state, Dr. Mahajan may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Mahajan is otherwise able to maintain full compliance with all other terms, conditions and limitations set forth in this Order.

8. **Tolling of Probationary Period While Out of Compliance**: In the event Dr. Mahajan is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

9. **Required Reporting of Change of Address:** Dr. Mahajan shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.

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

E. **VIOLATION OF THE TERMS OF THIS ORDER**: If Dr. Mahajan violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

F. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

1. **Required Reporting to Employers and Others**: Within 30 days of the effective date of this Order, Dr. Mahajan shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare services (including but not limited to third-party payors), or is receiving training; and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Mahajan shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

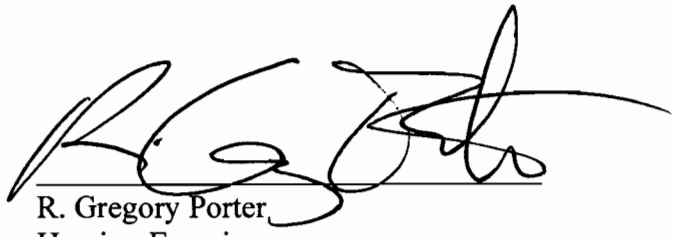
In the event that Dr. Mahajan provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, he shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities**: Within 30 days of the effective date of this Order, Dr. Mahajan shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Also, Dr. Mahajan shall provide a copy of this Order at the time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. Mahajan receives from the Board written notification of the successful completion of his probation.

3. **Required Documentation of the Reporting Required by Paragraph F**: Dr. Mahajan shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (1) the return receipt of certified mail within 30 days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

G. **SUPERSEDES PREVIOUS CONSENT AGREEMENT**: Upon becoming effective, this Order shall supersede the terms and conditions set forth in the September 2005 Consent Agreement between Dr. Mahajan and the Board.

EFFECTIVE DATE OF ORDER: This Order shall become effective 30 days from the date of mailing of the notification of approval by the Board.



R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF MAY 12, 2010

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Amato announced that the Board would now consider the Reports and Recommendations, and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Amato asked whether each member of the Board had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law and Proposed Orders, and any objections filed in the matters of: Mahendra Kumar Mahajan, M.D.; Joseph F. Karr, D.O.; Azamuddin Khaja, M.D.; Sonia Iris Otero; Jordon James Scuralli; and Ty James Tyjewski. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Ramprasad	- aye

Dr. Amato 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:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Ramprasad	- aye

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

participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

Dr. Amato reminded all parties that no oral motions may be made during these proceedings.

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

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MAHENDRA KUMAR MAHAJAN, M.D.

Dr. Amato directed the Board's attention to the matter of Mahendra Kumar Mahajan, M.D. He advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

Dr. Amato stated that on May 6, 2010, he [Dr. Amato] denied Dr. M. Mahajan's Motion to Stay Proceedings Pending Resolution of the Related Case, *State ex rel. Mahajan v. Ohio State Medical Board*, Case No. 2009-2293, and Dr. M. Mahajan's Motion to Overrule Hearing Examiner's Evidentiary Rulings and to Reopen the Hearing. Dr. Amato stated that he had also granted the State's Motion to Strike Additional Evidence on May 6, 2010.

Dr. Amato stated that on May 11, 2010, he [Dr. Amato] denied Dr. M. Mahajan's Motion to Reconsider Board President's Ruling Denying Respondent's Motion to Overrule Hearing Examiner's Evidentiary Rulings and to Reopen Hearing and Granting Board Staff's Motion to Strike Additional Evidence and Motion for Reconsideration of Board President's Ruling Denying Motion to Stay Proceeding Pending Resolution of the Related Case, *State ex rel. Mahajan v. Ohio State Medical Board*, Case No. 2009-2293.

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

Dr. M. Mahajan was accompanied by his attorney, Subodh Chandra.

Mr. Chandra stated that he had recently taught his 6-year-old triplet sons how to eat an artichoke. Mr. Chandra explained that to eat an artichoke, one must peel back the layers until one can almost see the heart, and then scrape away the mess until one can get to the heart. Mr. Chandra submitted that the matter of Dr. M. Mahajan before the Board was comparable to the mess that must be scraped away in order to get to the heart of the matter.

Mr. Chandra stated that the heart of Dr. M. Mahajan's case is that no patient harm occurred. Mr. Chandra stated that the undisputed evidence before the Board is that the ten patients in question improved under Dr. M. Mahajan's care and treatment. Mr. Chandra noted that the parents of Patient #2 and Patient #8 were present in support and gratitude for the treatment their children received from Dr. M. Mahajan.

Mr. Chandra stated that the State Medical Board has never before suspended the license of a physician for poor charting in the absence of another significant factor, such as patient harm or improper prescribing. Mr. Chandra stated that the notion that "if it is not charted, then it did not happen" is not the law in Ohio, but rather it is a manufactured standard. Mr. Chandra asserted that if the Medical Board took the unprecedented step of adopting such a standard, then malpractice lawsuits would be filed across the state due to documentation issues, even in the absence of patient harm.

Dr. Suppan entered the meeting at this time.

Mr. Chandra noted that 80% of the experts in this case found Dr. M. Mahajan's charts to be acceptable, including Thomas Gutheil, M.D., the Harvard psychiatrist who is recognized, even by the state's witness, Robert A. Karp, M.D., as the pre-eminent expert on charting. Mr. Chandra stated that Daniel S. Polster, M.D., is another expert who found Dr. M. Mahajan's charts to be acceptable. Mr. Chandra stated that the Board has ignored the review of 900 files by it's own appointed expert, Amita Patel, M.D., and that no reason has been given for ignoring Dr. Patel's report.

Regarding the state's witness, Dr. Karp, Mr. Chandra stated that Dr. Karp is not board-certified in child psychiatry and has no experience with a busy out-patient practice which requires quick note-taking before moving on to the next patient. Mr. Chandra stated that, more importantly, Dr. Karp is demonstrably wrong about his observations of Dr. M. Mahajan's files. For example, Dr. Karp claimed that Dr. M. Mahajan did not explain why he had switched a patient from one medication to another; however, the explanation for the change of medications was in the chart.

Mr. Chandra opined that even if Dr. M. Mahajan's records showed improper record-keeping, which Mr. Chandra maintained they did not, then the recommended punishment of suspension did not fit Dr. M. Mahajan's supposed offense. Mr. Chandra opined that suspending the medical license of the 63-year-old Dr. M. Mahajan and establishing criteria for reinstatement would be, for all intents and purposes, a death sentence.

Mr. Chandra respectfully submitted that no member of the Board or the medical profession could survive the scrutiny to which Dr. M. Mahajan had been subjected.

Dr. M. Mahajan addressed the Board and stated that he and his wife appreciate the opportunity to appear before the Board. Dr. M. Mahajan offered his sincere apologies that this matter has come to the Board's attention and stated that he has learned from the criticism leveled at his practice. Dr. M. Mahajan stated that he has a nerve condition which made handwriting difficult and has become progressively worse. As a result, Dr. M. Mahajan's handwriting has been difficult to read. Dr. M. Mahajan stated that before the investigations into the current matter had begun, he had taken steps to improve his documentation. Dr. M. Mahajan stated that he has implemented a voice-recognition system, a record-keeping system, and has enrolled in a record-keeping course for June 18, 2010.

Dr. M. Mahajan asked the Board to remember the tenet, "First, do no harm." Dr. M. Mahajan stated that he is one of the few board-certified child psychiatrists in Dayton who chooses to care for Medicaid patients. Dr. M. Mahajan noted that he had not harmed his patients and asked the Board how the children who are his patients would most benefit: From allowing Dr. M. Mahajan to continue to practice, or from suspending Dr. M. Mahajan's medical license.

Dr. M. Mahajan respectfully asked that the Board reconsider the hearing examiner's recommendations, for his sake and the sake of his patient.

Dr. Amato asked if the Assistant Attorney General wish to respond. Ms. Unver replied that she did wish to respond.

Ms. Unver stated that the Board can, in fact, discipline Dr. M. Mahajan solely for documentation issues. Ms. Unver stated that documentation is the cornerstone of good patient care. Ms. Unver observed that if something is not documented in the patient chart, then one cannot be certain that it happened. Ms. Unver stated that under 4731.22(B)(6), Ohio Revised Code, the Board can discipline a licensee for poor documentation even if there has not been patient harm.

Ms. Unver stated that the case against Dr. M. Mahajan does not rest solely on documentation issues, but also on Dr. M. Mahajan's care and treatment of Patients #1 through #10. Ms. Unver stated that Dr. M. Mahajan failed to perform and/or document psychiatric evaluations for several of his patients and failed to perform and/or document abnormal involuntary movement examinations at baseline or during treatment for several of his patients. Ms. Unver stated that the state's witness, Dr. Karp, testified thoroughly on the deficiencies of Dr. M. Mahajan's care and treatment of Patients #1 through #10 and that it fell far below the minimum standards of care.

Ms. Unver noted that the Ohio Supreme Court stated in the 1980 case *Arlen v. State Medical Board* that "This distinguished Medical Board is capable of interpreting technical requirements of the medical field and is quite capable of determining when certain conduct falls below a reasonable standard of care." Ms. Unver stated that the members of the Board are the experts and are able to use their clinical judgment in this case.

Ms. Unver stated that the case against Dr. M. Mahajan should not be Dismissed or have No Further Action. Ms. Unver stated that Dismissal would mean that no violation occurred. Ms. Unver stated that this simply did not apply and noted that Dr. M. Mahajan's own experts found that Dr. M. Mahajan's prescribing of Tegretol to Patient #8 was below the minimum standards of care. Also, Dr. M. Mahajan and his experts admitted to deficiencies in his care and treatment of Patient #2 and Patient #8 with regard to his prescribing of Depakote.

Ms. Unver read a portion of the hearing transcript in which Dr. M. Mahajan was questioned by his attorney, Nicholas E. Subashi, regarding his change of Patient #8's prescription from Adderall to Strattera:

> **Dr. M. Mahajan:** Mom's report is Adderall is not working and why not Strattera? How do you argue? So give Strattera a try.
>
> **Mr. Subashi:** Did you consider the use of Strattera to be the right thing at this point in time?
>
> **Dr. M. Mahajan:** No, sir. I cannot practice ideal psychiatry in clinical settings all the time.
>
> **Mr. Subashi:** So why did you? Why did you prescribe the Strattera?
>
> **Dr. M. Mahajan:** Because of all the outside influences. I don't know if it was also on the formulary. That part I cannot tell you. But there has to be a reason because even I know I don't agree.

Ms. Unver continued that No Further Action would also be inappropriate in this case. Ms. Unver stated that No Further Action would indicate that a violation has occurred, but no discipline is required. Ms. Unver noted that Dr. M. Mahajan was subject to a 2005 Consent Agreement with the Medical Board and stated that this is an aggrevating factor.

Ms. Unver stated that the Board has disciplined physicians for documentation issues in the past. For example, Jose Martinez, M.D., Claudia Metz, M.D., Alice Frazier, M.D., and Roger Princell, M.D., were all disciplined by the Medical Boad based on documentation issues and other patient care issues. Ms. Unver stated that the case against Dr. M. Mahajan was even more egregious than these other cases because it involves ten patients.

Ms. Unver stated that the state agrees with Mr. Porter's Report and Recommendation and urged the Board to adopt it.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF MAHENDRA KUMAR MAHAJAN, M.D. MR. HAIRSTON SECONDED THE MOTION.

Dr. Amato stated that he will now entertain discussion in the above matter.

Before discussion, Dr. D. Mahajan made note that, although they share the same surname, he is neither a relative nor an acquaintance of Dr. M. Mahajan.

Dr. D. Mahajan noted that the ten patients chosen for review were not chosen at random. Dr. D. Mahajan also noted that the state's witness, Dr. Karp, is not active in a clinical private practice, although he does see patients.

Dr. Talmage exited the meeting at this time.

Dr. D. Mahajan continued that Dr. M. Mahajan's charts were reviewed by four other psychiatrists, Dr. Gutheil, Dr. Polster, Dr. Patel, and James R. Hawkins, M.D. Dr. D. Mahajan observed that Dr. Patel had

made suggestions to improve Dr. M. Mahajan's documentation, and Dr. M. Mahajan adopted those suggestions. Dr. D. Mahjajan felt that this was a positive thing for Dr. M. Mahajan. Dr. D. Mahajan also stated that diskinesia occurs only rarely, especially in children, with use of neuroleptics or similar medications. Therefore, Dr. D. Mahajan was not concerned that Dr. M. Mahajan did not test for diskinesia.

Dr. D. Mahajan opined that Dr. M. Mahajan's documentation was deficient in many cases. Also, a representative from a drug company sought treatment from Dr. M. Mahajan, for which little documentation was made. Dr. D. Mahajan noted that the testimony of patients and patients' relatives were never positive for Dr. M. Mahajan.

Dr. D. Mahajan opined that Dr. M. Mahajan was not negligent in any of the cases brought before the Board. Additionally, no harm was done to Dr. M. Mahajan's patients and there were no bad outcomes of which the Board is aware. While acknowledging problems with Dr. M. Mahajan's documentation, Dr. D. Mahajan did not feel that these deficiencies and omissions warranted suspension of Dr. M. Mahajan's license. Dr. D. Mahajan also felt that the Proposed Order's provision for post-licensure assessment was unnecessary.

Dr. Steinbergh stated that all physicians are taught the same way to take a patient history, assess a patient, and perform an examination if one is indicated. Dr. Steinbergh stated that the medical record is one of the most important things a physician does beyond the assessment of the patient. Dr. Steinbergh stated that the medical record demonstrates how the physician is thinking and what the physician is doing, and therefore is a critical piece of medical care. Dr. Steinbergh supported Ms. Unver's statement that the Board has taken action against physicians in the past due to deficiencies in documentation. Dr. Steinbergh stated that if another physician had to assume the care of Dr. M. Mahajan's patients, the medical record would be vital to the continuation of the patients' care. Dr. Steinbergh opined that patients have a right to expect that their medical records will be appropriately maintained.

Dr. Steinbergh agreed with Mr. Porter's Findings of Fact and Conclusions of Law, but also agreed with Dr. D. Mahajan that the post-licensure assessment program is unnecessary. Dr. Steinbergh acknowledged that Dr. M. Mahajan is attempting to improve his practice and his medical records, noting that he has taken suggestions from Dr. Patel. Dr. Steinbergh disagreed with Dr. M. Mahajan's practice of documenting patients' diagnoses with a code instead of a written description; however, Dr. Steinbergh opined that this did not warrant concern.

Dr. Steinbergh agreed with Dr. D. Mahajan that there is no reason to suspend Dr. M. Mahajan's medical license, but also opined that Dr. M. Mahajan's monitoring should be increased and improved. Dr. Steinbergh also opined that Dr. M. Mahajan should attend a medical record-keeping course to improve his ability to produce a medical record that is recognizable by the medical community. Dr. Steinbergh suggested that a three-year probationary term with monitoring would be appropriate.

Dr. Stephens disagreed with Dr. D. Mahajan and Dr. Steinbergh and opined that that case against Dr. M. Mahajan should be dismissed. Dr. Stephens felt that there is prejudice against Dr. M. Mahajan due to his

prior Consent Agreement. Dr. Stephens noted that Dr. M. Mahajan is already being reviewed on a regular basis by Dr. Patel, who has not expressed any complaints or indications that further action should be taken.

Dr. Stephens agreed with Dr. Steinbergh that physicians are all taught the same way how to document, but stated that in practice it is very different. Dr. Stephens stated that oftentimes a physician's notes on a long-term patient are shorter than with a new patient. Dr. Stephens also opined that very few physicians have good handwriting. Dr. Stephens stated that documentation is subjective and is not governed by rule or law. Dr. Stephens stated that informed consent is often verbalized and not documented in writing except in specific cases. Dr. Stephens opined that documented informed consent is not required in Dr. M. Mahajan's case.

Regarding changes in prescriptions, Dr. Stephens stated that she herself changes her patient's prescriptions often and does not always document the reason for the change. Dr. Stephens stated that a change in prescriptions is usually an indication that the previous prescription is not working.

Dr. Stephens stated that physicians often have a pattern to the way they practice and tend to do the same things in the same way consistently. Dr. Stephens suggested that if a physician establishes a normal practice of recognizable patterns, then that can provide proof that certain actions were done in a particular patient's case even if they are not documented.

Dr. Stephens noted that Mr. Porter referred to expected guidelines. Dr. Stephens opined that expected guidelines are very subjective. Although Mr. Porter found Dr. M. Mahajan's initial evaluation to be insufficiently thorough, Dr. Stephens opined that initial evaluations in some specialties, such as psychiatry, tend to be very specific. Dr. Stephens was unconcerned that Dr. M. Mahajan did not order blood tests for suspected diskinesia and noted that diskinesia results in involuntary movements which can be observed by the physician, thus obviating the need to traumatize a child with a blood test. Dr. Stephens agreed with Dr. Steinbergh that Dr. M. Mahajan's use of diagnostic codes and not descriptive diagnoses in the medical records is not a concern.

Dr. Stephens opined that the case against Dr. M. Mahajan is unfair, judgmental, and an example of heavy-handedness.

Dr. D. Mahajan stated that a majority of his psychiatrist colleagues do not order blood tests for diskinesia. Dr. D. Mahajan stated that because children are fast metabolizers, physicians often prescribe higher doses to children to achieve therapeutic levels. Although concern has been expressed that Dr. M. Mahajan did not follow this practice, Dr. D. Mahajan stated that higher doses are not required to achieve the mood-stabilizing function of the medications in question.

DR. STEPHENS MOVED TO AMEND THE PROPOSED ORDER TO DISMISS THE CASE AGAINST DR. M. MAHAJAN. No member seconded the motion. The motion was lost for want of a second.

DR. D. MAHAJAN MOVED TO AMEND THE PROPOSED ORDER TO REMOVE THE PROVISIONS FOR SUSPENSION OF DR. M. MAHAJAN'S LICENSE AND THE REQUIREMENT OF A POST-LICENSURE ASSESSMENT PROGRAM. DR. D. MAHAJAN MOVED THAT OTHER ASPECTS OF THE PROPOSED ORDER REMAIN INTACT. DR. STEINBEGH SECONDED THE MOTION. A vote was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- nay
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Dr. Madia	- abstain
	Dr. Suppan	- aye
	Dr. Ramprasad	- aye

The motion to amend carried.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF NARENDRA KUMAR GUPTA, M.D. MR. HAIRSTON SECONDED THE MOTION. A vote was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- nay
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Dr. Madia	- abstain
	Dr. Suppan	- aye
	Dr. Ramprasad	- aye

The motion carried.

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

November 14, 2007

Case number: 07-CRF- 012

Mahendra Kumar Mahajan, M.D.
2614 Lantz Road
Beavercreek, OH 45434

Dear Doctor Mahajan:

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

(1) From in or about 2000 to in or about 2006, you undertook the care of Patients 1-10, as identified on the attached Patient Key in the course of your psychiatric practice (Patient Key confidential and to be withheld from public disclosure).

(a) You failed to complete and/or document a psychiatric evaluation of patients 1, 3, 4, 5, 6, 7, 9 and 10.

(b) You failed to order, review and/or document baseline and/or follow-up laboratory evaluations of patients 1, 3, 4, 5, 6, 7 and 9. Further, you failed to maintain any laboratory results in your patient record for Patients 2 and 8.

(c) You failed to order and/or document therapeutic levels of Depakote for Patients 2 and 8 and of Tegretol for Patient 8.

(d) You failed to document DSM-IV or DSM-IV-TR criteria having been met for any psychiatric diagnoses.

(e) You failed to properly document the performance of initial or ongoing discussion of informed consent regarding diagnoses, why a specific medication was recommended, the medication's intended benefits, potential medication side effects, and/or recommended duration of use or alternative medications for Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10.

Mailed 11-15-07

(f) You failed to consistently follow up on medication changes, additions and deletions in Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. You inappropriately prescribed to Patients 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 on an ad hoc basis.

(g) You failed to document the presence or absence of adverse effects for medications prescribed by you to Patients 1, 2, 3, 4, 5, 6, 7, 8 and 9.

(h) You failed to discuss and/or document the discussion, either initially or in follow-up, of Tardive Dyskinesia for Patients 2, 5, 7, 8, 9 and 10 who were prescribed anti-psychotic medications by you. Further, despite the fact that you prescribed anti-psychotic medications to Patients 2, 5, 7, 8, 9 and 10, you failed to perform and/or document Abnormal Involuntary Movement examinations at baseline or during treatment.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

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

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

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

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

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

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Lance A. Talmage, M.D.
Secretary

LAT/DPK/flb

Enclosures

CERTIFIED MAIL #91 7108 2133 3931 8317 4945
RETURN RECEIPT REQUESTED

cc: Nicholas E. Subashi, Esq.
The Greene Towne Center
50 Chestnut St., # 230
Dayton, OH 45440

CERTIFIED MAIL #91 7108 2133 3931 8317 4952
RETURN RECEIPT REQUESTED

CONSENT AGREEMENT
BETWEEN
MAHENDRA KUMAR MAHAJAN, M.D.
AND
THE STATE MEDICAL BOARD OF OHIO

This Consent Agreement is entered into by and between Mahendra Kumar Mahajan, M.D., and the State Medical Board of Ohio [Board], a state agency charged with enforcing Chapter 4731., Ohio Revised Code.

Dr. Mahajan enters into this Consent Agreement being fully informed of his rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

BASIS FOR ACTION

This Consent Agreement is entered into on the basis of the following stipulations, admissions and understandings:

A. The Board is empowered by Section 4731.22(B)(12), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand you or place on probation the holder of a certificate for "commission 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."

B. The Board enters into this Consent Agreement in lieu of formal proceedings based upon the violation of Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 3719.99(E), Ohio Revised Code, "Penalties," to wit: Section 3719.06(A), Ohio Revised Code, "Authority of Licensed Health Professional; Contents of Prescription," as set forth in Paragraph E, below, and expressly reserves the right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Consent Agreement.

C. Dr. Mahajan is licensed to practice medicine and surgery in the State of Ohio, License # 35-043538.

D. Dr. Mahajan states that he is ~~not~~ MKM licensed to practice medicine and surgery in ~~any~~ MKM ~~other~~ MKM state of Indiana MKM 8/20/05

E. Dr. Mahajan admits that on repeated occasions in and prior to 2003, and in accordance with the practice of the mental health clinics at which he was working, he signed otherwise blank prescriptions that were to be kept in a double-locked system

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and used only to obtain patient medications in specified situations, including patient emergencies. Dr. Mahajan states that subsequent to the discovery that a nurse had completed one or more of these prescriptions to obtain medications for her own use, he cooperated with investigating authorities, including the Board, and ceased the practice of pre-signing otherwise blank prescriptions.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, Dr. Mahajan knowingly and voluntarily agrees with the Board to the following terms, conditions and limitations:

Mahendra Kumar Mahajan, M.D., is hereby REPRIMANDED.

Further, Dr. Mahajan knowingly and voluntarily agrees with the Board to the following PROBATIONARY terms, conditions and limitations:

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

2. Dr. Mahajan shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Consent Agreement. 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 Consent Agreement becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. Dr. Mahajan shall appear in person for an interview before the full Board or its designated representative during the third month following the effective date of this Consent Agreement. Subsequent personal appearances must occur every six months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.

4. In the event Dr. Mahajan is found by the Secretary of the Board to have failed to comply with any provision of this Consent Agreement, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Consent Agreement.

Monitoring Physician

5. Within fifteen days of the effective date of this Consent Agreement, Dr. Mahajan shall submit the name and curriculum vitae of a monitoring physician for written

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approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Mahajan and who is engaged in the same or similar practice specialty.

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

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

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

Continuing Medical Education Courses in Prescribing Controlled Substances and Professional Ethics

6. Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Mahajan shall provide acceptable documentation of successful completion of a course dealing with the prescribing of controlled substances and a separate course dealing with professional ethics. The exact number of hours and the specific content of these 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 Continuing Medical Education acquisition period(s) in which they are completed.

   In addition, at the time Dr. Mahajan submits the documentation of successful completion of a course dealing with the prescribing of controlled substances and at the time he submits the documentation of successful completion of a course dealing with professional ethics, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

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Required Reporting by Licensee

7. Within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall provide a copy of this Consent Agreement to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Mahajan shall provide a copy of this Consent Agreement to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments.

8. Within thirty days of the effective date of this Consent Agreement, Dr. Mahajan shall provide a copy of this Consent Agreement by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Mahajan further agrees to provide a copy of this Consent Agreement by certified mail, return receipt requested, at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license. Further, Dr. Mahajan shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. Mahajan appears to have violated or breached any term or condition of this Consent Agreement, the Board reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including, but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Consent Agreement.

If the Secretary and Supervising Member of the Board determine that there is clear and convincing evidence that Dr. Mahajan has violated any term, condition or limitation of this Consent Agreement, Dr. Mahajan agrees that the violation, as alleged, also constitutes clear and convincing evidence that his continued practice presents a danger of immediate and serious harm to the public for purposes of initiating a summary suspension pursuant to Section 4731.22(G), Ohio Revised Code.

DURATION/MODIFICATION OF TERMS

Dr. Mahajan shall not request termination of the probationary terms, conditions and limitations contained in this Consent Agreement for a minimum of three years. In addition, Dr. Mahajan shall not request modification to the probationary terms, limitations, and conditions contained herein for at least one year. Otherwise, the above-described probationary terms, limitations and

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conditions may be amended or terminated in writing at any time upon the agreement of both parties.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. Mahajan acknowledges that he has had an opportunity to ask questions concerning the terms of this Consent Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

Dr. Mahajan hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data banks and governmental bodies. Dr. Mahajan acknowledges that his social security number will be used if this information is so reported and agrees to provide his social security number to the Board for such purposes.

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

Mahendra K. Mahajan

MAHENDRA KUMAR MAHAJAN, M.D.

8/22/05

DATE

Lance A. Talmage MD

LANCE A. TALMAGE, M.D.
Secretary

9-14-05

DATE

RAYMOND J. ALBERT
Supervising Member

9/14/05

DATE

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David P. Katko

DAVID. P. KATKO
Enforcement Attorney

08/25/05

DATE

Rev. 12/2/03

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Rev. 2/3/04