

**CONSENT AGREEMENT
BETWEEN
JEANNE M. KIRKLAND, M.D.
AND
THE STATE MEDICAL BOARD OF OHIO**

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

Dr. Kirkland enters into this Consent Agreement being fully informed of her rights under R.C. Chapter 119, including the right to pursue her appeal on the issues considered herein as well as her right to representation by counsel.

BASIS FOR ACTION

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

- A. The Board is empowered by R.C. 4731.22(B), 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 any of the enumerated violations.
- B. Dr. Kirkland is currently licensed to practice medicine and surgery in the State of Ohio, License #35-455430.
- C. Dr. Kirkland states that she does not hold a license to practice medicine and surgery in any other state.
- D. The Board issued Dr. Kirkland a Notice of Opportunity for Hearing on May 14, 2003. Dr. Kirkland requested a hearing, which was held January 5 through 9, 2004. A Report and Recommendation was issued by the Hearing Examiner on August 12, 2004. The Board considered the matter at its October 13, 2004 meeting and entered an Order indefinitely suspending Dr. Kirkland's license to practice medicine and surgery in the State of Ohio. The Order imposed conditions for reinstatement of Dr. Kirkland's license that included a medical records course and a controlled substance prescribing course. The Order further provided that following reinstatement, Dr. Kirkland's license would be subject to probationary terms for a minimum of five years. Dr. Kirkland appealed the Board's Order to the Franklin County Common Pleas Court, Case No. 04CVF-11-11491 on November 2, 2004, and simultaneously requested that the Court grant a stay of execution of the Board's Order. That stay of execution of the Order was granted on November 2, 2004, subject to the limitation that Dr. Kirkland would not prescribe any of the controlled substances or their generic equivalents that were at issue in the case.

- E. Dr. Kirkland and the Board agree that Dr. Kirkland's license was suspended from October 19, 2004 until November 2, 2004, and that Dr. Kirkland has met the Conditions for Reinstatement as set forth in the October 13, 2004 Order.
- F. Dr. Kirkland and the Board desire to resolve their claims and differences with respect to the above administrative proceeding and appeal by entering into this Consent Agreement. The Board expressly reserves the right to institute additional formal proceedings based upon any other violations of R.C. Chapter 4731., whether occurring before or after the effective date of this Consent Agreement.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, Dr. Kirkland knowingly and voluntarily agrees with the Board to the following terms, conditions and limitations:

Terms, Conditions and Limitations

- A. Upon the Order by the Court adopting the terms of the Settlement Agreement, attached hereto as Exhibit A, the Board will ratify this Consent Agreement and reinstate Dr. Kirkland's certificate to practice medicine and surgery in Ohio.
- B. **PROBATION:** Dr. Kirkland's certificate shall be subject to the PROBATIONARY terms, conditions, and limitations set forth in the October 13, 2004, Order for a period of at least four years.
- C. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Kirkland's certificate will be fully restored.
- D. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Kirkland shall provide a copy of this Order to all employers or entities with which she is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where she has privileges or appointments. Further, Dr. Kirkland shall provide a copy of this Order to all employers or entities with which she contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where she applies for or obtains privileges or appointments.
- E. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Kirkland shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any

state or jurisdiction in which she currently holds any professional license. Dr. Kirkland shall also provide a copy of this Order by certified mail, return receipt requested, at the time of application to the proper licensing authority of any state in which she applies for any professional license or reinstatement or restoration or restoration of any professional license. Further, Dr. Kirkland shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt, unless otherwise determined by the Board.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. Kirkland appears to have violated or breached any term or condition of the 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 the Consent Agreement.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. Kirkland acknowledges that she has had an opportunity to ask questions concerning the terms of the 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 the Consent Agreement shall comply with the Administrative Procedure Act, R.C. Chapter 119.

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

The Consent Agreement shall be considered a public record as that term is used in R.C. 149.43. Further, this information may be reported to appropriate organizations, data banks, and governmental bodies. Dr. Kirkland acknowledges that her social security number will be used if this information is so reported, and agrees to provide her social security number to the Board for such purposes.

EFFECTIVE DATE

It is expressly understood that the 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.

Jeanne Kirkland MD
JEANNE M. KIRKLAND, M.D.

Date: 1/7/05

Karen T. Dunlevy
Karen T. Dunlevy, Esq.
Attorney for Dr. Kirkland.

Date: 1/10/05

Lance Talmage MD
LANCE TALMAGE, M.D.

Secretary
Date: 1-13-05

Raymond J. Albert
RAYMOND J. ALBERT
Supervising Member

Date: 1/13/05

Rebecca J. Albers per authorization
By Tara L. Bernier
Rebecca J. Albers
Senior Assistant Attorney General

Date: 1/13/05

**SETTLEMENT AGREEMENT
BETWEEN
JEANNE M. KIRKLAND, M.D.
AND
THE STATE MEDICAL BOARD OF OHIO**

This Settlement Agreement is entered into by and between Jeanne M. Kirkland, M.D., ("Dr. Kirkland") and the State Medical Board of Ohio ("Board"), the agency of the State of Ohio charged with enforcing R.C. Chapter 4731.

This Settlement Agreement is entered into on the basis of the following stipulations, statements and understandings:

- A. The Board issued a Notice of Opportunity for Hearing on May 14, 2003, to Dr. Kirkland advising her that it proposed to take disciplinary action regarding her license to practice medicine and surgery in Ohio based upon her alleged violations of R.C. 4731.22(B)(2), (6) and (20).
- B. A hearing was held on January 5 through 9, 2004 before a hearing examiner. On August 12, 2004 the hearing examiner issued a Report and Recommendation and proposed order indefinitely suspending Dr. Kirkland's certificate to practice medicine and surgery in Ohio with reinstatement conditions that required Dr. Kirkland to take a controlled substance prescribing course and a medical records course. The proposed order also included probationary conditions following reinstatement of her license. The Board considered the matter at its October 13, 2004 meeting. At that time, the Board adopted the Findings of Fact, Conclusions of Law and Proposed Order.
- C. Pursuant to R.C. 119.12, on November 2, 2004, Dr. Kirkland appealed the Board's Order to the Franklin County Court of Common Pleas, Case No.04-CVF-11-11491 and simultaneously requested that the Court stay the Board's order. A stay of execution of the Board's order was granted on November 2, 2004 subject to a limitation that Dr. Kirkland not prescribe any of the medications that were at issue in the case or their generic equivalents. The Notice of Appeal and the Order and Entry Granting Stay are attached as Exhibit A.
- D. Dr. Kirkland and the Board (collectively, the "Parties") desire to completely and finally settle all claims and differences with respect to the administrative proceedings and appeal as set forth below.

Therefore, in consideration of the mutual covenants and promises contained herein, Jeanne M. Kirkland, M.D., and the State Medical Board of Ohio agree as follows:

- 1. Dr. Kirkland agrees to execute the Consent Agreement that is attached hereto as Exhibit B.
- 2. The Parties shall file a joint motion to the Franklin County Court of Common Pleas asking the Court to enter an Order adopting this Settlement Agreement in the form attached as Exhibit C.

3. Upon entry of the order from the Court, the Board shall ratify the Consent Agreement, which includes an acknowledgement of Dr. Kirkland's satisfaction of all reinstatement conditions and reinstates Dr. Kirkland's license to practice medicine and surgery.
4. Dr. Kirkland hereby releases and forever discharges the Board, its members, employees, agents, officers and representatives, jointly and severally, from any and all liabilities, rights, causes of action, costs, expenses, attorney fees and any other possible claims arising from the within matter.
5. The terms of this Settlement Agreement bind the Parties hereto and their assigns and successors in interest. This Settlement Agreement is not to be construed as an admission of any type of liability or wrongdoing by the Board. This Settlement Agreement is not to be construed as precedent for actions taken or to be taken by the Board against any other individual(s).
6. This Settlement Agreement contains the entire agreement between the Parties, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this Agreement.
7. This Settlement Agreement shall be considered a public record as that term is used in R.C. 149.43.

THE STATE MEDICAL BOARD OF OHIO


JEANNE M. KIRKLAND, M.D.

1/11/05
DATE


KAREN T. DUNLEVY
Attorney for Dr. Kirkland

1/10/05
DATE


LANCE TALMAGE, M.D.

Secretary
1-12-05
DATE


RAYMOND J. ALBERT
Supervising Member

1/12/05
DATE


REBECCA J. ALBERS
Senior Assistant Attorney General

1/12/05
DATE

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

FILED
COMMON PLEAS COURT
FRANKLIN COUNTY, OHIO
2005 JUN 12 PM 1:08
CLERK OF COURT

JEANNE M. KIRKLAND, M.D. :
Appellant, :
v. : Case No. 04CVF 11 11491
: JUDGE BRUNNER
STATE MEDICAL BOARD OF OHIO :
Appellee. :

JOINT MOTION TO ADOPT SETTLEMENT AGREEMENT

Having reached a settlement of this R.C. 119.12 appeal, the Appellant, Jeanne M. Kirkland, M.D., and the Appellee, the State Medical Board of Ohio, jointly move this Court to enter an order adopting said Settlement Agreement and to dismiss this case with prejudice. The grounds for this motion are more fully explained in the accompanying memorandum in support.

Respectfully submitted,

JIM PETRO (0022096)
Attorney General


DAVID C. GREER (0009090)
KAREN T. DUNLEVY (0067056)
Biser, Greer & Landis LLP
400 National City Center
6 North Main Street
Dayton, Ohio 45402-1908
(937) 223-3277
Facsimile (937) 223-6339

Attorneys for Dr. Kirkland


REBECCA ALBERS (0059203)
KYLE WILCOX (0063219)
Assistant Attorneys General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3428
(614) 466-8600
Facsimile (614) 466-6090

Attorneys for the State Medical Board

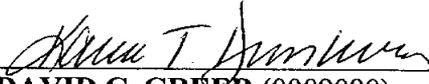
MEMORANDUM IN SUPPORT

This matter concerns the administrative appeal pursuant to R.C. 119.12 filed by Appellant, Jeanne M. Kirkland, M.D., of an Order of the State Medical Board (Board) entered in her case.

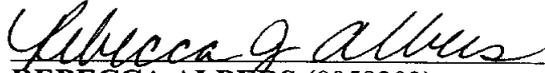
Dr. Kirkland and the Board have reached a resolution of the issues raised by her appeal. Dr. Kirkland and the Board ask the Court to enter an Order adopting the Settlement Agreement between the Board and Dr. Kirkland and dismissing this case with prejudice. The Settlement Agreement (without exhibits) is attached as Appendix A. A proposed order is also attached.

Respectfully submitted,

JIM PETRO (0022096)
Attorney General


DAVID C. GREER (0009090)
KAREN T. DUNLEVY (0067056)
Biser, Greer & Landis LLP
400 National City Center
6 North Main Street
Dayton, Ohio 45402-1908
(937) 223-3277
Facsimile (937) 223-6339

Attorneys for Dr. Kirkland


REBECCA ALBERS (0059203)
KYLE WILCOX (0063219)
Assistant Attorneys General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3428
(614) 466-8600
Facsimile (614) 466-6090

Attorneys for the State Medical Board

TERMINATION NO. 7
BY _____

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

JEANNE M. KIRKLAND, M.D. :

Appellant, :

v. :

Case No. 04CVF 11 11491

JUDGE BRUNNER

STATE MEDICAL BOARD OF OHIO :

Appellee. :

FILED COURT
COMMON PLEAS CO. OHIO
FRANKLIN CO. OHIO
2005 JAN 12 PM 4:14
CLERK OF COURTS - CA

AGREED ENTRY ADOPTING SETTLEMENT AGREEMENT

Pursuant to the joint motion of Jeanne M. Kirkland, M.D. and the State Medical Board, it is hereby

ORDERED that Settlement Agreement, which is attached hereto and incorporated by reference as if fully rewritten herein, is ADOPTED and this case is DISMISSED with prejudice.

The parties are hereby ordered to carry out the terms of the Settlement Agreement.

Costs to Appellant, Jeanne M. Kirkland, M.D.

Jennifer L. Brunner
JUDGE BRUNNER

JIM PETRO (0022096)
Attorney General

Karen T. Dunlevy
DAVID C. GREER (0009090)
KAREN T. DUNLEVY (0067056)
Biser, Greer & Landis LLP
400 National City Center
6 North Main Street
Dayton, Ohio 45402-1908
(937) 223-3277
Facsimile (937) 223-6339

Attorneys for Dr. Kirkland

Jana Albers for Rebecca Albers
REBECCA ALBERS (0059203)
KYLE WILCOX (0063219)
Assistant Attorneys General
Health and Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3428
(614) 466-8600
Facsimile (614) 466-6090

Attorneys for the State Medical Board

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

Civil Division

04CVF 11 1 1491

JEANNE M. KIRKLAND, M.D.

: Case No. _____

Appellant,

: Judge _____

vs.

: **ORDER AND ENTRY GRANTING
STAY OF EXECUTION**

STATE MEDICAL BOARD OF OHIO

:

Appellee.

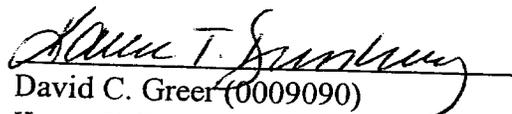
:

FILED
COMMON PLEAS COURT
FRANKLIN COUNTY, OHIO
2004 NOV - 2 11 30
CLERK OF COURT

This matter came before the Court on the Appellant's Expedited Motion for Stay of Execution of Order of the State Medical Board of Ohio indefinitely suspending the Appellant's license to practice medicine. *All parties were present through their counsel at the court's consideration of this motion.* For the grounds set forth in the Appellant's Motion and for other good cause shown, said Motion is hereby GRANTED and a stay of execution of the State Medical Board's Order suspending Dr. Kirkland's license is hereby issued permitting Dr. Kirkland to continue practicing medicine pending the disposition of this appeal. *Appellant shall not prescribe any of the medications at issue in this matter or their generic equivalent* IT IS SO ORDERED. *pending the period this order is in effect.*


JUDGE *Nov. 2, 2004*

Submitted by,



David C. Greer (0009090)

Karen T. Dunleavy (0067056)

BIESER, GREER & LANDIS LLP, Of Counsel

400 National City Center

6 North Main Street

Dayton, Ohio 45402-1908

Telephone: (937) 223-3277

Facsimile: (937) 223-6339

Attorneys for Appellant Jeanne M. Kirkland, M.D.

STATE MEDICAL BOARD
OF OHIO

2004 NOV 12 P 1:54

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO
Civil Division

04CVF 11 1 149 1

JEANNE M. KIRKLAND, M.D.	:	Case No. _____
Appellant,	:	Judge _____
vs.	:	<u>NOTICE OF APPEAL OF</u>
STATE MEDICAL BOARD OF OHIO	:	<u>ADMINISTRATIVE</u>
Appellee.	:	<u>DETERMINATION BY STATE</u>
	:	<u>MEDICAL BOARD OF OHIO</u>

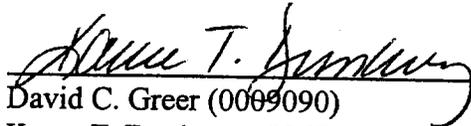
Now comes the Respondent to this action, Jeanne M. Kirkland, M.D., by and through counsel, and pursuant to Ohio Revised Code Section 119.12 hereby provides notice of her appeal of the State Medical Board's Entry of Order dated October 15, 2004 and mailed October 19, 2004 to the Franklin County Court of Common Pleas. Attached as Exhibit 1 is a copy of the Board's Entry and Order. Notice of this Appeal has also been forwarded to the State Medical Board of Ohio for filing simultaneously herewith.

COMMON PLEAS COURT
 FRANKLIN COUNTY, OHIO
 FILED
 2004 NOV 2 4 10:57
 CLERK OF COURT

The Findings of Fact and Conclusions of Law issued by the Hearing Examiner and adopted by the Board in this case are not supported by reliable, probative and substantial evidence and are not in accordance with the law. Similarly, the Board's chosen penalty of indefinite suspension is also not supported by reliable, probative and substantial evidence and is not in accordance with the law.

Accordingly, the Respondent asks the Franklin County Common Pleas Court to review the evidence and reverse the Board's decision. In addition, the Appellant is filing herewith an Expedited Motion to Stay Execution of the State Medical Board's Order, asking this Court to stay execution of the Order pending determination of this Appeal due to the unusual hardship such execution would cause the Appellant.

Respectfully submitted,


David C. Greer (0069090)
Karen T. Dunlevey (0067056)
BIESER, GREER & LANDIS LLP
400 National City Center
6 North Main Street
Dayton, Ohio 45402-1908
Telephone: (937) 223-3277
Facsimile: (937) 223-6339
Attorneys for Appellant Jeanne M. Kirkland, M.D.

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Notice of Appeal has been mailed this ___ day of November, 2004 to Rebecca Albers, Assistant Attorney General, Health & Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3428.

BIESER, GREER & LANDIS, LLP

By 

8965.203210 \ 250090.1

STATE MEDICAL BOARD
OF OHIO
2004 NOV 12 P 1:54



State Medical Board of Ohio

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

October 13, 2004

Jeanne M. Kirkland, M.D.
5928 Springboro Pike
Dayton, OH 45449

Dear Doctor Kirkland:

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 October 13, 2004, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and 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. 7000 0600 0024 5149 9689
RETURN RECEIPT REQUESTED

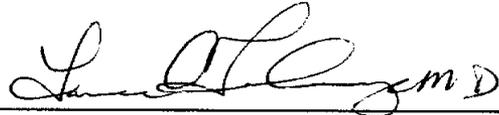
Cc: Karen T. Dunlevey and David C. Greer, Esqs.
CERTIFIED MAIL NO. 7000 0600 0024 5149 9702
RETURN RECEIPT REQUESTED

Mailed 10-19-04

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 October 13, 2004, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Jeanne M. Kirkland, M.D., as it appears in the Journal of the State Medical Board of Ohio.

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



Lance A. Talmage, M.D.
Secretary

(SEAL)

October 13, 2004
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

JEANNE M. KIRKLAND, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on October 13, 2004.

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 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. **SUSPENSION OF CERTIFICATE:** The certificate of Jeanne M. Kirkland, 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. Kirkland's certificate to practice medicine and surgery until all of the following conditions have been met:
 - 1. **Application for Reinstatement or Restoration:** Dr. Kirkland shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

 - 2. **Controlled Substances Prescribing Course:** At the time she submits her application for reinstatement or restoration, Dr. Kirkland shall provide acceptable documentation of successful completion of a course dealing with the prescribing of controlled substances. The exact number of hours and the

specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which they are completed.

3. **Medical Records Course:** At the time she submits her application for reinstatement or restoration, Dr. Kirkland shall provide acceptable documentation of satisfactory completion of a course on maintaining adequate and appropriate medical records, such course to be approved in advance by 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.
4. **Additional Evidence of Fitness To Resume Practice:** In the event that Dr. Kirkland 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/her fitness to resume practice.

C. **PROBATION:** Upon reinstatement or restoration, Dr. Kirkland's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least five years:

1. **Obey the Law:** Dr. Kirkland 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. Kirkland shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which 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. Kirkland 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 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. **Controlled Substances Log**: Dr. Kirkland shall keep a log of all controlled substances she prescribes, orders, administers, or personally furnishes. Such log shall be submitted in a format approved by the Board thirty days prior to Dr. Kirkland's personal appearance before the Board or its designated representative, or as otherwise directed by the Board. Further, Dr. Kirkland shall make her patient records with regard to such controlled substances available for review by an agent of the Board upon request.
5. **Monitoring Physician**: Within thirty days of the date of Dr. Kirkland's reinstatement or restoration, or as otherwise determined by the Board, Dr. Kirkland shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Kirkland and who is engaged in the same or similar practice specialty. The Board shall not consider any individual who is related to or formerly related to Dr. Kirkland, either by blood or marriage, to serve in this capacity.

The monitoring physician shall monitor Dr. Kirkland and her medical practice, and shall review Dr. Kirkland'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. Kirkland and her medical practice, and on the review of Dr. Kirkland's patient charts. Dr. Kirkland 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. Kirkland's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Kirkland must immediately so notify the Board in writing. In addition, Dr. Kirkland 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. Kirkland shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

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

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

(SEAL)



Lance A. Talmage, M.D.
Secretary

October 13, 2004

Date

**REPORT AND RECOMMENDATION
IN THE MATTER OF JEANNE M. KIRKLAND, M.D.**

The Matter of Jeanne M. Kirkland, M.D., was heard by R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on January 5 through 9, 2004.

INTRODUCTION

I. Basis for Hearing

- A. By letter dated May 14, 2003, the State Medical Board of Ohio [Board] notified Jeanne M. Kirkland, M.D., that it had proposed to take disciplinary action against her certificate to practice medicine and surgery in Ohio. The Board based its proposed action upon allegations concerning Dr. Kirkland's care and treatment of ten specified patients.

The Board asserted that the alleged conduct of Dr. Kirkland constitutes "[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,' as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code (as in effect prior to March 9, 1999)."

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

Furthermore, the Board asserted that the alleged conduct of Dr. Kirkland that occurred on or after November 11, 1986, constitutes "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,' as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code."

Accordingly, the Board advised Dr. Kirkland of her right to request a hearing in this matter. (State's Exhibit 1A)

- B. By document received by the Board on June 9, 2003, Karen T. Dunlevey, Esq., requested a hearing on behalf of Dr. Kirkland. (State's Exhibit 1B)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Rebecca J. Albers and Kyle C. Wilcox, Assistant Attorneys General.
- B. On behalf of the Respondent: David C. Greer and Karen T. Dunlevey, Esqs.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 - 1. Jeanne M. Kirkland, M.D., as upon cross-examination
 - 2. Karen Winter, M.D.
- B. Presented by the Respondent
 - 1. Patient 7
 - 2. Patient 10
 - 3. Patient 8
 - 4. Robert Trent Sickles, M.D.
 - 5. Patient 1
 - 6. Patient 9
 - 7. Jeanne M. Kirkland, M.D.

II. Exhibits Examined

- A. Presented by the State
 - * 1. State's Exhibits 1 through 10: Copies of Dr. Kirkland's medical records for Patients 1 through 10, respectively.
 - 2. State's Exhibit 11A through 11 O, 11Q, and 11S through 11W: Procedural exhibits. (Note that State's Exhibit 11U has been sealed to protect patient confidentiality.) (Further note that an attachment to State's Exhibit 11V was removed, was marked as Respondent's Exhibit P, and will be held as proffered material. See Hearing Transcript at pages 12-13)
 - * 3. State's Exhibit 11P: Patient Key.
 - 4. State's Exhibit 11R: Copy of a December 19, 2003, letter to Respondent's Counsel from Rebecca J. Albers, Senior Assistant Attorney General, advising, among other things, that the dates indicated in the notice of opportunity for

hearing for Dr. Kirkland commencing treatment of Patient 4 should be July 1994 rather than October 1994, and for Patient 8 the date should be June 1988 rather than November 1984.

5. State's Exhibit 11X: Copy of a January 2, 2004, letter to Respondent's Counsel from Ms. Albers advising, among other things, that the State would not present evidence concerning certain factual allegations made in the Board's notice of opportunity for hearing. (See Procedural Matters 5, below.)
 - * 6. State's Exhibit 12: Copy of a written report of Karen Winter, M.D.
 7. State's Exhibit 13: Dr. Winter's curriculum vitae.
 - * 8. State's Exhibit 14: May 11, 2001, letter to Dr. Winter from Board staff concerning Dr. Winter's services as an expert.
 9. State's Exhibits 15 and 16: Copies of excerpts from the Ohio Revised Code.
 10. State's Exhibit 17: State's Proposed Redactions to Respondent's Exhibits A and M, with attached copy of a March 29, 2004, letter to Respondent's Counsel. (Note that additional attachments were removed from this document and renumbered as Board Exhibits B and C. See Procedural Matters 2, below.)
 11. State's Exhibit 18: State's Closing Argument.
 12. State's Exhibit 19: State's Reply to Dr. Kirkland's Post-Hearing Brief.
- B. Presented by the Respondent
- * 1. Respondent's Exhibit A: Not admitted. Redacted version admitted as Board Exhibit B. (See Procedural Matters 2, below.)
 2. Respondent's Exhibit B: Copy of Expert Report of Jeanne M. Kirkland, M.D., with attached copy of her curriculum vitae.
 3. Respondent's Exhibit C: Copy of Expert Report of R. Trent Sickles, M.D., with attached copy of his curriculum vitae.
 4. Respondent's Exhibit D: Copy of a November 13, 2003, letter to Dr. Kirkland from the Montgomery County Medical Society concerning pain management physicians in Dr. Kirkland's geographical area who are members of that organization.
 5. Respondent's Exhibit E: Not presented or admitted.

6. Respondent's Exhibit F: Not presented or admitted.
 7. Respondent's Exhibit G: Copy of a pamphlet from The Ohio State University Medical Center entitled *Health for Life: About Pain and Pain Control*.
 8. Respondent's Exhibits H and I: Printouts from the Online Medical Dictionary concerning the definitions of fibromyalgia and fibrositis, respectively.
 - * 9. Respondent's Exhibit J: Copy of a May 27, 1987, Discharge Instruction Summary from the Kettering Medical Center Department of Psychiatry concerning Patient 3.
 10. Respondent's Exhibits K and L: Not admitted. See Proffered Exhibits, below.
 11. Respondent's Exhibit M: Not admitted. Redacted version admitted as Board Exhibit C. (See Procedural Matters 2, below.)
 12. Respondent's Exhibit N: Respondent's Post-Hearing Brief.
 13. Respondent's Exhibit O: Respondent's Reply to the State's Closing Argument.
- C. Admitted sua sponte by the Hearing Examiner post hearing
1. Board Exhibit A: Copy of a February 19, 2004, Entry concerning the filing of written closing arguments.
 - * 2. Board Exhibit B: Redacted copy of Respondent's Exhibit A, consisting of Dr. Kirkland's written patient summaries. (See Procedural Matters 2, below.)
 - * 3. Board Exhibit C: Redacted copy of Respondent's Exhibit M, consisting of Dr. Kirkland's handwritten patient summaries. (See Procedural Matters 2, below.)

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

PROFFERED MATERIALS

The following documents were neither admitted to the hearing record nor considered by the Hearing Examiner, but are being sealed and held as proffered material:

1. Respondent's Exhibit A: Unredacted copies of Dr. Kirkland's typewritten patient summaries. (Note that a redacted version of this exhibit was admitted as Board Exhibit B. See Procedural Matters 2, below.)

2. Respondent's Exhibits K and L: Copies of October 31, 1994, and October 4, 1996, radiology reports concerning Patient 5.
3. Respondent's Exhibit M: Unredacted copies of Dr. Kirkland's handwritten patient summaries. (Note that a redacted version of this exhibit was admitted to the record as Board Exhibit C. See Procedural Matters 2, below.)
4. Respondent's Exhibit P: Expert report of a witness who did not testify, that had been attached to a procedural exhibit, State's Exhibit 11.
5. Respondent's Exhibit Q: Unredacted copy of page 3 of the Appendix to Respondent's Post-Reply Brief, concerning Patient 1. (See Procedural Matters 3, below.)

PROCEDURAL MATTERS

1. At the close of hearing, the hearing record was held open to allow the State to consider presenting rebuttal evidence, and to allow the parties to present written closing arguments. On February 19, 2004, the Hearing Examiner participated in a telephone conference with the parties' representatives, during which the State indicated that it would not present rebuttal evidence. In addition, a schedule for filing written closing arguments was established, and the hearing record was held open until April 12, 2004, for that purpose.
2. At hearing, the Respondent present as exhibits her typewritten and handwritten summaries of her treatment of Patients 1 through 10, which were marked Respondent's Exhibits A and M, respectively. The State objected to the admission of those documents, in part because they included information about patient care that had not been included in the patient records, and/or which occurred after January 1998, outside the relevant time period of this hearing. The Hearing Examiner ruled that he would admit copies of those exhibits with that information redacted. The Respondent agreed to provide redacted versions of those exhibits post hearing to the State's Assistant Attorneys General for their review and possible further objection.

In the State's April 12, 2004, Reply to Dr. Kirkland's Post-Hearing Brief, the State indicated that it had not yet received from the Respondent the redacted versions of Respondent's Exhibits A and M. However, the State provided copies of State's Exhibits A and M with its own proposed redactions. Those redactions are accepted, and the documents are admitted to the record as Board Exhibits B and C.

3. In the State's April 12, 2004, Reply to Dr. Kirkland's Post-Hearing Brief, the State objected to and moved to strike certain statements included in the Respondent's Post-Hearing Brief. The State asserted that those statements addressed issues that fall outside the time period relevant to this matter. However, all but one of the statements referred to were based upon statements made at hearing that are part of the Hearing

Transcript. Accordingly, the State's objection to those statements is overruled, and the motion to strike denied.

Nevertheless, a statement on page 3 of the Appendix to the brief that concerns Patient 1 had been based on information that has been redacted from the document now proffered as Respondent's Exhibit A. The State's objection to that statement is sustained, and the motion to strike granted. Accordingly, the Hearing Examiner redacted the offending statement, and a copy of the unredacted page was marked as Respondent's Exhibit Q, which will be held for the Respondent as a proffered exhibit.

4. Page 268, line 24 of the Hearing Transcript references a patient name. The Hearing Examiner redacted that name from the Hearing transcript. Note that the numerical identification of the patient referred to in the redacted statement, Patient 2, remains clear from the surrounding context.
5. State's Exhibit 11X is a copy of a January 2, 2004, letter to Respondent's Counsel from Ms. Albers, advising, among other things, that the State would not present evidence concerning certain factual allegations made in the Board's notice of opportunity for hearing. Specifically, the letter states,

Please be advised that the State will not be presenting evidence on the factual allegations set forth in the second paragraph of paragraph (b) of the Notice of Opportunity for Hearing related to Dr. Kirkland's continued prescribing of Methadone to Patient 2 after his treatment began with the Methadone specialist. Further, the State will not be presenting evidence on the factual allegation set forth in paragraph (j) of the Notice of Opportunity for Hearing related to the prescribing of Stadol in the time period of January, 1992, through June, 1992.

(State's Exhibit 11X) The Respondent expressed no objection.

SUMMARY OF THE EVIDENCE

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

Background Information

Jeanne M. Kirkland, M.D.

1. Jeanne M. Kirkland, M.D., testified that she had obtained her medical degree in 1978 from the University of Texas at San Antonio, and completed a family practice residency in 1981 at St. Elizabeth's Medical Center in Dayton, Ohio. After finishing her residency in 1981,

Dr. Kirkland joined her husband in his practice.¹ Dr. Kirkland noted that both she and her husband practice family medicine, and have been engaged in that practice continuously in the same location for 23 years. (Respondent's Exhibit [Resp. Ex.] B; Hearing Transcript [Tr.] at 32-33, 1018-1019)

Dr. Kirkland was certified by the American Board of Family Practice in 1981, and was recertified in 1984. Her certification expired in 1987, and she has not yet recertified. However, Dr. Kirkland testified that she has submitted her paperwork to recertify in 2004. Dr. Kirkland explained that she has raised five children and has been very busy, but is aware "that's not an excuse." Her children range in age from 13 to 23. Finally, Dr. Kirkland testified that, at the present time, both of her parents are very ill. (Resp. Ex. B; Tr. at 30-31, 1021-1022)

2. Dr. Kirkland has held a license to practice medicine in Ohio since 1981. She does not hold a license to practice in any other state. (Tr. at 29)
3. Dr. Kirkland testified that she sees patients three full days per week in her office—about thirty-five patients on each of those days—and does administrative work another two days. Dr. Kirkland further testified that she has about 1,500 active patients, most of whom are long-term. Moreover, Dr. Kirkland testified that her patient population includes newborns, elderly patients, and everyone in between, and that she does "a little bit of everything except OB." Finally, Dr. Kirkland testified that she has "always assisted on [her] patients in surgery since [she] got out of residency just on the big cases, such as bowel surgery, carotid endarterectomies, hysterectomies." (Tr. at 1020-1023)

In addition, Dr. Kirkland testified that she is on the clinical faculty of Wright State University, and is on the admissions committee for that medical school. (Resp. Ex. B; Tr. at 1020)

Moreover, Dr. Kirkland testified that she has been involved in clinical studies, most recently two that concerned migraine headaches. She has also participated in clinical studies concerning depression, hypertension, and cholesterol. (Resp. Ex. B; Tr. at 1023, 1026)

Karen Winter, M.D.

4. Karen Winter, M.D., testified as an expert on behalf of the State. Dr. Winter obtained her medical degree in 1984 from the Medical College of Pennsylvania in Philadelphia. From 1984 through 1985, Dr. Winter completed a general surgery internship at the U.S. Navy Hospital in Oakland, California. In 1989, following active service and medical practice in the U.S. Navy, Dr. Winter entered a family practice residency at Fairview General Hospital in Cleveland, Ohio, which she completed in 1991. Dr. Winter was certified by the American Academy of Family Physicians in 1992, and by the American Board of Family Practice in 1999. (State's Exhibit [St. Ex.] 13; Tr. at 228-229)

¹ Dr. Kirkland testified that they built an office building that they share with Dr. Deepak Kumar. (Tr. at 1019)

Dr. Winter testified that she had joined the U.S. Navy in 1980 to participate in their medical education scholarship program. Dr. Winter further testified that she left the navy in 1989 as a Lieutenant Commander in the U.S. Navy Reserve. (St. Ex. 13; Tr. at 230-231)

5. Dr. Winter described her practice history and current practice as follows,

My initial private practice was as an employee of a fellow who graduated a year before me from residency. It was a complete family practice with the exception of doing OB. And this was in Amherst, Ohio.

After 18 months, we had a falling out. And I took a position with Amherst Hospital as an employee physician and started up a family practice medical group at that point. And this went until July of '96.

At that point, I took some time out. I did some locum tenens to keep my skills up. I started with a new medical group in February of '97 in Olmsted Falls. From '97 to—through June of 2002, I worked with this medical group called Ohio Medical Group.

(Tr. at 232-233)

Dr. Winter further testified that she left the Ohio Medical Group in 2002 for a variety of reasons, and she is currently in the process of developing her own practice. Dr. Winter described her current practice as nontraditional. “I guess you could say [I am] retired from the traditional practice of family practice, but I am far from retired.” Dr. Winter testified that she operates a small practice from her home where she assists patients who have chronic severe medical problems such as diabetes to improve their fitness and lose weight. Dr. Winter testified that the concept is “something like having a personal trainer with an M.D. to assist” those patients to lose weight in a safe way. Dr. Winter further testified that, along with her patients’ primary care physicians, she monitors her patients’ cholesterol and hemoglobin A1c. Dr. Winter testified that she currently sees only four patients in her practice. (St. Ex. 13; Tr. at 451-455)

Dr. Winter testified that at present she does not belong to any insurance plans, nor does she maintain medical malpractice insurance. Dr. Winter further testified, “I do consider myself, you know, in part, clinically treating patients because I do prescribe some medications. But at this point, it’s not financially feasible to get the malpractice insurance. I will at some point. However, my patients also know that I don’t carry the malpractice insurance.” (Tr. at 453-454)

In addition to her own private practice, Dr. Winter testified that, since 2002, she has done locum tenens work primarily in urgent care center settings. (St. Ex. 13; Tr. at 233)

Finally, Dr. Winter testified that, since 1991, she has hosted a television program called “Housecalls with Dr. Karen Winter” on a cable channel in Amherst, Ohio. Dr. Winter testified that, up until a couple years ago, she had taped two shows per month. However, she stated that it was very time consuming, and now only tapes shows occasionally. (St. Ex. 13; Tr. at 233-234)

6. Dr. Winter testified that she is familiar with the statutes and rules governing the prescribing of controlled substances in Ohio. Dr. Winter further testified that she is familiar with the standard of care for prescribing controlled substances. Moreover, Dr. Winter testified that she is familiar with the standard of care for documenting the utilization of controlled substances. Finally, Dr. Winter testified that she is familiar with the standard of care for the practice of medicine in Ohio. (Tr. at 234-235)

With regard to the standard of care for documenting the utilization of controlled substances, Dr. Winter testified, “I believe it’s very important to make it very clear what is being prescribed, the reasons for prescribing it, and the plan with the medication. In addition, it’s very important to have an appropriate physical exam to support your decision to use the controlled drugs.” (Tr. at 235)

Robert Trent Sickles, M.D.

7. Robert Trent Sickles, M.D., testified as an expert on behalf of Dr. Kirkland. Dr. Sickles received his medical degree from The Ohio State University [OSU] College of Medicine in 1981. From 1981 through 1984, Dr. Sickles completed an internship and residency in family medicine. Dr. Sickles joined the faculty of the OSU Department of Family Medicine immediately after completing his residency. Dr. Sickles became the Residency Director in 1990, and then left that position in 1995 to join the Sports Medicine Division in the Department of Family Medicine. Dr. Sickles is currently the Medical Director for Family Health in that office. Dr. Sickles is also an Associate Professor in the Department of Family Medicine. (Resp. Ex. C; Tr. at 781-782)

Dr. Sickles testified that approximately 75 percent of his time is spent in family practice, where he sees a patient population that ranges in age from about ten years through geriatric. Dr. Sickles further testified that it is a traditional family practice that includes preventive care and management of chronic health problems. The other 25 percent of Dr. Sickles’ time is spent practicing sports medicine. Dr. Sickles testified that that entails seeing patients for musculoskeletal problems. In addition, Dr. Sickles testified that he goes to nursing homes for two half-days per week, and acts as a team physician for OSU athletic teams. Finally, Dr. Sickles testified that he also spends some time doing administrative duties in his department, and medical malpractice review. (Tr. at 778-779)

8. Dr. Sickles was board certified in family medicine in 1984 by the American Board of Family Practice, and received a Certificate of Added Qualifications in Sports Medicine in 1993. Dr. Sickles has active privileges at OSU Medical Center and courtesy privileges at Riverside Methodist Hospital in Columbus, Ohio. (Resp. Ex. C; Tr. at 782)

9. Dr. Sickles testified that, in preparing for his testimony, he had reviewed Dr. Kirkland's medical records for Patients 1 through 10, the expert report of Dr. Winter, and summaries prepared by Dr. Kirkland that included supplemental information concerning her care of Patients 1 through 10. Dr. Sickles further testified that he had reviewed the Physicians' Desk Reference [PDR] concerning some of the medications that Dr. Kirkland had prescribed. (Tr. at 786-787, 905-913)
10. Dr. Sickles testified that he is familiar with the standard of care for family practice physicians in Ohio. Dr. Sickles further testified that he is familiar with the rules and regulations governing physicians in Ohio "[o]nly in the sense of what [Dr. Kirkland's counsel] sent to [Dr. Sickles] to review." (Tr. at 790)

Testimony Concerning the Standard of Medical Documentation

11. Dr. Winter testified concerning appropriate medical documentation,

A general standard in family practice that we were all taught in medical school is the SOAP note. And that is not just family practice; that's pretty much all physicians. The SOAP note, S-O-A-P: Subjective, what the patient states, what their concerns are, what they feel; objective, your exam and your supporting laboratory or other physical evidence; your assessment is the A; and P is your plan.

And it's generally felt that if you incorporate those items well, you have a good note that's documentable and can pass on the information to any other medical practitioners that need to use that.

(Tr. at 239) Dr. Winter further testified that additional documentation is required when a physician utilizes controlled substances. In that case, the physician must document the diagnosis or presumed diagnosis, and the purpose for prescribing the medication. Moreover, the physician must periodically assess the patient. Finally, the physician must document the amount of medication being prescribed, the dosage, and the frequency. (Tr. at 239-240)

Dr. Winter testified that the adage that "if it's not documented, it's not done" has been followed for at least the past 20 years. (Tr. at 412)

12. Dr. Sickles testified concerning the issue of documentation by family physicians,

Well, it comes up all the time in the medicolegal medical malpractice type cases in that we bump into documentation issues where one side takes the position that if it's not written in the medical record, it didn't happen; and obviously, the physician generally takes the opposite position in that there were a lot of things that transpired in the care of that patient that may have

been said or done that didn't necessarily get documented in the medical record, though.

And I've testified and my position has always been that the standard of care is dictated more by what transpires between the physician and patient and the care that's actually rendered to the patient as opposed to what actually gets written down in the medical record. Certainly, the medical record is an important document that, you know, helps to determine what transpired between the physician and patient. But there's a lot of variability, I think, in terms of how physicians write things, document things, what certain things mean to them.

And so my belief is, at least, that the standard isn't dictated strictly by what's in the record. It's dictated, again, more by what actually transpired between the physician and patient.

(Tr. at 785-786)

Dr. Sickles testified that he would also consider the statements of the physician and the patient to determine what had transpired in the medical office. (Tr. at 894)

13. Dr. Kirkland testified that she has never heard the adage that if something is not documented in the medical record, it is deemed not to have occurred. (Tr. at 133-134)
Dr. Kirkland maintained that just because something isn't noted in the medical record does not mean that it was not done. (Tr. at 83)

Patient 1

14. Patient 1 is a female born March 27, 1947. Dr. Kirkland's medical record indicates that Patient 1 has a history of kidney transplant surgery in 1981. Dr. Kirkland further noted the following chronic illnesses on the first page of the patient record: hypertension, Raynaud's syndrome, hypercholesterolemia, fibromyalgia, bulging cervical disc, and anxiety. There are no dates indicating when these entries had been made, however. (St. Ex. 1 at 1)

Dr. Kirkland testified that she began treating Patient 1 on October 1, 1990, although Patient 1 had received a flu shot from her office in 1988. (Tr. at 34-35)

Dr. Kirkland's Prescribing of Valium and/or Ativan to Patient 1

15. Dr. Kirkland prescribed Valium and/or Ativan for Patient 1 as follows:

Date	Medication	Relevant Findings and/or Diagnosis
01/07/93	Valium 5 mg #100, one per day	None
04/01/93	Valium 5 mg #100, one per day	None

Date	Medication	Relevant Findings and/or Diagnosis
06/15/93	Valium 5 mg #100, one per day	None
09/27/93	Valium 5 mg #14, one per day	None
10/10/93	Valium 5 mg #100, one per day	Prescribed by another physician.
12/06/93	Valium 5 mg #90, one per day	None
01/31/94	Ativan 1 mg #30, one at bedtime	None
02/16/94	Valium 5 mg #30, one per day	None
03/07/94	Valium 5 mg #30, two refills, one per day	None
05/19/94	Valium 5 mg #30, two refills, one per day	None
08/16/94	Valium 5 mg #100, one per day	None
10/24/94	Valium 5 mg #100, one per day	None
01/02/95	Valium 5 mg #30, one per day	None
01/23/95	Valium 5 mg #90, one per day	None
04/03/95	Valium 5 mg #90, one per day	None
06/06/95	Valium 5 mg #90, one per day	None
07/12/95	Valium 5 mg #90, one per day	Prescribed by another physician.
08/31/95	Valium 5 mg #30, one at bedtime	"Can't find Valium Rx."
09/22/95	Valium 5 mg #30, one per day	Prescribed by another physician.
10/16/95	Valium 5 mg #30, one at bedtime	None
11/12/95	Valium 5 mg #30, one at bedtime	None
11/28/95	Valium 5 mg #30, one at bedtime	None
12/11/95	Valium 5 mg #30, one at bedtime	None
01/02/96	Valium 5 mg #30, one at bedtime	None
01/18/96	Valium 5 mg #30, one at bedtime	None
02/29/96	Valium 5 mg #30, one at bedtime	Anxiety
04/02/96	Valium 5 mg #30, one at bedtime	None
04/24/96	Valium 5 mg #30, one at bedtime	None
05/13/96	Valium 5 mg #30, one at bedtime	None
05/30/96	Valium 5 mg #15, one at bedtime	None
06/11/96	Valium 5 mg #30, one at bedtime	None
06/27/96	Valium 5 mg #30, one at bedtime	None
07/11/96	Valium 5 mg #30, one at bedtime	None
07/30/96	Valium 5 mg #30, one at bedtime	None
08/29/96	Valium 5 mg #30, one at bedtime	None
09/16/96	Valium 5 mg #30, one at bedtime	None
10/03/96	Valium 5 mg #30, one at bedtime	None
10/24/96	Valium 5 mg #30, one at bedtime	None
11/18/96	Valium 5 mg #30, one at bedtime	None
12/16/96	Valium 5 mg #30, one at bedtime	None
01/06/97	Valium 5 mg #30, one at bedtime	None
01/23/97	Valium 5 mg #30, one at bedtime	None

Date	Medication	Relevant Findings and/or Diagnosis
02/13/97	Valium 5 mg #30, one at bedtime	None
03/06/97	Valium 5 mg #30, one at bedtime	“Stress—doing OK w/ meds.”
03/25/97	Valium 5 mg #30, one at bedtime	“Stress—Valium helps. Advised pt to try & cut back. Has been on 17 yrs.” Diagnosed stress.
04/17/97	Valium 5 mg #30, one at bedtime	“does well with meds.” Diagnosed stress.
05/15/97	Valium 5 mg #30, one at bedtime	“Stress—pt. requests Valium hs.” Diagnosed stress.
07/07/97	Valium 5 mg #30, one at bedtime	“Stress no change.” Diagnosed stress.
07/24/97	Valium 5 mg #30, one at bedtime	None
08/12/97	Valium 5 mg #30, one at bedtime	“Office will be closed when due for prescriptions.” Diagnosed stress.
08/28/97	Valium 5 mg #30, one at bedtime	“Going out of town needs meds.” Diagnosed stress.
09/15/97	Valium 5 mg #30, one at bedtime	None
10/20/97	Valium 5 mg #30, one at bedtime	“Insomnia—Valium helps.” Diagnosed insomnia.
11/17/97	Valium 5 mg #30, one at bedtime	“Requests Valium for stress.” Diagnosed stress.
12/15/97	Valium 5 mg #30, one at bedtime	Diagnosed stress
01/15/98	Valium 5 mg #30, one at bedtime	“Feeling about the same.” Diagnosed anxiety.

(St. Ex. 1)

16. In her written report, Dr. Winter noted that Patient 1 “was begun on doses of Valium or Ativan in 1993 without documentation of a diagnosis, or even of a problem for which these medications might help. Throughout the record, no appropriate evaluation of follow-up of ‘anxiety’ was undertaken.” (St. Ex. 12 at 3)

At hearing, Dr. Winter testified that “Anxiety” is listed on the first page of Dr. Kirkland’s medical records for Patient 1 as one of the patient’s chronic illnesses. Dr. Winter further testified that, although Valium is an appropriate medication to treat anxiety, “simply to write ‘anxiety’ would not be appropriate documentation.” (St. Ex. 1 at 1; Tr. at 243-244)

Dr. Winter further testified, “Valium is a medication that has a wide range of uses. It is most commonly used for helping with anxiety. It is also useful in seizure disorders, especially stopping an acute seizure. It can be used on occasion as a muscle relaxer.” (Tr. at 242) Moreover, Dr. Winter testified that the documentation required to support a prescription for Valium is dependent upon the reason for prescribing it. If the condition

were anxiety, a physician would need to document the patient's subjective complaints of anxiety, "the situation, a background history, a physical exam, any[thing] that might note any pertinent signs of anxiety." Dr. Winter testified that the physician may also want to rule out other conditions that may appear similar to anxiety, such as rapid heartbeat or hyperthyroidism. (Tr. at 243)

Finally, Dr. Winter testified that, throughout Dr. Kirkland's medical record for Patient 1, Dr. Winter was unable to find documentation that Dr. Kirkland had performed an assessment concerning the effectiveness of the Valium she was prescribing. Dr. Winter further testified that Patient 1 was prescribed Valium on a regular basis, without follow-up. (Tr. at 255)

17. Dr. Sickles testified that he believes that Dr. Kirkland's prescribing of Valium to Patient 1 had been appropriate. Dr. Sickles testified that Patient 1 had been prescribed Valium for years prior to her seeing Dr. Kirkland. Dr. Sickles further testified that Valium was an appropriate medication both for treating Patient 1's history of chronic anxiety, and for controlling her fibromyalgia. (Tr. at 850)

Examples of Dr. Kirkland's Prescribing of Valium and/or Ativan to Patient 1

18. In her note dated January 7, 1993, under the heading "Subjective/Objective," Dr. Kirkland recorded Patient 1's weight, blood pressure (132/92), as well as "TM - clear Wax plug [left][,] Chest clear[,] Throat - red[,] sinuses tender[,] heart [normal sinus rhythm.]" Under the heading "Plans," Dr. Kirkland recorded a diagnosis of hypertension, and ordered a chemistry panel, complete blood count, and HDL, with copies sent to Patient 1's nephrologist. Dr. Kirkland ordered an ear lavage, gave an IM injection of Lincocin 2 cc, and prescribed: Dilacor 180 mg #30 with two refills, to be taken once per day; Amoxil #30; and Valium 5 mg #30 (no refills), to be taken once per day. (St. Ex. 1 at 4a)
 - At hearing, Dr. Kirkland acknowledged that she had not documented a reason for the Valium prescription on January 7, 1993. However, later in the medical record, on March 25, 1997—over four years later—Dr. Kirkland recorded, among other things, "Stress - Valium helps. Advised pt to try & cut back[.] Has been on 17 yrs." (St. Ex. 1 at 14a; Tr. at 39)

Dr. Kirkland testified that January 7, 1993, had been the first time that she had prescribed Valium to Patient 1, but it had not been the first time that Patient 1 had been taking the medication. Dr. Kirkland testified that the patient had been taking Valium to control anxiety since before her kidney transplant. (Tr. at 40, 1098-1098)

19. Concerning Dr. Kirkland's prescription for Valium on April 1, 1993, Dr. Winter testified that no diagnosis appropriate to that prescription had been documented; the only diagnosis listed is hypercholesterolemia. Dr. Winter further testified that there is no documented treatment plan for the use of Valium. Moreover, Dr. Winter testified that there is no

documentation that Dr. Kirkland had performed an appropriate evaluation or assessment of the patient to support such a prescription. (St. Ex. 1 at 4a; Tr. at 242-243)

20. On October 24, 1994, Dr. Kirkland prescribed both Vicodin and Valium to Patient 1. The only diagnoses documented were hypertension and hypercholesterolemia. (St. Ex. 1 at 6b)

- Dr. Winter testified that there is no diagnosis for a condition requiring either Vicodin or Valium. (Tr. at 251) Concerning whether it is sufficient for documentation purposes to have had a valid diagnosis for the use of Vicodin or Valium recorded for a previous visit, Dr. Winter stated,

If prior to this time and on a routine basis the medication is refilled, such as if the patient has a documented anxiety problem, it can be refilled with this type of simple list: 'Patient refilling the routine meds.' But periodically there needs to be assessment of that condition being treated with the Valium. This, we did not find.

(Tr. at 251-252)

21. A note dated March 6, 1997, states, among other things, "Stress—doing OK w/ meds. Arthritis still bothering her." (St. Ex. 1 at 13b)

- When asked if that would be sufficient for a diagnosis of stress, Dr. Winter replied that it would had there been previous, more extensive evaluations. (Tr. at 260)

22. A note dated March 25, 1997, states, in part, "Stress—Valium helps. Advised [patient] to try & cut back. Has been on 17 yrs." (St. Ex. 1 at 14a)

- Dr. Winter testified that that note causes her concern, because "[t]his is the first notation in the chart that this has been a chronic medication for the patient * * *. Prior to that, there's no indication of the history of the Valium use or the presumed stress disorder that it's treating." (Tr. at 260-261)

When asked if it is appropriate to continue a new patient on Valium if the patient states that a previous physician has prescribed it for years, Dr. Winter replied,

It's certainly acceptable for the first few visits to prescribe the medication while you're getting to know the patient, while you're waiting to review the previous patient records, to make an evaluation yourself whether that medication is appropriate. Because you become the prescriber, you need to know the appropriateness of the medication.

(Tr. at 261)

- Concerning Patient 1's March 25, 1997, visit, Dr. Kirkland testified that she had advised Patient 1 to cut back on her use of Valium "but that doesn't always mean that they can do it." Dr. Kirkland further testified that she tries to maintain that patient on the least amount of medication possible. (St. Ex. 1 at 14a; Tr. at 56-57)

Dr. Kirkland's Prescribing of Narcotic Pain Medication to Patient 1

23. Dr. Kirkland prescribed Tylenol No. 3 and/or Vicodin for Patient 1 as follows:

Date	Medication	Relevant Findings and/or Diagnosis
01/05/94	Tylenol No. 3 #15, q 6 hours	Prescribed by another physician.
01/13/94	Tylenol No. 3 #20, q 6 hours	"Pt going out of town. * * * Needs f/u appt."
04/29/04	Vicodin ES [quantity and dosing frequency illegible]	Prescribed by another physician.
05/19/94	Tylenol No. 3 #50, q 6 hours	"tender neck & back." Diagnosed fibrositis. Noted that patient had refused ultrasound.
07/07/94	Tylenol No. 3 #100, q 6 hours	"Follow-up Southview ER on 6-21-94. Tender dorsal aspect. Both hands ganglion cysts." Diagnosed ganglion cysts.
07/27/94	Tylenol No. 3 #40, q 6 hours as needed	None
08/29/94	Vicodin #7, q 6 hours	Prescribed by another physician.
09/07/94	Vicodin #50, [dosing frequency illegible]	Prescribed by another physician.
10/24/94	Vicodin ES #90, q 6 hours	None
12/05/94	Vicodin ES #30	None
01/02/95	Vicodin ES #30	None
01/23/95	Vicodin ES #90, q 6 hours as needed	None
02/20/95	Vicodin ES #30, q 6 hours as needed	None
02/28/95	Vicodin ES #50, q 6 hours as needed	"Headaches, pain [right] neck, Tender [right] neck." Diagnosed headache. Ordered neck x-ray and CT scan of neck.
03/06/95	Vicodin ES #30, q 6 hours	"Follow-up CT scan results. Taking less Vicodin. Muscle relax. helping." Diagnosed headaches.
04/03/95	Vicodin ES #50, q 6 hours	Diagnosed headache.
04/24/95	Vicodin ES #60, q 6 hours	Diagnosed "sub"?
05/19/95	Vicodin ES #60, q 6 hours	Prescribed by another physician.
06/06/95	Vicodin ES #75, q 6 hours	None
07/12/95	Vicodin ES #75, q 6 hours	Prescribed by another physician.
08/07/95	Vicodin ES #75, q 6 hours	Diagnosed headaches.

Date	Medication	Relevant Findings and/or Diagnosis
08/31/95	Vicodin ES #75, q 6 hours	Diagnosed headaches.
09/22/95	Vicodin ES #75, q 6 hours	Prescribed by another physician.
10/16/95	Vicodin ES #70, q 6 hours	None
11/02/95	Vicodin ES #70, q 6 hours	“needs refills.”
11/28/95	Vicodin ES [quantity illegible], q 6 hours	“c/o pain neck & carpal tunnel to see Dr. [illegible].” Diagnosed headaches.
12/11/95	Vicodin ES #90, q 6 hours	“going out of town, refills.” Diagnosed headaches.
01/02/96	Vicodin ES #90, q 6 hours	Diagnosed headaches.
01/18/96	Vicodin ES #90, q 6 hours	None
02/05/96	Vicodin ES #90, q 6 hours as needed	“Going out of town. Sister had MI—Patient took all prev. Vicodin—had surgery done. Patient advised to [decrease] pain meds.” Diagnosed headaches.
04/02/96	Vicodin ES #90, q 6 hours	“needs refills.”
04/24/96	Vicodin ES #90, q 6 hours	“refills” Diagnosed headaches.
05/13/96	Vicodin ES #90, q 6 hours	“needs refills. Sprained [left] leg—went into the garage to smoke. Slipped on back step. Bruise [right] knee. Saw chiropractor.” Diagnosed headaches.
05/30/96	Vicodin ES #50, q 8 hours	None
06/11/96	Vicodin ES #50, q 8 hours	Diagnosed arthritis.
06/27/96	Vicodin ES #50, q 8 hours	“Wants refills.”
07/11/96	Vicodin ES #50, q 8 hours	“c/o pain in neck. * * * More headaches lately. Neck bothering her.” Diagnosed arthritis.
07/22/96	Vicodin ES #50, q 8 hours	“to go to DMI for tests.” Diagnosed arthritis.
07/30/96	Vicodin ES #50, q 8 hours as needed	Diagnosed bulging disc. “PMR consult evaluate & treat.”
08/07/96	Vicodin ES #50, q 8 hours	“Office will be closed. Needs meds. Some limitation of motion of neck.” Diagnosed bulging disc.
08/29/96	Vicodin ES #50, q 8 hours as needed	“neck same.”
09/16/96	Vicodin ES #50, q 8 hours as needed	“Hasn’t been to therapy. Advised therapy.” Diagnosed bulging disc.
09/26/96	Vicodin ES #50, q 8 hours as needed	“Going to therapy. Neck better” Diagnosed bulging disc.

Date	Medication	Relevant Findings and/or Diagnosis
10/03/96	Vicodin ES #50, q 8 hours as needed	Diagnosed bulging disc.
10/15/96	Vicodin ES #50, q 8 hours as needed	“Needs refill on Vicodin & Soma. * * * Hasn’t started w/ therapy, waiting on ins. * * * neck tender * * * refuses HP—has moist heating pad at home.” Diagnosed bulging disc. “US neck.”
10/24/96	Vicodin ES #50, q 8 hours as needed	“US” Diagnosed bulging disc
11/04/96	Vicodin ES #50, q 8 hours as needed	Ultrasound. “Requests Soma & Vicodin. * * * Neck OK ROM.” Diagnosed bulging disc.
11/07/96	None	“US. Requests refill Soma & Vicodin. Pt. states she picked them up @ pharm – then lost rx.”
11/18/96	Vicodin 7.5 #50, q 8 hours as needed	“Needs refills on meds.” Ultrasound. Diagnosed bulging disc.
12/02/96	Vicodin 7.5 #50, q 8 hours as needed	“[Recheck] back and neck, some improvement. * * * Neck tender.” Diagnosed bulging disc. Refused ultrasound.
12/16/96	Vicodin 7.5 #75, q 8 hours	“refills, leaving out of town for 3 wks. – after Jan 1 st .” Diagnosed bulging disc.
01/06/97	Vicodin 7.5 #75, q 8 hours	Tender neck and decreased range of motion. Diagnosed bulging disc.
01/23/97	Vicodin 7.5 #75, q 8 hours	“Neck still tender. Pain comes & goes. Exam unchanged.” Diagnosed bulging disc.
02/13/97	Vicodin 7.5 #75, q 8 hours	“Arthritis doing better, trying to [decrease] medication. Exam unchanged.” Diagnosed arthritis.
03/06/97	Vicodin 7.5 #75, q 8 hours	“Arthritis still bothering her.”
03/25/97	Vicodin 7.5 #75, q 8 hours as needed	“Neck still bothers her at times. Good ROM. Some tenderness. Muscle pain [right].” Diagnosed arthritis.
04/17/97	Vicodin 7.5 #75, q 8 hours as needed	“Extrem—arthritis – neck bothers her. Does well with meds.” Diagnosed arthritis.

Date	Medication	Relevant Findings and/or Diagnosis
05/15/97	Vicodin 7.5 #75, q 8 hours as needed	“Arthritis – status quo – good days & bad days. Needs to take meds.” Diagnosed arthritis.
07/07/97	Vicodin 7.5 #75, q 8 hours	“Arthritis bothers her off & on.” Diagnosed arthritis.
07/24/97	Vicodin 750/7.5 #75, q 8 hours as needed	“c/o arthritis bothering her.”
08/12/97	Vicodin 750/7.5 #75, q 8 hours as needed	“Office will be closed when due for prescriptions. * * * Neck stable but tender.” Diagnosed arthritis.
08/28/97	Vicodin 750/7.5 #75, q 8 hours	“going out of town needs meds. neck bothering her.” Diagnosed arthritis.
09/15/97	Vicodin 750/7.5 #75, q 8 hours	“Arthritis—status quo. requests meds.” Diagnosed arthritis.
10/20/97	Vicodin 750/7.5 #75, q 8 hours as needed	“Arthritis status quo needs meds.” Diagnosed arthritis.
11/17/97	Vicodin 750/7.5 #60, q 8 hours	“Arthritis present.” Diagnosed arthritis.
12/08/97	None	“Pt requesting more Vicodin—Has been taking q8h & not as needed. Has been advised to take only as needed per Dr. JK.”
12/15/97	Vicodin 750/7.5 #60, q 8 hours	“Pt requesting more pain meds—c/o spasm in back. Advised pt to go for PMR. Pt going out of town wants to wait until end of Jan.”
01/15/98	Vicodin 750/7.5 #60, q 8 hours	“Feeling about the same. * * * Advised to [decrease] pain meds.” Diagnosed arthritis.

(St. Ex. 1)

Examples of Dr. Kirkland’s Prescribing of Narcotic Pain Medication to Patient 1

24. On January 13, 1994, Dr. Kirkland documented that Patient 1 was going out of town, that her mother had had a stroke, and that Patient 1 needed a follow up appointment. Dr. Kirkland prescribed Tylenol No. 3 #20, to be taken every six hours. No other subjective or objective information was documented, nor was any assessment or diagnosis. (St. Ex. 1 at 5a)
- Dr. Kirkland testified that her husband had previously seen Patient 1 on January 5, 1994, in follow-up to an Emergency Room [ER] visit occasioned by a fall. Dr. Kirkland further testified that an ER Report dated January 2, 1994, had been

- included in her medical record for Patient 1. Dr. Kirkland acknowledged that she had not referenced that ER visit or report in her progress note for January 13, 1994. (St. Ex. 1 at 5a, 76-78; Tr. at 40-43)
- Dr. Winter testified that a notation for the previous, January 5, 1994, visit, “Seen in ER,” does not by itself justify the prescription. “I think some explanation is necessary. What was she seen in the ER for? What is currently being treated with the Tylenol No. 3?” Moreover, after reviewing the January 2, 1994, ER report—which indicates that Patient 1 had been seen for a knee injury and advised, among other things, to use ice, elevation, and take Tylenol for pain—Dr. Winter testified that that she does not believe that that information had justified the prescription. (St. Ex. 1 at 76-78; Tr. at 244-246)
25. On July 7, 1994, Dr. Kirkland diagnosed ganglion cysts, and prescribed Tylenol No. 3 #100 to be taken every six hours as needed. A subsequent entry dated July 27, 1994, simply states “Pharmore,” and documents a prescription for Vicodin #50 to be taken every six hours as needed. (St. Ex. 1 at 6a)
- Dr. Kirkland acknowledged that there was no notation in the July 27, 1994, entry concerning the reason for the Vicodin prescription; however, she stated that, when she prescribed a different medication from that previously prescribed, “it’s because the first one wasn’t working or they had a problem with it.” (Tr. at 43-44)
26. A note in Dr. Kirkland’s medical records for Patient 1 dated March 6, 1995, indicates that the purpose of the visit was to “[f]ollow-up CT scan results.” The note also states, “Taking less Vicodin. Muscle relax helping.” Dr. Kirkland diagnosed headaches, and prescribed Soma and Vicodin ES. (St. Ex. 1 at 7a)
- Dr. Winter testified that the CT scan report documented a normal result, and “rules out one potential cause for headaches, and that would be stenosis of the cervical spine causing pinching of the nerves that might lead to headache.” (St. Ex. 1 at 42; Tr. at 253-254)
27. On February 5, 1996, Dr. Kirkland documented that Patient 1 was “[g]oing out of town. Sister had MI—Patient took all [illegible] Vicodin—had surgery done.” Dr. Kirkland further documented that she had advised Patient 1 to decrease her use of pain medication. She diagnosed headaches, and prescribed Vicodin ES #90 to be taken every six hours. (St. Ex. 1 at 9b)
- Dr. Winter testified that, first, she would expect that, if the patient had had surgery, that the surgeon would have prescribed pain medication following the surgery. Moreover, Dr. Winter testified that, despite the fact that Dr. Kirkland had documented that she advised Patient 1 to decrease her use of pain medication, she continued to prescribe Vicodin ES to Patient 1 at the same dosing frequency as before. (Tr. at 255-256)

- Dr. Kirkland testified that Patient 1 had gone to see a surgeon, Dr. Percy, who does hand surgery. When asked if the surgeon would have been the physician who would have prescribed the pain medication, Dr. Kirkland replied, “Not necessarily[,]” and that it depended on what medications the patient had been taking prior to the surgery. (Tr. at 49-51)
28. On January 15, 1998, Dr. Kirkland advised Patient 1 to decrease her use of pain medication. (St. Ex. 1 at 16b)
- However, Dr. Winter noted that the dosing frequency remained the same as previously prescribed. Dr. Winter testified that when a physician advises a patient to decrease his or her use of pain medication, the physician also usually decreases the amount of medication given to the patient. Dr. Winter testified that she would not leave it up to the patient to decrease the amount used because “patients can be very creative in finding ways not to decrease medication.” (Tr. at 263-264)

Additional Evidence Concerning Dr. Kirkland’s Diagnoses

29. A July 22, 1996, report of a cervical spine MRI states, in part, as follows,

Sagittal and axial sequences were obtained. Osseous marrow signal is preserved. The craniocervical junction is free of stenosis. The cord is not widened.

The C3-4 level demonstrates end-plate ridge formation with bony hypertrophic changes posteriorly causing flattening of the ventral aspect of the thecal sac. Some uncovertebral arthrosis is also present bilaterally with secondary foraminal encroachment of mild degree, greater on the left. No focal soft disc herniations are detected.

The C4-5 level appears generally unremarkable.

The C5-6 level shows broad based disc protrusion centrally and to the left with some focal protrusion to a lesser degree posterolaterally on the right. This does cause effacement of the thecal sac anteriorly and to the left here. Changes are mild. Canal dimensions are generally preserved. No bony foraminal stenosis is reported.

The upper dorsal spine is unremarkable.

In summary, mild disc protrusion is seen centrally and to the left at the C5-6 level in broad based fashion. End-plate spondylitic ridge formation is seen posteriorly at the C3-4 level. * * *

(St. Ex. 1 at 27)

- When asked about the July 22, 1996, MRI report, Dr. Winter testified,

These are very mild and generally not very significant findings. The mild disc protrusion is probably what I believe is being referred to as bulging discs.

It also specifies the canal dimensions are preserved and there is no stenosis in the canal, which is very—which is significant because that pertains more to a process that could pinch the nerves again.

(St. Ex. 1 at 27; Tr. at 258)

Concerning a diagnosis of bulging disc that appears throughout the medical record, Dr. Winter testified that she could find no documentation concerning what part of the spine this references—whether it was cervical, thoracic, lumbosacral, etc.—nor could she find documentation of the evidence that led to that diagnosis. (St. Ex. 1; Tr. at 257)

- Dr. Kirkland testified that the MRI indicated that Patient 1 had some disc protrusion and “also had some arthritis present.” Dr. Kirkland testified that she advised physical therapy. “Initially, we weren’t able to get this done, as noted in the chart, because there was some problem with her insurance. * * * So I elected to give her some ultrasound treatments in the office.” (Tr. at 1101-1102)
- Dr. Sickles disagreed with a statement in Dr. Winter’s written report that an MRI report had ruled out nerve damage because he does not believe that an MRI can either rule in or rule out nerve damage. Dr. Sickles testified that the MRI does rule out marked nerve root compression. However, Dr. Sickles testified that MRI results also do not necessarily correlate with the severity of the symptoms that a patient is experiencing. (Tr. at 852-853)

Dr. Sickles testified that this puts a physician in a difficult position, because the patient is presenting with symptoms, and there are positive findings on an MRI that are subtle and not severe. (Tr. at 853-854)

- Dr. Sickles testified that he believes that the patient’s MRI report was not normal, but that the results “make it difficult to determine exactly where the patient’s pain is coming from.” (Tr. at 854-855)
- When asked if the findings on the MRI report are consistent with a patient who has arthritis, Dr. Sickles noted that there were no comments in the radiologist’s report concerning the facet joints, where arthritis would more likely be seen. Dr. Sickles stated, from the perspective of being able to diagnose arthritis, he would deem the report to be incomplete. Nevertheless, Dr. Sickles testified that there is no reason to

doubt that the patient had arthritis based on the results of that report, or based upon the medical record as a whole. (Tr. at 855-856)

30. A report of EMG, also dated July 22, 1996, states, under the heading, "EMG Interpretation,"

This EMG is abnormal due to the presence of:

1. A mild median neuropathy at the wrist on the right or carpal tunnel syndrome with electrodiagnostic evidence of good prognosis.
2. Mild change is noted in the cervical paraspinal muscles may indicate a mild or early cervical radiculopathy.

(St. Ex. 1 at 28)

- Dr. Sickles testified that a report of an EMG on Patient 1 indicated that Patient 1 had some nerve irritation. Dr. Sickles further testified that mild findings on an EMG do not necessarily correlate to the pain symptoms that a patient is suffering. Dr. Sickles testified that he has had patients in significant pain who had normal EMGs whose pain was eventually relieved by having carpal tunnel surgery. Dr. Sickles testified that he has had other patients who have had EMGs with moderate findings who do not have very severe symptoms. In any case, Dr. Sickles testified that the EMG results in this case confirm "that there clearly was something going on." (Tr. at 851-852)

31. A CT scan report dated March 2, 1995, based upon a CT scan of the cervical spine, noted an impression of a normal cervical spine. (St. Ex. 1 at 42)

- When asked if she had documented Patient 1's level of pain, Dr. Kirkland referenced an entry dated August 7, 1996, in which she stated, "some limitation of motion of neck." Moreover, Dr. Kirkland testified that Patient 1 had had a CT scan of the cervical spine in February 1995 that showed "some muscle spasm, straightening of the normal lordotic curvature of the neck." (St. Ex. 1 at 11a; Tr. at 51-52) However, the report that so indicated, dated March 1, 1995, was based on "AP and lateral views of the cervical spine," not a CT scan. This report stated, in summary,

The radiographs of the cervical spine demonstrate straightening of the normal lordotic curvature which may be due to muscle spasm or musculoligamentous injury. Note is made that the odontoid is not well visualized on this exam. If there is a history of trauma, I would recommend additional views to better visualize the odontoid in order to exclude abnormal pathology in this region.

(St. Ex. 1 at 43)

- Dr. Kirkland testified that a CT scan “won’t show muscle spasm, [and] it won’t show pain.” (Tr. at 53)

Conclusions Regarding Dr. Kirkland’s Care of Patient 1

32. In her written report, Dr. Winter stated,

[Patient 1] began to receive Tylenol #3 for injuries and pain in 1994, which gradually grew to continuous therapy with Vicodin. Prescriptions were obtained for seemingly minor problems, such as having a ganglion cyst (7/4/94) or a tender neck and back (5/19/94). Additional prescriptions for Vicodin were phoned in for the patient, within a brief time frame, without further exam or documentation.

* * *

In 1995 [Patient 1] began to complain of headache and right-sided neck pain. A CT scan of her neck on 3/2/95 was negative. On 7/22/96 an EMG interpretation suggested ‘mild changes in the cervical paraspinal muscles that may suggest mild or early cervical radiculopathy.’ This appears to have become the basis for continuing and increased prescription of pain medications. She did not receive additional appropriate therapy other than continuing a muscle relaxant. On 8/7/96 she had an MRI done of the cervical spine which showed ‘mild disc protrusion,’ but noted no ‘canal or foraminal stenosis’ which rules out nerve compression in the neck as the source for her pain or headache. In late 1996 she did receive a few ultrasound treatments for her condition, which did not continue past November 1996. However, the continuous treatment with narcotic pain medication did continue through the end of her care with Dr. Kirkland. In December 1997, she was advised to be evaluated for Physical Medicine and Rehabilitation, which she declined until a later date. At her final visit on 1/15/98 while refilling her usual dose of Valium and Vicodin, she was advised to decrease her pain medication.

(St. Ex. 12 at 3)

33. Dr. Winter testified that, in her opinion, “the use of continuing narcotic pain medications for a variety of diagnoses, beginning with headaches and progressing through arthritis, was very inappropriate. The management of the narcotic pain medication was absent. In addition, the oversight of the controlled pain medic—or, the controlled drug, Valium, was absent.” (Tr. at 264-265) Dr. Winter further testified,

I feel that [Patient 1’s history of kidney transplant in 1981] did limit the choices available to Dr. Kirkland. And in saying that, it eliminates the possibility of using the nonsteroidal anti-inflammatory pain medications, which are commonly used to treat conditions that she did appear to have.

However, there remains still a very large area of alternative medications, modalities, and treatments that could have been used.

(Tr. at 265)

34. Dr. Winter testified that Dr. Kirkland's ongoing prescribing of Vicodin to Patient 1 caused her concern because the documentation does not indicate "that there is a chronic problem being treated and followed." Dr. Winter further testified, "[E]ach time * * * the Vicodin is prescribed, there should be a documentation of what this is for. If it is a chronic medicine that's being given in a chronic, continuing way, it should be noted for a certain time period." (Tr. at 252-253) Dr. Winter further testified that such documentation is required under the Board's rules. (Tr. at 253)

Dr. Winter testified concerning her opinion of whether Dr. Kirkland's treatment of Patient 1 had failed to conform to the minimal standard of care,

My opinion is that narcotic medication, narcotic pain medication, was prescribed for injuries which should have been short term, but gradually became prescriptions with more frequent doses, larger doses, and for inappropriate diagnoses, such as ganglion cyst or tender neck or back.

In addition, there was very poor documentation of physical exams or diagnoses. The patient was also prescribed Valium and Ativan without any appropriate documentation or follow-up during the course of the care.

(Tr. at 241)

35. Dr. Sickles testified that, in his opinion, Dr. Kirkland's treatment of Patient 1 conformed to the minimal standard of care for similar physicians under the same or similar circumstances. Dr. Sickles further testified that Dr. Kirkland had used reasonable care discrimination and employed acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. Dr. Sickles further testified that he believes that Dr. Kirkland had used appropriate diagnostic tests in her treatment of Patient 1. (Tr. at 842-844)

Moreover, Dr. Sickles testified that he believes that Dr. Kirkland's use of narcotic pain medication to treat Patient 1 had been appropriate and within therapeutic dosages. Dr. Sickles noted that Patient 1's history of kidney transplant had somewhat limited the options for her pain medications. Dr. Sickles testified that such history effectively ruled out chronic treatment with NSAIDs. (Tr. at 844-847)

36. Dr. Kirkland testified that she had tried ultrasound to try to alleviate Patient 1's pain in November 1996. Dr. Kirkland also testified that she had ordered that earlier, in 1994, but the patient had not wanted to try it then. Moreover, Dr. Kirkland testified that she had tried

using Dilacor, a calcium channel blocker, to help alleviate Patient 1's headaches. (St. Ex. 1 at 12b; Tr. at 54-55)

37. Dr. Kirkland testified that, before prescribing medication such as Vicodin, she discusses with her patients the addictive potential of the medication. Dr. Kirkland further testified that she tries to document those discussions in her medical records. When asked to find in Patient 1's medical record where she had documented such a discussion, Dr. Kirkland referred to a note in the chart dated February 5, 1996, where she had advised Patient 1 to decrease her use of medication. (St. Ex. 1 at 9b; Tr. at 46-47)

Dr. Kirkland further testified that the dosages of medication she prescribed for Patient 1 for anxiety and pain had been "on the low side" and had been appropriate. (Tr. at 1103)

38. Dr. Kirkland testified that she had correctly diagnosed Patient 1's conditions. Dr. Kirkland stated that those diagnoses had been confirmed by specialists and by x-rays. Dr. Kirkland further testified that she treated those conditions appropriately. Finally, Dr. Kirkland testified that she fully discussed with Patient 1 all issues concerning the risks and benefits of her use of controlled substances. (Tr. at 1104)

Testimony of Patient 1

39. Patient 1 testified at hearing on behalf of Dr. Kirkland. Patient 1 stated that she had been a patient of Dr. Kirkland's for about eight or ten years until 1999, when she moved out of the area. (Tr. at 916-917)

Patient 1 testified that she had had to stop working in 1995 due to pain in her hands and neck. Patient 1 testified that she has been diagnosed with arthritis, Raynaud's disease, a bulging disc in her back, and fibromyalgia. Patient 1 noted that Dr. Kirkland had referred her to other physicians concerning the Raynaud's disease. (Tr. at 917-919)

Patient 1 testified that Dr. Kirkland had prescribed pain medication for her, and that she would not have been able to function without that medication. Patient 1 further testified that Dr. Kirkland had discussed with her on several occasions that her pain medication could potentially cause addiction. Patient 1 further testified that Dr. Kirkland always questioned her concerning the severity of her symptoms, and told her that Dr. Kirkland should lower her dosage or get her off the medication. Moreover, Patient 1 testified that Dr. Kirkland had tried to reduce the medication that she was using, although that was not always successful. (Tr. at 919-921, 922-923)

Patient 1 further testified that Dr. Kirkland had prescribed Valium for her, and that she had been using Valium for many years, before 1980, prior to her seeing Dr. Kirkland. Patient 1 further testified that the Valium helped her. (Tr. at 921-922)

Patient 1 testified that she believes that Dr. Kirkland is a very good and thorough physician. (Tr. at 924-925)

Patient 2

40. Patient 2 is a male born August 25, 1964. (St. Ex. 2 at 1) Dr. Kirkland's medical records contain a letter dated October 28, 1992, from Dr. Kirkland to a law firm concerning Patient 2's disability status. The letter provides some background concerning Patient 2's condition and course of treatment:

[Patient 2] was first seen January 28, 1986, for injury to his lower back after slipping on ice. He related having fractured his pelvis one and a half years prior in a car accident. He was complaining of left leg pain with numbness. Physical at that time showed tenderness mid back and left buttock area with deep tendon reflexes 2+/4+. He was given an injection of Decadron 8 mg IM, Naprosyn, EMG of lower extremities and lumbo-sacral spine x-rays all unremarkable. He was to return in two weeks. He was next seen July 7, 1986, complaining of his back pain being worse the past two to three weeks. He did relate he had no further numbness in his leg and stated it disappeared in February. He had a positive straight leg raising on left, reflexes were normal and he was tender in the right sacro-lumbar area. July 28, 1996, he came back relating the pain had moved up to his shoulder blade. He was given Darvocet. CT scan of lumbo-sacral spine, August 5, 1986, was negative. He was given a prescription for Parafon Forte and Clinoril and referred to Dr. Bernstein. Dr. Robbins saw and admitted him August 12 to August 13. Myelogram, EKG, and lab were normal. EMG was ordered by Dr. Robbins as an outpatient—I do not have a record of this. On August 25, he complained of back pain, physical therapy was ordered at Sycamore Medical Center and prescription for Tylenol #3.

January 31, 1989, was the next visit for his back and states that he pulled something at work on January 30, 1989, and his lower back was hurting. He states he pushed a drum at work approximately 450 lbs. He was given ultrasound treatments until seen by Dr. Sheridan. He was seen by Dr. Sheridan on February 21, 1989, who did the initial laminectomy at L3-4 and at the time a hemangioma or hemangio blastoma [sic] was encountered. Because of the fact that they were not prepared to handle that type of situation, the patient was closed and on March 3, 1989, re-opened apparently for removal of the disc as well as the tumor, as per letter by Dr. West on March 3, 1989. * * *

On May 16, 1989, [Patient 2] was again seen complain[ing] his back pain worse. He was placed on Percodan and Duricef (because of drainage at the surgical site). June 1, 1989, after stating he was no better, he was sent back to Dr. Bernstein and given a prescription for Orudis and Valium. He saw Dr. Margolis on June 12, 1989. He ordered an MRI and back exercises * * *. A myelogram was done on June 28, 1989, showing L3-4 fibrosis * * *.

Dr. Margolis asked Dr. Dunsker in Cincinnati to see [Patient 2] and consultation was August 29, 1989, * * * and September 20, 1989, with no more recommendations other than a bone scan. [Patient 2] was becoming very depressed through all of this and related that he did not feel like he was getting any better. He was started on Elavil in August of 1989 and periodically received Percocet and Valium for his back. He was referred to Dr. Nekrosius in January 1990.

[Patient 2] underwent surgery for the third time on March 20, 1990, by Dr. Jenkins, an orthopedic doctor. [Patient 2] continued to complain of back pain after the surgery. [Patient 2] saw Dr. Sickler also a neurosurgeon prior to the operation with Dr. Jenkins. [Patient 2] did not tell me on June 11, 1990, that Dr. Jenkins had released him to Dr. Sickler but [Patient 2] did not want to see Dr. Sickler at this point. He became more depressed and Elavil was discontinued and he was placed on Prozac. He came in July 2, 1990, and stated he needed another surgery. I have no consultation reports from Dr. Sickler or Dr. Jenkins [Patient 2] was sent to Dr. Bernstein September 20, 1990, and Dr. Robbins suggested [Patient 2] see a Dr. Bell at Cleveland Clinic * * * because he felt like he had nothing to offer him.

[Patient 2] fell December 27, 1990, on buttocks and was seen at Good Samaritan Hospital. Throughout all of this [Patient 2] complained of back pain and being no better. He elected to go to Ohio State University Spin Clinic on May 24, 1991, and saw Dr. Gary Rea * * *. He operated on [Patient 2] on August 28, 1991, * * *. On September 11, 1991, Dr. Rea reported a skin infection and need for rehospitalization. Shortly thereafter an appointment was made with Dr. Bruce at the pain clinic at Kettering Medical Center and Dr. Bruce did not feel he could help [Patient 2]. December 15, 1991, [Patient 2] was in an auto accident and complained of pain in his back and left knee. He was sent to the West Group for further evaluation and physical therapy consult was obtained per Dr. Braunlin * * *. At his visit July of 1992 an appointment was made at Miami Valley Hospital pain clinic and in October he was sent back to Dr. Robbins. He continues to have back and leg pain with no improvement, probably a lot of it is from scar tissue from six previous surgeries. He continues to be tearful and depressed everytime he comes in with a loss of interest in things. I do not see him able to return to gainful work activity. He has difficulty walking, sitting and is unable to lift. His prognosis is poor for rehabilitation and I consider him totally and permanently disabled.

(St. Ex. 2 at 159-160)

Dr. Kirkland's assessment of Patient 2's disability status was subsequently corroborated in a State of Ohio Industrial Commission Specialist's Report dated November 4, 1994.
(St. Ex. 2 at 31-33)

41. Subsequent to Dr. Kirkland's October 1992, letter, Patient 2 continued to complain of back pain and depression. Among other things, from March 10 through 12, 1994, he was hospitalized at Kettering Memorial Hospital for diagnoses of herniated disc and lumbosacral neuritis. Later that month, beginning March 27, 1994, Patient 2 was hospitalized at Miami Valley Hospital for "Agitation, homicidal and suicidal threats." Patient 2 was under the care of Kenneth Welty Sr., M.D., a psychiatrist, during the psychiatric hospitalization. (St. Ex. 2 at 47-51; Tr. at 67)

Dr. Kirkland continued to refer Patient 2 to specialists and for diagnostic testing. Dr. Kirkland further referred Patient 2 to pain clinics at Kettering Memorial Hospital and to Miami Valley Hospital. In addition, Dr. Kirkland referred Patient 2 to physical therapy and for whirlpool treatment. In September 1994, she began treating him with Methadone under the direction of Mark Thomas, M.D. (St. Ex. 2 at 6a-23a, 73-74, 76, 152-153, 154-158, 161-162)

Dr. Kirkland's Prescribing of Valium and Narcotic Pain Medication to Patient 2

42. On January 15, 1991, Dr. Kirkland prescribed to Patient 2, among other things, Valium 5 mg #60 with one refill, to be taken twice daily as needed; and Percocet #60, to be taken every six hours. No complaints or findings are noted that day. (St. Ex. 2 at 15b)

Dr. Kirkland acknowledged that her January 15, 1991, note does not state why Valium had been prescribed to Patient 2 that visit. (Tr. at 64-65)

Dr. Kirkland also prescribed Valium 5 mg #60 with one refill, to be taken twice per day, on March 13, 1991; and the same prescription with no refill on April 9, May 9 and 30, July 1 and 29, and August 22, 1991. No basis for prescribing Valium was documented for any of those prescriptions. (St. Ex. 2 at 15b-17b)

During this same period, and thereafter until March 5, 1992, Dr. Kirkland prescribed Percocet, to be taken every 6 hours, in varying quantities, but usually in quantities of 100. These prescriptions occurred on at least a monthly basis during this time, with exceptions that on April 15, 1991, Dr. Kirkland prescribed Tylenol No. 3 #120, and on April 18 and May 19, 1991, Dr. Kirkland prescribed Vicodin. In addition, Dr. Kirkland prescribed Fiorinal #3 #60 on September 12, 1991, but issued a prescription for Percocet #40 the following day when Patient 2 complained that the Fiorinal made him too drowsy. (St. Ex. 2 at 15b-19a)

Subsequently, starting July 23, 1992, Dr. Kirkland began prescribing Vicodin ES #60, to be taken every six hours. This prescription was repeated in August 24, September 14, and October 8, 1992. On November 5, 1992, the number prescribed increased to ninety and, in March 1993, to one hundred twenty. These prescriptions continued on roughly a monthly basis until November 29, 1993, when Dr. Kirkland prescribed Lorcet 10/650 #120. Vicodin ES #120 was prescribed on December 6, 1993, because Patient 2 did not like the Lorcet. Vicodin ES was subsequently prescribed regularly in varying quantities until

September 1, 1994. On April 11, 1994, the dosing frequency had been increased from one every six hours to one to two every six hours. Moreover, prescriptions for Percocet #30 or #50 were issued on June 6, July 5, and August 4, 1994, in addition to the prescriptions for Vicodin ES. (St. Ex. 2 at 19a-24b, 8a-9b)

Beginning on October 24, 1994, Dr. Kirkland began prescribing Methadone under the direction of another consulting physician. These prescriptions continued until Dr. Kirkland dismissed Patient 2 from her practice on August 16, 1995, for having obtained Methadone from another physician without informing her. (St. Ex. 2 at 5a-8a, 25-26)

During these times, Dr. Kirkland had prescribed Valium 10 mg to Patient 2 to be taken four times per day in quantities of fifty on November 5, 1992; five on March 23 and 29, 1993; one hundred twenty on July 12, 1993, and February 21 and July 5, 1994; and sixty on September 19, 1994. No rationale for the Valium prescriptions was documented in the medical record. (St. Ex. 2 at 9a-9b, 19b, 20b, 21a, 22a)

43. Within the time frame of the prescriptions noted above, in December 1991, Dr. Kirkland referred Patient 2 to a back specialist. (St. Ex. 2 at 18b) By letter dated January 24, 1992, Drs. Rea and Venesy, physicians from The Ohio State University Spine Clinic, informed Dr. Kirkland that they had seen Patient 2 in their clinic that day. They further informed Dr. Kirkland, in part,

Dr. Venesy and I both feel that [Patient 2] has a significant amount of chronic pain behaviors, and very significantly needs psychological counseling with stress management and behavior modifications.

This is not to say at all that his pain is not real or that he is making it up. However, it has affected him in such a way that he has developed into a chronic pain patient, with depression and problems that need to be addressed. At the present time, he says that he is not suicidal but that is always a concern. We discussed this with him for almost an hour and we recommended that he enter a chronic pain program with behavior modification and maybe be taken off his narcotic medications. He is strongly opposed to this and says that he has already been to one and it won't help him. I also told him that I would refer him to Dr. Stewart Dunsker in Cincinnati, and he said he would think about that.

I am very sorry that we were not able to help you more with [Patient 2], but both of us feel very strongly that he will not improve with further surgery and that his chronic pain behavior is so overwhelming that without dealing with that, there is very little else to be done. Because of his differences of opinion with me, he has also requested that his evaluations of his neck be done at a

different hospital with another neurosurgeon. In view of our clashes, I think that would be very reasonable and to his benefit.

(St. Ex. 2 at 86-87)

44. Concerning Drs. Rea's and Venesy's letter, Dr. Kirkland testified that she did not interpret that letter to mean that Patient 2 had to be weaned from narcotic medications. "[I]t said 'may be taken off' is how I read this. He didn't say definitely taken off." Dr. Kirkland further testified that, by the time she got Drs. Rea's and Venesy's letter, Patient 2 had already tried numerous alternative modalities such as physical therapy and a TENS unit, neither of which was helpful. (Tr. at 71-72)
45. Dr. Kirkland related a history for Patient 2 that included back injury and numerous back surgeries. Dr. Kirkland testified that, in 1989, following several back surgeries that were unsuccessful in relieving Patient 2's pain, and following an MRI evaluation that "showed dense scarring" in his back, as well as psychological evaluations, Dr. Kirkland kept Patient 2 on Elavil and Valium, and switched him from Vicodin to Percocet. Concerning her decision to prescribe Percocet to Patient 2, Dr. Kirkland testified, "I rarely, and I will say rarely, use anything like this unless it would be for a cancer patient. However, this patient had so much pain and was in so much distress, that I tried to alleviate his pain. He was miserable." (Tr. at 1044-1046) Moreover, Dr. Kirkland testified that, prior to this,

This patient had been on numerous medications. I mean, he had been on muscle relaxants; he had been on anti-inflammatories; he had been on antidepressants to try to help alleviate the pain. He had had physical therapy. He had had the surgeries with the hopes that they would relieve his pain. And none of this worked.

(Tr. at 1047)

Dr. Kirkland testified that, following his sixth back surgery in June 1991, Patient 2's back pain was worse than it had been before the surgery. Dr. Kirkland further testified that she referred Patient 2 to a pain specialist who, in an October 3, 1991, phone conversation with Dr. Kirkland, reported that he had evaluated Patient 2 and "had nothing to offer him." Moreover, Dr. Kirkland testified, "[Patient 2] didn't want any more surgeries at this time. He didn't want any more testing at this time. He was depressed. And I continued him on his pain medication as I felt I had exhausted all the resources at this time." (Tr. at 1050-1052)

46. Evidence was presented that Patient 2 engaged in drug-seeking behavior, showed signs of drug dependency, and demonstrated compromised judgment. For example:
 - a. An entry dated January 6, 1992, stated that Patient 2 had stolen tires from a car dealership in summer 1991, and received probation. (St. Ex. 2 at 18b)

- Dr. Winter testified that this note indicates that Patient 2 is “not too concerned about following the law, for one.” Tr. at 269)
- b. A January 20, 1992, entry indicates that Patient 2 had been “crying & upset because he might go to jail. He missed class—states he found out too late—now has to see judge. He has agreed to start clean in Feb. He states he has been attending drug classes.” (St. Ex. 2 at 18b)
- Dr. Winter testified that this is an indication that there was some concern about Patient 2’s drug abuse. (Tr. at 268-269)
- c. A November 12, 1992, letter to Dr. Kirkland from Dr. Bronstein related Patient 2’s extensive history of back surgeries and further stated, in part,

On examination he is a very anxious man who hyperventilates while talking. He wears a brace and has no range of motion. He has a functional Romberg. He has giveaway weakness of all muscles in both lower extremities with symmetrically depressed deep tendon reflexes. Surprisingly, he can walk on his heels but not his toes. I am afraid this is also volitional.

At this point I am sure he has enough anatomic substrata with scar tissue to cause him to have significant pain, however, there is a certain amount of overlay involved in this, and I do not think that any surgical consideration should be entertained. I have reviewed his last CAT scan dated 9/2/92, and I do not see any significant root or dural compression that would explain his problem, and certainly this could not be helped by surgery. I feel it would be in his best interests to be referred to a pain clinic, not for injections, but one such as Miami Valley, where they work on behavioral modification, although frankly the chances of anything helping this unfortunate man are very slim.

(St. Ex. 2 at 73-74)

- Dr. Winter testified that Dr. Bronstein’s letter “pointed out some inconsistencies in [Patient 2’s] physical exam as far as damage.” Dr. Winter further testified that the fact that Patient 2 could walk on his heels but not his toes had appear to be intentional. Moreover, the term “overlay” as used by Dr. Bronstein meant that he had believed that there was a psychological or behavioral issue involved. (Tr. at 272-274)
- d. An entry dated September 1, 1994, states, among other things, that Patient 2 “has been getting med from Dr. Welty & Dr. Thomas. Will try to taper [Patient 2] off Vicodin. Dr. Thomas to arrange for drug rehab. * * * [Patient 2 requesting more

- pain medication.” Dr. Kirkland prescribed Soma #120, to be taken every six hours; and Vicodin ES #60, to be taken twice per day. (St. Ex. 2 at 9a)
- Dr. Winter testified that the September 1, 1994, note indicates that Patient 2 had drug problems. (St. Ex. 2 at 9a; Tr. at 267-268)
 - Dr. Kirkland testified that she had prescribed Vicodin to Patient 2 that day because she had not wanted him to go into withdrawal. Dr. Kirkland noted that she had prescribed the dosing frequency to be twice per day, whereas before she had written for one to two tablets every six hours. (St. Ex. 2 at 9a; Tr. at 67-68)
Dr. Kirkland further testified that Patient 2 had not been receiving Vicodin from the other physicians. (Tr. at 70)
- e. On January 23, 1995, Dr. Kirkland documented that Patient 2 had reported that his methadone had been stolen. Dr. Kirkland issued a prescription for methadone #290. Note that the typical monthly script called for #330. (St. Ex. 2 at 6a)
- Dr. Kirkland acknowledged that she had given Patient 2 another prescription for methadone, but that she had subtracted from the amount prescribed the amount that he should have already taken. (Tr. at 76-77)
- f. A note dated April 4, 1995, states that the Montgomery County jail had called and advised that Patient 2 would be in jail for three days for “DUI.” (St. Ex. 2 at 6b)
- When asked if she would consider that to be a warning sign that Patient 2 might have an alcohol abuse problem, Dr. Kirkland replied, “It’s possible. But he had also been seeing a psychiatrist at that time that would have handled that problem.” (Tr. at 77)
 - Dr. Winter testified that the April 4, 1995, entry “is a very large red flag when a patient who you are treating with narcotic pain medications gets a DUI. (St. Ex. 2 at 6b; Tr. at 267)
- g. On August 16, 1995, Dr. Kirkland wrote a termination letter to Patient 2 that stated,
- I can no longer see you as a patient. On 6-12-95 you were given enough medication until your next appointment. On 7-10-95 you saw Dr. Carol Ryan and received 330 Methadone. You were seen in our office on 7-13-95 with no mention of your appointment with her or that your medication was renewed. You were therefore given a full prescription again. This is the reason you need to find another physician to take over your care.

(St. Ex. 2 at 25)

Other Issues

47. A note dated September 29, 1994, stated that Dr. Kirkland had called Dr. Welty, a psychiatrist, and informed him that she “would no longer be giving [Patient 2] Valium, Sinequan, or Prozac.” The note also states that Patient 2 had seen Dr. Welty on September 23 and received Tuinal #32, Valium 10 mg #120 with five refills, Wellbutrin #100 with six refills, and Sinequan with six refills. (St. Ex. 2 at 8a; Tr. at 67)

The following note, dated October 4, 1994, states “Prozac qod 20. Sinequan 300 [1] hs, Methadone.” However, rather than being written in the right-hand column of the progress note, as Dr. Kirkland typically does when documenting prescriptions, it is written across the page where she normally records the patient’s complaint, history, and physical examination. (St. Ex. 2 at 8a) Dr. Kirkland testified that she had not given those prescriptions to Patient 2 on October 4, 1994. She had simply noted what Patient 2 was receiving from Dr. Welty. (Tr. at 68)

Conclusions Regarding Dr. Kirkland’s Care of Patient 2

48. Dr. Winter testified that Patient 2 had a long history of multiple injuries and multiple surgeries. Dr. Winter further testified that Patient 2 was noncompliant with a number of treatments offered to him. He declined to attend a pain clinic, although he had numerous opportunities to do so. He would not participate in physical therapy. Moreover, he deferred rehabilitation services authorized through the Bureau of Workers’ Compensation. Dr. Winter stated, “The overall picture with the noncompliance appears that he was not concerned about actually getting better.” (Tr. at 269-270)

Dr. Winter further testified that the medical record indicates that consultants had believed that Patient 2 was becoming a chronic pain patient, and had expressed concern with regard to the amount of narcotic pain medication that Patient 2 was receiving. (Tr. at 271)

49. Dr. Winter testified that Dr. Kirkland’s “management of this case was a gross departure from the standard of care.” Moreover, Dr. Kirkland failed to use reasonable care in the selection and management of drugs. Dr. Winter testified that Dr. Kirkland had prescribed to Patient 2 increasing doses of narcotic pain medication. Moreover, “there were numerous red flags in his care that strongly suggested abuse, yet this was not addressed in the chart. The medications kept continuing. There were a couple of verbal encouragements for him to decrease the dose, but none were enforced.” (Tr. at 276)
50. Dr. Sickles testified that, in his opinion, Dr. Kirkland had conformed to the standard of care in her treatment of Patient 2, and she had used sound medical judgment in the selection of medication to treat Patient 2. Dr. Sickles testified that he based that opinion on the medical records that show multiple consultations and diagnostic tests, as well as Dr. Kirkland’s written summary. Dr. Sickles testified that the multiple surgeries that Patient 2 had had provide “pretty substantial evidence that * * * there were legitimate pain issues that needed to be dealt with.” Dr. Sickles further testified, “Dr. Kirkland’s prescribing of narcotic pain

medicines to this gentleman was perfectly appropriate in trying to control the chronic pain symptoms that obviously weren't adequately dealt with on multiple occasions with—with surgical or other interventions.” (Tr. at 791-793)

Dr. Sickles further testified that Dr. Kirkland appropriately ordered diagnostic studies as they were needed, attempted to employ alternative treatment modalities, and referred Patient 2 to specialists as appropriate. (Tr. at 793-794)

51. With regard to Dr. Winter's expert report concerning Dr. Kirkland's treatment of Patient 2 despite numerous “red flags” in his history, Dr. Sickles testified that he agreed that Patient 2 had at times been noncompliant with Dr. Kirkland's treatment recommendations. (St. Ex. 12 at 5; Tr. at 795) Dr. Sickles further testified,

[W]hen you're dealing with a patient with this severe an injury and the number of surgeries and problems he's had, that's not unusual to see patients that won't participate in certain recommended programs. And that's certainly not a deviation from the standard of care as a physician to try and continue to work with patients and treat them with regard to their chronic pain just because they are unwilling, for whatever their reasons, to necessarily try alternative treatments that you're recommending for them.

(Tr. at 795) Dr. Sickles further testified that, in his opinion, Patient 2 will require pain medication for the rest of his life to control his severe back pain. Moreover, Dr. Sickles testified that even stronger pain medication could have been used than that which Dr. Kirkland had prescribed for Patient 2. Furthermore, although Dr. Sickles agreed that Patient 2 had chronic pain syndrome, Dr. Sickles did not believe that Patient 2 sought to “benefit” from his pain, but was trying to find relief from his pain. Finally, Dr. Sickles testified that he does not believe that “there would be anything you could do to wean this gentleman off of narcotic pain medication and still have him live any kind of reasonable life.” (Tr. at 796-798)

52. With regard to Patient 2's conviction for DUI, Dr. Sickles testified that this situation would require that Patient 2 be counseled “about the appropriate use of alcohol in the presence of taking chronic pain medication.” Dr. Sickles further testified, however, that the physician is not required to withhold pain relief from Patient 2. (Tr. at 799-800)
53. Dr. Sickles acknowledged that a consultation report from Dr. Rea had recommended that Patient 2 be weaned from his narcotic pain medication. Dr. Sickles further acknowledged that Dr. Kirkland did not follow that recommendation. When asked if it had been appropriate for Dr. Kirkland to ignore a consultant's recommendation concerning medication, Dr. Sickles testified,

I believe it's important to factor consultants' recommendations into your patient care-making decisions. Certainly that's—that's an important factor you need to consider in the decisions you're making about whether to

continue or not to continue any treatment. But it's—it's not the only one. And I think it puts the physician in a difficult position, but sometimes you still act in what you believe is the best interests of the patient but not necessarily doing what the consultant is recommending.

(Tr. at 949-950)

54. When asked what he would do with a patient with problems such as those documented for Patient 2, Dr. Sickles replied,

I would, again, discuss these issues with the patient; clarify with the patient who was going to be prescribing what particular medications for them, how his pain problems would be managed. Again, just trying to develop a plan with the patient about how we were going to proceed in terms of prescribing these things and managing the problem.

(Tr. at 951-952) Dr. Sickles further testified that he would document these discussions in the patient's medical record to remind himself that he had discussed those things with the patient, and what had been negotiated between himself and the patient. Dr. Sickles acknowledged that that documentation could also be useful for another physician who took over the patient's care. (Tr. at 952)

55. Dr. Kirkland testified that, when she discovered that Patient 2 had been obtaining methadone from a pain specialist, Dr. Thomas, she confronted Patient 2 about that issue. Dr. Kirkland further testified that, at that time, she started to taper Patient 2 from Vicodin. In addition, Dr. Kirkland testified that she had contacted Dr. Thomas and received a written release from him to treat Patient 2 with methadone. (St. Ex. 2 at 7; Tr. at 1057)

Dr. Kirkland testified that, in August 1995, when she again found out that Patient 2 was obtaining medication from another physician, she terminated Patient 2 from her practice.

And this was difficult to do because I had—I had treated this patient for a long time. I had treated him for nine years. And I had been through an awful lot with him. I had treated his family and I had treated him. And I treated him to the—the best I could. I felt that I was compassionate. I felt like I tried to relieve his pain. I sent him to numerous specialists. And I kept him on the least possible dose of medication that I could.

(Tr. at 1058-1059)

56. Dr. Kirkland testified that in September 1994, Dr. Welty, Patient 2's psychiatrist, had Patient 2 on 40 mg of Valium per day. Dr. Kirkland testified that when she prescribed Valium to Patient 2 she had prescribed, at most, 15 mg of Valium per day. (Tr. at 1056-1057) Note, however, that the medical records indicate that on seven occasions between November 5, 1992, and September 19, 1994, inclusive, Dr. Kirkland

had prescribed Valium 10 mg to Patient 2 with instructions to take the medication four times per day. This would amount to 40 mg of Valium per day. (St. Ex. 2 at 9a-9b, 19b, 20b, 21a, 22a)

57. Dr. Kirkland testified that she had had ongoing discussions with Patient 2 concerning his condition and the nature of the medications that he was receiving. Dr. Kirkland further testified, "My policy from day one has always been to let the patients know that the medication that I'm giving them is a controlled substance and that there is a possibility for addiction." (Tr. at 1059-1060) Dr. Kirkland further testified, "I didn't have the luxury of having a dictating system, being in a small office, and I couldn't put everything in the records." Dr. Kirkland further testified that she had verbal discussions with the various specialists who treated Patient 2. (Tr. at 1061-1062)
58. Dr. Kirkland testified that her diagnoses of Patient 2's conditions had been appropriate, and were corroborated by other specialists and studies. Dr. Kirkland further testified that the treatment she provided Patient 2 had been appropriate and proper for his conditions. Dr. Kirkland added that specialists had corroborated the appropriateness of her treatment. Dr. Kirkland noted that another physician had originally placed Patient 2 on methadone, and that Dr. Kirkland had never before, or since, prescribed that drug to any other patient. (Tr. at 1062-1064)

Patient 3

59. Patient 3 is a female born November 20, 1958. (St. Ex. 3 at 1) Dr. Kirkland testified that she first saw Patient 3 in August 1981. (Tr. at 80, 1106)

Treatment with Controlled Substance Anxiolytics

60. From March 28, 1985, through January 13, 1998, Dr. Kirkland prescribed controlled substance anxiolytics, usually Xanax, to Patient 3 for complaints of depression and/or anxiety.² Beginning in April 1985, the dosing frequency of Xanax 0.5 mg was three times per day. On May 29, 1986, it was changed to twice per day. On July 28, 1986, Dr. Kirkland prescribed Xanax 1 mg to be taken twice per day. Later, on May 18, 1988, the dosing frequency of Xanax 1 mg was increased to three times per day and, beginning June 27, 1988, she increased it to four times per day. Aside from an attempt in December 1990 to reduce the dose to one taken at bedtime, and an attempt of Tranxene 7.5 mg twice per day in January 1991, Dr. Kirkland continuously prescribed Xanax 1 mg, to be taken four times per day, through December 1997. In December 1997, she reduced the dosing frequency to three times per day. At the last visit on record, January 13, 1998, Dr. Kirkland reduced the dose to 0.5 mg three times per day. (St. Ex. 3 at 2b-20b)

² Xanax was, the controlled substance anxiolytic most frequently prescribed by Dr. Kirkland, although she also prescribed Ativan on a handful of occasions, including on March 8, 1985. In addition, Valium was prescribed once, in August 1987, and Tranxene was prescribed once, in January 1991. These prescriptions were issued instead of, and not in addition to, prescriptions for Xanax. (St. Ex. 3)

61. Dr. Kirkland's medical record for Patient 3 includes a May 3, 1988, letter to her from Mark A. Smith, M.D., a psychiatrist. In his letter, Dr. Smith stated,

[Patient 3] has continued problems with depression and we continue her on Prozac. She has been on Xanax through our office and I have suspicions reported by family and friends that she has not been taking the medication properly and obviously this is a concern. At this time I have talked to [Patient 3] and have reviewed with her a schedule to taper her off the Xanax.

(St. Ex. 3 at 63) Despite Dr. Smith's letter, as stated above, Dr. Kirkland continued to prescribe Xanax to Patient 3 through January 1998. (St. Ex. 3)

62. Dr. Winter testified that, if a patient is being seen and treated for psychiatric disorders by a psychiatrist, it is not normal practice for the family physician to prescribe psychiatric medications such as antidepressants or anti-anxiety medications. "If a patient is seeing a psychiatrist, generally that portion of their care is overseen by the psychiatrist." (Tr. at 284)
63. An entry dated May 18, 1988, shortly after Dr. Smith's letter was written, states that Patient 3 had told Dr. Kirkland that she could not afford a psychiatrist, and that she wanted to see her family doctor instead. Dr. Winter testified, "It makes me suspicious because it occurs at a time just after the psychiatrist discussed decreasing the medication with the patient, she decides she doesn't want him and she states she would prefer to have her medication with Dr. Kirkland." (St. Ex. 3 at 8a, 63; Tr. at 282-283)
64. Dr. Sickles testified that, when Patient 3 had refused to continue seeing the psychiatrist, Dr. Kirkland had decided to continue to treat her. Dr. Sickles testified that patients commonly report that they cannot see a psychiatrist as a result of financial issues, because psychiatric care is often not covered by medical insurance plans. Dr. Sickles stated that this puts a primary care physician in a difficult position, to have to decide whether to continue trying to treat the patient. (Tr. at 862-863)
65. Dr. Kirkland testified that Dr. Smith was a psychiatrist who had admitted Patient 3 to the hospital two or three times on previous occasions when Patient 3 had been suicidal. Dr. Kirkland further testified that Dr. Smith had actually increased the dosage of Xanax that Dr. Kirkland had previously been prescribing to Patient 3. Dr. Kirkland testified that "I had tried to keep her on a low dose and he continued to increase it. And I had decided to decrease it and he increased it again." (Tr. at 88)
66. Dr. Kirkland testified that she originally began treating Patient 3 in 1985 with Xanax for depression. Dr. Kirkland testified that she also tried her on numerous antidepressants without success. Dr. Kirkland testified, "At this time, I felt that the patient was depressed. She was having trouble sleeping. She had numerous complaints, none of which we could ever find an etiology for." (Tr. at 1107-1108)

Dr. Kirkland further testified that in 1987 Patient 3 had been admitted to the hospital for depression by Dr. Smith. Dr. Kirkland testified that Dr. Smith had placed her on Xanax 1 mg twice per day, and Asendin, an antidepressant. Moreover, Dr. Kirkland testified, “[Dr. Smith] confirmed during that hospitalization what I had known all along, that the patient was under considerable stress. She had a husband who was an alcoholic. She had trouble communicating with her husband. And she was trying to raise three children, one of which had Down’s syndrome * * *.” (Tr. at 1108-1109)

Dr. Kirkland testified that, later that same year, in May 1987, Dr. Smith again admitted Patient 3 to the hospital for psychiatric problems. Dr. Kirkland further testified that Dr. Smith had increased Patient 3’s daily dose of Xanax to 1mg three times per day and two at night, and started her on Triavil, another antidepressant. (Tr. at 1109-1110)

Moreover, Dr. Kirkland testified that, shortly thereafter, in June 1987, Patient 3 had overdosed on Triavil, and was hospitalized again. Dr. Kirkland further testified that Dr. Smith had continued Patient 3 on Xanax following that episode. (Tr. at 1110)

Furthermore, Dr. Kirkland testified that, around May 1988, at a time Dr. Smith had had Patient 3 on Xanax 1 mg four times per day, he had advised that she be tapered off that drug. Dr. Kirkland testified that Patient 3 “was decreased to a milligram three times a day. And she was not able to—to come off the medication at all.” Dr. Kirkland further testified that “[t]here’s notes in the chart to indicate that she was crying, she was anxious, she was shaking all over.” (Tr. at 1112-1113) [Note, however, that there is no mention of crying or shaking in Dr. Kirkland’s progress notes for the period from May 1988, when Dr. Kirkland prescribed Xanax 1 mg to be taken three times per day, through June and July 1988 when she increased Patient 3’s dosing frequency to four times per day. (St. Ex. 3 at 8a)]

67. Dr. Kirkland testified that she had communicated with Dr. Smith during the course of their treating Patient 3, and she had been aware at all times of the medications that Dr. Smith was prescribing for Patient 3. (Tr. at 1116)
68. Dr. Kirkland testified that Patient 3 had required no further psychiatric hospitalizations after Dr. Kirkland took over treatment of Patient 3’s psychiatric problems. (Tr. at 1118)
69. When asked if Patient 3 had had any further suicide attempts after her care was transferred from a psychiatrist to Dr. Kirkland, Dr. Winter testified that “it is not the standard of care in family practice to measure one’s mental health by the lack of suicide attempts or the lack of hospitalization for suicide attempts.” (Tr. at 700)
70. When Dr. Sickles was asked whether he would measure the success of a patient’s treatment with medication by lack of hospitalizations for suicide attempts, he replied,

Well, that’s certainly one measure of success when you’re dealing with psychiatric patients. Certainly repetitive hospitalizations in severely depressed or anxious patients is a complication of the disease process, just like

it is with patients that have congestive heart failure. One of the measures of success is how frequently they're hospitalized. Gives you some sense of how well their heart failure is controlled. It's certainly not the only measure of success in terms of treatment, but it's—it is one.

(Tr. at 984)

71. Dr. Winter testified that, during the course of her treatment, Patient 3's dose of Xanax increased. Dr. Winter testified that it started at 0.5 mg three times per day, and increased to 1 mg four times per day. Dr. Winter characterized that as a "significant increase over time." Furthermore, Dr. Winter testified that she could not discern the reason for that increase from the medical records. (Tr. at 281)
72. With regard to Dr. Kirkland's diagnosis of depression, Dr. Winter testified that she could not determine how that diagnosis had been made. (Tr. at 281)

Dr. Kirkland's Treatment of Patient 3 with Narcotic Pain Medication

73. On August 12, 1981, Dr. Kirkland prescribed Tylenol No. 3 #15 to be taken every four to six hours as needed for headache. On a few occasions in 1987, Patient 3 received a few prescriptions for Darvocet N-100 or Vicodin. Beginning in 1989, Dr. Kirkland began prescribing Vicodin to Patient 3 on a more frequent basis for back pain. By mid-1993, Patient 3 was regularly receiving prescriptions for Vicodin to be taken every six hours. These prescriptions continued until the date of the last visit on record, January 13, 1998, at which time Dr. Kirkland was tapering Patient 3 off the medication. (St. Ex. 3 at 2a-20b)
74. With regard to Dr. Kirkland's prescribing of pain medication to Patient 3, Dr. Winter testified that Dr. Kirkland had made appropriate referrals for physical therapy, and for orthopedic and neurological consultations. However, Dr. Winter further testified that "Dr. Kirkland continued to use narcotic pain medication for the back pain." With regard to Dr. Kirkland's continued prescribing, Dr. Winter testified,

I have several concerns. One is that it's narcotic pain medication given on a continuing basis, which is never a good idea. And the other is that when she was sent to—when the patient was sent to see a specialist for the back pain, generally the specialist takes over management of that back pain unless it's specifically referred back to the primary care physician.

(Tr. at 284-285)

75. Dr. Sickles testified that Dr. Kirkland's prescribing of narcotic pain medication to Patient 3 had been appropriate. Dr. Sickles noted that Dr. Kirkland had referred Patient 3 for other modalities as well. Further, Dr. Sickles testified that Patient 3 had a history of GERD, which is a potential contraindication to using NSAIDs. (Tr. at 865)

76. With regard to her prescribing of pain medication, Dr. Kirkland testified that, around 1988, Patient 3 had been complaining of pain radiating down her leg. Dr. Kirkland further testified that Patient 3 had numbness in a foot, and walked with a limp. In addition, Dr. Kirkland testified that Patient 3 had had increased back pain when she flexed or extended her back, and decreased sensation on physical examination. Dr. Kirkland testified that x-rays had revealed that Patient 3 had scoliosis in her lumbar vertebrae, and “Grade 1 to 2 spondylolisthesis in the lower lumbar area.” Moreover, Dr. Kirkland testified that an EMG “confirmed evidence of L5 radiculopathy.” Furthermore, Dr. Kirkland testified that a physical therapist had agreed that Patient 3 “should be continued on Darvocet.” (Tr. at 1111)

Dr. Kirkland further testified that Patient 3 had fallen and injured her ankle and back in 1992, and had complained of hip pain in 1993. Dr. Kirkland noted that Patient 3 was at one point placed in a back brace. Moreover, Dr. Kirkland testified that, in May 1996, Patient 3 had been admitted to a hospital for severe headaches. (1113-1114)

Finally, Dr. Kirkland testified that Patient 3 had had reactions to most nonsteroidal anti-inflammatory medication. Dr. Kirkland noted that, around late 1997, she had tried Patient 3 on Vioxx, which Patient 3 tolerated well. (Tr. at 1114)

Early Refills

77. On numerous occasions, Dr. Kirkland prescribed early refills of Xanax. No rationale for issuing these early prescriptions was documented. Examples of these early refills include the following,
- On July 5, 1990, Dr. Kirkland prescribed Xanax 1 mg #120 to be taken four times per day, a thirty-day supply. Dr. Kirkland then issued another prescription for Xanax to Patient 3 on July 23, 1990, only eighteen days later. (St. Ex. 3 at 11a)
 - On August 27, 1990, Dr. Kirkland prescribed Xanax 1 mg #120 with one refill, to be taken four times per day, a sixty-day supply. Twenty-four days later, on September 20, 1990, Dr. Kirkland prescribed #120, a thirty day supply. Eighteen days later, on October 8, 1990, she prescribed #120 with two refills, a ninety-day supply. This prescription was repeated on December 18, 1990, seventy-one days later. (St. Ex. 3 at 11a-11b)
 - On June 3, 1991, Dr. Kirkland issued a prescription for Xanax 1 mg #120 with one refill, to be taken to be taken four times per day, a sixty-day supply. This prescription was repeated on July 23, 1991, fifty days later. (St. Ex. 3 at 13a)
 - On March 13, 1995, Dr. Kirkland prescribed Xanax 1 mg #120 to be taken four times per day, a thirty-day supply. This prescription was repeated on April 6, 1995, twenty-four days later. (St. Ex. 3 at 16a)

78. Dr. Winter testified that Patient 3 had received medications “at much shorter intervals than is written for without any notation or documentation of an intent to increase the dosage or explanation why the dosage is given more frequently than the dosage you would expect by the prescription.” (Tr. at 698) When asked if Dr. Kirkland closely managed and observed Patient 3 by frequent office visits, Dr. Winter replied that she had not.

We see that she has come to the office frequently. We don't see very much at all in the progress notes. We don't see much at all in terms of evaluation. How is she doing? What's her emotional state? We go through office visit after office visit, including simply a notation for prescription after prescription without any evidence of office visits during these periods of time, as well. So we do not see any close following or monitoring of her condition in any of the documentation at this time.

So what appears is management by a psychiatrist who is trained and generally regarded as the expert in management of these conditions transferred to a family physician who is not attempting to keep the patient on a stable dosage but, instead, allowing increasing doses by prescribing much more frequently than is appropriate, and a lack of documentation which implies a lack of evaluation of her condition.

(Tr. at 698-699)

79. Dr. Sickles acknowledged that he had seen documentation of premature refills in this case. Dr. Sickles further acknowledged that he had not seen documentation of discussions with the patient concerning the premature refills. (Tr. at 975)

Concerning early refills of medication, Dr. Sickles was asked if he believed that Dr. Kirkland's treatment was with the standard of care. He replied,

I think that what the standard requires is for the physician to discuss these premature requests for refilling the medications and discussions with the patient regarding why they're requiring additional medication.

And so if—For that particular issue, I guess I have to make the assumption that that, indeed, was taking place by Dr. Kirkland for her to meet the requisite standard of care as I would view it in terms of these premature refills of prescriptions.

(Tr. at 985-986) When asked why he made that assumption, Dr. Sickles replied,

Again, that's one of those things where, again, we talked about various options when patients come in and—and how things have to happen. Again, if I'm going to be able to testify that she met the requisite standard of care, then I think I probably have to make that assumption, that those conversations

were ongoing. Because as I testified, I think if you're not at least discussing with the patient the reasons why they're requiring premature refills, then that doesn't meet the standard of care.

(Tr. at 986) Finally, when asked if there was documentation of those discussions in Dr. Kirkland's medical record for Patient 3, Dr. Sickles acknowledged that there was not.
(Tr. at 986)

Drug-Seeking Behavior

80. Dr. Kirkland's medical record for Patient 3 documents what may be construed as drug-seeking behavior on the part of Patient 3. Specifically,

- On August 21, 1985, Patient 3 reported that she had lost her prescription. (St. Ex. 3 at 3b)
- On November 21, 1988, she reported that her purse and jacket had been stolen along with her prescriptions. (St. Ex. 3 at 9a)
- On August 21, 1989, a pharmacist called Dr. Kirkland's office and an early refill of Xanax was authorized. (St. Ex. 3 at 9b)
- On April 6, 1995, the patient was noted to be "one week early on Vicodin." (St. Ex. 3 at 16a)
- On July 16, 1996, the patient reported that her medications had been stolen. (St. Ex. 3 at 18a)
- On September 25, 1997, the patient reported that a fire alarm had gone off and the patient's purse was stolen. (St. Ex. 3 at 20a)

During and following each of these visits, Dr. Kirkland continued to prescribe Xanax to Patient 3 on a regular basis, along with Vicodin on a number of occasions. No discussion with Patient 3 concerning possible drug-seeking behavior was documented. (St. Ex. 3 at 3b, 9a, 9b, 16a, 18a, 20a)

81. Dr. Winter testified that each of the episodes noted above would be a cause for concern, and would warrant a discussion with the patient. Dr. Winter testified that if she were confronted with a patient who was exhibiting drug-seeking behavior, she would discuss with the patient whether the patient feels he/she needs more medication than he/she is receiving, or if she could help the patient some other way. Dr. Winter testified that "[t]here are a lot of constructive ways that this can be dealt with with the patient." Dr. Winter further testified that such discussions should be documented in the medical record.
(Tr. at 286-287)

82. With regard to documentation concerning reports of lost prescriptions and a call from a pharmacist who was concerned about Patient 3's medications, Dr. Sickles acknowledged that, "There's no question those would be red flags for [potential drug-seeking] behavior * * *." (Tr. at 986-987) Dr. Sickles further testified that, for one of his patients, "by the time we got to the third or fourth incident, in all likelihood, I would not give them a refill on the prescription." Dr. Sickles added that, at the very least, he would refuse to refill the prescription until the refill was due. (Tr. at 988-989)
83. Dr. Kirkland testified that, because the incidents of possible drug-seeking behavior had not followed each other closely in time, she had probably not recalled that these events had happened before. Dr. Kirkland acknowledged that it would be good to have a system whereby such files would be flagged to note that the patient may be drug seeking. However, Dr. Kirkland further testified, "I'm not prescribing pain medicine anymore, though, so it's not going to be an issue with me." (Tr. at 86-88)

Failure to Document Visits

84. On several occasions when prescriptions for controlled substances were issued, Dr. Kirkland failed to document whether Patient 3 had been seen in the office or had called the office requesting a prescription. This occurred on September 2, October 3, and November 17, 1988; March 27 and April 7, 1989; July 10 and November 29, 1990; April 16, 1991; March 5, 1992; February 25, 1993; and July 2, 1996. (St. Ex. 3 at 8b-9b, 11a, 11b, 12b, 13b, 15a, and 18a)

Conclusions Regarding Dr. Kirkland's Care of Patient 3

85. Dr. Winter testified that, in her treatment of Patient 3, Dr. Kirkland had failed to use reasonable care discrimination, or had failed to employ acceptable scientific methods, in the selection of drugs or other modalities for the treatment of disease. Dr. Winter further testified that Dr. Kirkland's treatment of Patient 3 had departed from the minimal standard of care. (Tr. at 278, 292-293)
86. Dr. Sickles testified that Dr. Kirkland's treatment of Patient 3 had conformed to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Sickles further testified that Dr. Kirkland had used reasonable care discrimination and acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. (Tr. at 858-859)

Dr. Sickles testified that Patient 3 had had severe problems, as well as chronic anxiety and depression that was severe enough to require hospitalization. Dr. Sickles further testified that Dr. Kirkland had attempted to modify the dosages of Patient 3's medications during times when Patient 3 was doing better. Dr. Sickles testified that, at other times, the patient

wasn't doing as well and was taking "fairly high doses" of medications such as Xanax. Dr. Sickles further testified,

[T]hese can be oftentimes very difficult patients to manage. But it appeared to me that Dr. Kirkland made a reasonable attempt over the years to try and control this lady's symptoms, keep her out of the hospital, keep her somewhat functioning in what sounded like a pretty pathologic psychosocial environment that she was in; again, based on what I can glean from bits and pieces in the records with problems with family and so forth.

And, again, these are always difficult patients. But at some point you have to, as a physician, decide what's in the best interest of this patient: For me to try and continue to manage them, work with them, deal with these difficult problems; or am I going to sever the relationship because the patient's not willing to work with me in a way I'm comfortable.

(Tr. at 859-860)

87. Dr. Kirkland testified that she does not believe that she had prescribed excessive quantities of Xanax and Vicodin to Patient 3. Dr. Kirkland further testified that Patient 3 had legitimate, documented back problems. Moreover, Dr. Kirkland testified that she had had continuing discussions with Patient 3 concerning the nature of the medication she was prescribing, and the potential effects of them. (Tr. at 94-95, 1117-1118)

Further, Dr. Kirkland testified that she had correctly and appropriately diagnosed Patient 3's conditions during the course of her treatment. Dr. Kirkland also testified that those diagnoses had been confirmed by specialists and by objective studies. Finally, Dr. Kirkland testified that the treatment she offered Patient 3 for those conditions had been appropriate. (Tr. at 1118)

Patient 4

88. Patient 4 is a male born January 5, 1951. Dr. Kirkland first saw Patient 4 in July 1994. (St. Ex. 4 at 2a; Tr. at 95)

Hospital documents dated November 1997 that are included in Dr. Kirkland's medical records for Patient 4 indicates that Patient 4 had undergone spinal fusion in 1993, prior to seeing Dr. Kirkland. Further, in May 1995, during the period that Dr. Kirkland treated him he fell and fractured his pelvis and right wrist. Patient 4 had four plates placed into his pelvis, as well as wrist surgery with placement of an external fixator. (St. Ex. 4 at 13, 23)

Dr. Kirkland's Prescribing of Vicodin to Patient 4

89. At Patient 4's first visit to Dr. Kirkland's office on July 5, 1994, Dr. Kirkland noted, "F/U meds (Prozac/Vicodin) "Long term back pain." No examination findings are documented

other than “chest-clear,” “Heart NSR,” and “Abd benign.” Dr. Kirkland diagnosed herniated disc and prescribed, among other things, Vicodin ES #100, to be taken every eight hours as needed. (St. Ex. 4 at 2a) Dr. Kirkland continued prescribing Vicodin or Vicodin ES to Patient 4 on at least a monthly basis with varying dosing frequencies through the last visit on record, January 5, 1998. (St. Ex. 4 at 2a-11a)

On August 4, 1994, Patient 4’s next visit, Dr. Kirkland noted that the patient reported that his right leg had been numb since he jumped off a scaffold two weeks earlier. Dr. Kirkland repeated the prescription for Vicodin ES #100, to be taken every eight hours as needed. On August 25, 1994, Dr. Kirkland increased the dosing frequency to every 6 hours. Subsequently, on September 22, 1994, she prescribed Vicodin [not ES] #100, to be taken every six hours. Dr. Kirkland repeated this prescription on a monthly basis—or slightly more frequently than monthly—through June 19, 1995, when she substituted Vicodin ES for Vicodin. On August 1, 1995, the dosing frequency was increased to two pills every six hours. At the following visit, August 14, 1995, Dr. Kirkland prescribed a dosing frequency of one or two pills every six hours. This continued through October 23, 1995, when the dosing frequency was decreased to three times per day. Subsequently, on December 11, 1995, the dosing frequency was decreased to three times a day as needed, and Vicodin was substituted for Vicodin ES. (St. Ex. 4 at 2a-5b)

Subsequently, on January 2, 1996, Dr. Kirkland prescribed Vicodin to be taken every eight hours as needed. The quantity prescribed at that visit was #100. That same dosing frequency continued until March 11, 1996, when Vicodin ES was substituted for Vicodin. Such prescribing continued until June 11, 1997, when the dosing frequency was increased to every six hours as needed. Dr. Kirkland continued Patient 4 on that dosage through the final visit on record. (St. Ex. 4 at 5b-11a)

Throughout her treatment of Patient 4, Dr. Kirkland failed to document her evaluation or assessment of Patient 4’s back pain. Further, although Dr. Kirkland’s progress notes occasionally reference arthritis as a problem for Patient 4, there is no documentation of Dr. Kirkland’s evaluation or assessment of that condition. Moreover, although Dr. Kirkland sometimes referenced complaints such as tender lower back, there is a lack of documentation of objective information concerning Patient 4’s condition, with a few exceptions. Exceptions include a June 19, 1995, note that Patient 4 had shattered his right hip and wrist in a fall; a December 26, 1995, note that Patient 4 had broken an arm during physical therapy; a February 13, 1996, note that Patient 4 was “moving better”; and an October 23, 1997, note that Patient 4 had decreased range of motion, although that note did not specify where or to what degree Patient 4’s range of motion had decreased. (St. Ex. 4)

Further, although there is a notation dated August 25, 1994, that Patient 4 needed an MRI of his back, there is no documentation of such MRI. Finally, there is no documentation in the medical record of any diagnostic study of Patient 4’s back or for arthritis. (St. Ex. 4)

90. There are a few documented examples of what could be construed as drug-seeking behavior or inappropriate use of medication by Patient 4. On August 1, 1995, Dr. Kirkland

documented that Patient 4 had been taking two Vicodin ES every six hours, rather than one every six hours as prescribed, evidently because of pain in his right leg. Dr. Kirkland's response at that visit was to issue a prescription for Vicodin ES #100 with a dosing frequency of two every six hours. (St. Ex. 4 at 4b)

Subsequently, on December 11, 1995, Dr. Kirkland noted that Patient 4 had been taking four Vicodin ES per day, instead of three per day as prescribed. Dr. Kirkland reduced his dosage to Vicodin (rather than Vicodin ES), and instructed him to reduce his intake to three per day as needed. Dr. Kirkland later increased Patient 4's dosage back to Vicodin ES on March 11, 1996, and increased his dosing frequency to every six hours on June 11, 1997. (St. Ex. 4 at 5b-11a)

On December 12, 1996, Dr. Kirkland prescribed Vicodin ES #90 to be taken three times per day as needed. On December 16, 1996, Dr. Kirkland noted that Patient 4 had informed her that he had left his prescription in a grocery cart. Dr. Kirkland re-issued the prescription. (St. Ex. 4 at 8b)

Finally, on April 7, 1997, Dr. Kirkland noted that she had advised Patient 4 that he was "taking too much meds." (St. Ex. 4 at 9b)

91. Dr. Kirkland frequently provided Patient 4 with early refills of prescriptions for Vicodin or Vicodin ES, with no explanation. For example, on July 22, 1996, she prescribed Vicodin ES #90 to be taken every eight hours as needed. Assuming that Patient 4 needed to take the medication around the clock, that prescription should have lasted thirty days. However, the same prescription was issued seventeen days later on August 8, 1996, with no explanation for the early refill. The prescription was repeated twenty-one days later on August 29, 1996, again with no explanation. Subsequently on September 19, 1996, twenty-one days later, she again repeated the prescription without explanation. After another nineteen days, on October 8, 1996, it was issued again with no explanation. This pattern of early refills of Vicodin or Vicodin ES occurred almost continuously throughout Dr. Kirkland's care of Patient 4. (St. Ex. 4 at 2a-11a. For examples of early refills, see St. Ex. 4 at 7b-8a.)
92. Dr. Winter testified that, at Patient 4's first visit with Dr. Kirkland on July 5, 1994, he had requested refills of his medications, Prozac and Vicodin. The diagnosis rendered by Dr. Kirkland at that visit was herniated disc. Dr. Winter testified, "There isn't any thorough physical exam or exam of studies that have been done to substantiate this; so most likely, I would assume that this is what the patient told Dr. Kirkland." Moreover, Dr. Winter testified that it is acceptable to continue new patients on their medications for a few visits until the physician gets to know them. Accordingly, Dr. Winter testified that she did not have a problem with Dr. Kirkland's initial prescriptions for Vicodin. (St. Ex. 4 at 2a; Tr. at 293-295)

Dr. Winter testified that Patient 4 was placed on pain medication, and until later in his care, around 1997, nothing else was done to improve his condition. "It's not an appropriate

regimen for chronic, long-term pain. * * * He is not receiving appropriate modalities for improving his pain. He is not going through physical therapy. He is not in a strengthening program.” (Tr. at 592-594)

93. Dr. Kirkland testified that, when she first saw Patient 4 on July 5, 1994, he had given a history of long term back pain. She further testified that, even though it is not documented in the medical record, she had performed an examination of Patient 4’s back during that visit. Dr. Kirkland acknowledged, however, “if you looked at [this record], you couldn’t tell what I did.” (St. Ex. 4 at 2a; Tr. at 95-96)

Dr. Kirkland testified that she had not ordered imaging studies of Patient 4’s back at that time, and stated that she does not usually do that with patients the first time that she sees them. Dr. Kirkland further testified that Patient 4 had been hospitalized previously and had had x-rays done at that time. However, Dr. Kirkland testified that she did not have copies of those x-rays in her medical record for Patient 4. (Tr. at 96-97)

Dr. Kirkland testified that she had ordered an MRI on Patient 4 in August 1994; however, because Patient 4 was a Bureau of Workers Compensation [BWC] case, prior approval was needed. Dr. Kirkland testified that the MRI was never done. (Tr. at 98)

94. Dr. Kirkland testified that, in June 1995, after Patient 4 had fallen and broken his right hip and wrist, she had attempted other methods to control Patient 4’s pain. Dr. Kirkland further testified that a note written by her husband dated October 4, 1995, references the fact that Patient 4 had been receiving physical therapy. Dr. Kirkland further testified that Patient 4’s arm was broken during physical therapy in December 1995. (St. Ex. 4 at 3b, 5a, 5b; Tr. at 102, 1088-1089)

95. With regard to her December 16, 1996, entry that Patient 4 had left his medication in a grocery cart, Dr. Kirkland testified that she had not believed that Patient 4 was drug-seeking. Dr. Kirkland further testified that she had seen Patient 4 for two years. Moreover, Dr. Kirkland testified that, if she hadn’t refilled his medication, with as much pain as Patient 4 had, he would have had to go to an emergency room. (Tr. at 108)

Moreover, concerning her April 7, 1997, entry that she had advised Patient 4 that he was taking too much medication, when asked why she had not reduced the amount of Vicodin prescribed, Dr. Kirkland replied that “this gentleman was in a lot of pain with all the injuries he had had. I can advise it. But whether they can do it or not is a different story a lot of times.” (St. Ex. 4 at 109)

96. Dr. Kirkland testified that when she first prescribed narcotic pain medication to Patient 4, she had discussed with him the nature and purpose of the medication. Dr. Kirkland further testified that she “told him it was controlled and that [she] wanted to keep him on the least possible dose.” (Tr. at 1089-1090)

97. Concerning Patient 4's requests for early refills of medication, Dr. Kirkland was asked what discussions, if any, she had had with Patient 4 on those occasions. Dr. Kirkland replied,

I had discussions with him that I didn't want him to be taking a lot of pain medicine. And this is documented in my records that I had discussions with him to try and decrease his pain medication. But this patient had significant injury. This was not somebody with just a slight back strain. He had had several back surgeries. He had had a significant fracture with plates in his—in his pelvis, and he had documented nerve damage.

(Tr. at 1094)

98. A series of laboratory reports concerning Patient 4 listed high values for total cholesterol. In response, Dr. Kirkland prescribed cholesterol-lowering medication. However, Patient 4's medical records indicate that he was not always compliant in taking his medication. For example, on March 23, 1995, Dr. Kirkland noted "didn't take chol meds." (St. Ex. 4 at 3b) Further, a handwritten note on a laboratory report states, "Take meds. Chol up." (St. Ex. 4 at 19) A handwritten note on another laboratory report states "take chol meds!" (St. Ex. 4 at 17)

99. In her written report, Dr. Winter stated, "On his laboratory monitoring for hyperlipidemia, his total cholesterol values were noted to range from 238 to 358 while on medication, which should alert the physician to questions of medical compliance. This was not addressed." (St. Ex. 12 at 9)

Dr. Winter testified that a lack of compliance with medications is often "a red flag in people who tend to abuse alcohol." Dr. Winter further testified that Patient 4's lack of compliance concerning his cholesterol medication was noted on multiple occasions. (Tr. at 584-585)

100. Dr. Kirkland testified that Patient 4 had suffered from elevated cholesterol. Dr. Kirkland testified that she had first tried to treat it with diet, then medication. Dr. Kirkland testified that the medication was expensive, and was either not covered or minimally covered by Patient 4's insurance. Dr. Kirkland testified that she had tried to give him samples and to encourage him to take his medication, but he was nevertheless noncompliant. (Tr. at 1091-1092)

101. With regard to financial considerations as an element in Patient 4's noncompliance, Dr. Winter testified that, "[i]f that were the case, I would expect it to be more consistently noncompliant." Dr. Winter further testified that there was no documentation in the chart that Patient 4 was noncompliant due to financial considerations. (Tr. at 585-586)

102. A series of laboratory reports concerning Patient 4 listed high values for GGT, although two listed normal values:

Date	GGT Value	Normal Range	Result
08/26/94	86 IU/L	7-65 IU/L	High
07/14/95	53 IU/L	7-65 IU/L	Normal
11/07/95	89 IU/L	0-65 IU/L	High
02/14/96	106 IU/L	0-65 IU/L	High
07/02/96	93 IU/L	0-65 IU/L	High
02/04/97	57 IU/L	0-65 IU/L	Normal
11/18/97	122 IU/L	0-65 IU/L	High

(St. Ex. 4 at 16, 22, 33a, 38a, 43a, 48, 53)

Two laboratory reports listed values for red blood cell indices:

Date	MCV	Normal Range	MCH	Normal Range
08/07/96	97 fL	81-95 fL	33.5 pg	27-33 pg
02/04/97	94.1 fL	87 ± 7 fL	32.8 pg	29 ± 2 pg

(St. Ex. 4 at 22, 25a)

103. In her written report, Dr. Winter stated that “elevated red blood cell indices and a frequently elevated GGT brings into question possible excessive alcohol intake in a patient with excessive use of narcotics.” (St. Ex. 12 at 9)

Dr. Winter testified that Patient 4’s elevated GGT, by itself, would not lead her to believe that the patient abused alcohol. “However, combined with a number of other factors concerning his care, one might use that as—to make one’s suspicions stronger. And that’s the significance of the GGT.” (Tr. at 582-583)

104. Dr. Kirkland testified that, on some occasions, Patient 4’s GGT level was elevated, but at other times it was not. Dr. Kirkland testified that GGT is a liver enzyme that can indicate if the patient has liver disease. Moreover, Dr. Kirkland testified that GGT can be elevated in patients who abuse alcohol. However, Dr. Kirkland testified that she had never smelled alcohol on Patient 4, and that she does not believe that Patient 4 had an addiction problem. (Tr. at 114-116) Finally, Dr. Kirkland testified, “The patient was taking medications that could have caused some elevation of his liver enzymes both in the cholesterol medication and the pain medicine. And I wasn’t concerned about it. I felt like he had anemia of chronic disease.” (Tr. at 1095)

105. Dr. Winter testified that the fact that Dr. Kirkland had never smelled alcohol on the patient's breath does not change Dr. Winter's opinion. Dr. Winter testified that patients who smell of alcohol when they come to the doctor's office "are [by that time] pretty far into alcoholism." Dr. Winter testified that alcoholics generally do not exhibit such obvious signs of the disease until very late in the progression of the disease. (Tr. at 302)
106. Dr. Sickles testified that "GGT is a very nonspecific, very sensitive liver enzyme that can be elevated from innumerable things." Dr. Sickles further testified that Patient 4's GGT level was "only minimally elevated on a few occasions." Dr. Sickles testified that that could have resulted from his cholesterol medication, or "from taking a couple ibuprofen." Moreover, Dr. Sickles testified that the GGT level of alcohol abusers is much higher, and is also accompanied by elevated AST and ALT values. Dr. Sickles testified that, in his opinion, it is "highly unlikely that this gentleman was a long-term abuser of alcohol based on the elevation of liver enzymes." (Tr. at 837)
107. Dr. Winter disagreed that Patient 4's cholesterol medication had cause the elevated GGT. "Cholesterol medication generally elevates the other LFTs [liver function tests] more than GGT." (Tr. at 583)
108. Dr. Sickles testified that an elevation of red blood cell indices typically indicates that the patient is suffering from end-stage alcoholism. However, Dr. Sickles further testified that, based on Patient 4's other normal liver enzymes, he does not believe that the mildly elevated values present had anything to do with alcohol abuse in this case. (Tr. at 837-838)

Conclusions Regarding Dr. Kirkland's Care of Patient 4

109. Dr. Winter testified that Dr. Kirkland had prescribed Vicodin to Patient 4 throughout his treatment, and that that prescribing had been excessive, and had increased over time. Dr. Winter further testified that it had been excessive because she had used Vicodin to treat a chronic problem. "In general, narcotic medication is best not used in that manner." Moreover, Dr. Winter testified that the dosing frequency increased over time from every eight hours to every six hours. (Tr. at 295-296)

Dr. Winter explained why she does not believe Vicodin is best used on a long-term basis,

When people have long-term pain, if it is from a musculoskeletal problem, which it appears to be in this case, there are many better modalities that actually improve the pain. Physical therapy, anti-inflammatory medications can decrease pain, improve function, strengthening. The problem—One of the problems, besides addiction, with narcotic pain medications is that patients develop a tolerance to it where it does not cover their pain as well as previously. And it is not improving their condition in any way to continue an addicting substance as this occurs.

(Tr. at 296-297)

Dr. Winter further testified that Patient 4 had received prescriptions for Vicodin too frequently for the dosage being prescribed, “[s]o he was either using, selling, or in some other way consuming those medications. That suggests some problem with control and compliance.” Dr. Winter further testified that there were multiple notations of poor compliance with other medications such as cholesterol medications. Dr. Winter testified that that suggests “that the patient did what he wanted to do.” Moreover, Dr. Winter testified that Patient 4 had some abnormal blood values, including elevated GGT, which Dr. Winter testified is a marker for liver damage. Dr. Winter testified that that is frequently due to alcohol use, although other things can cause it. Finally, Dr. Winter testified that Patient 4’s red blood cell indices were large and had a lot of hemoglobin. Dr. Winter testified that such macrocytic changes in the blood are caused mainly by two things, either vitamin B-12 deficiency or by alcohol abuse, and that these warning signs of abuse should have been noted in the medical record. (Tr. at 300-302)

Moreover, Dr. Winter testified that Dr. Kirkland had not paid adequate attention to drug-seeking behaviors, and had not obtained confirmatory studies or evaluations concerning Patient 4’s medical problems. Dr. Winter further testified that Dr. Kirkland had “failed to note probable signs of medication abuse or other substance abuse problems.” (Tr. at 295)

Finally, Dr. Winter testified that, even though Patient 4 had first presented to Dr. Kirkland on July 5, 1994, the first indication that Dr. Kirkland had examined Patient 4’s back did not occur until January 22, 1996, when she wrote, “tender lower back.” Even so, Dr. Winter testified that she could not tell if that had been an examination—which would have been inadequate—or Patient 4’s complaint. (St. Ex. 4 at 5b; Tr. at 297)

110. Dr. Sickles testified that, in his opinion, Dr. Kirkland’s treatment of Patient 4 had conformed to the minimal standard of care for similar practitioners under the same or similar circumstances. Dr. Sickles further testified that Dr. Kirkland had used reasonable care discrimination and employed acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. (Tr. at 824-825)

Dr. Sickles testified that Patient 4 had had a history of significant injury including back surgery, pelvic fracture, and wrist fracture. Dr. Sickles testified that such patients are at high risk of developing chronic pain problems. Dr. Sickles further noted that other physicians had been consulted, and other treatment modalities had been attempted. For example, Dr. Sickles noted that Patient 4 had been treated with antidepressant medication and physical therapy, and even suffered an arm fracture during a physical therapy session. Accordingly, Dr. Sickles testified that Dr. Kirkland had been within the standard of care to prescribe various narcotic pain medications to help control Patient 4’s pain. (Tr. at 824-826)

Dr. Sickles further testified that the dosages of pain medication prescribed to Patient 4 by Dr. Kirkland had been appropriate. (Tr. at 827)

Dr. Sickles acknowledged that there had been problems with Patient 4 in terms of his compliance with taking medication for elevated cholesterol. Dr. Sickles stated that elevated cholesterol and blood pressure problems are asymptomatic from the patient's perspective, and a lot of patients are in denial concerning those issues. Dr. Sickles further noted that the medications available to treat those problems also tend to be expensive. On the other hand, Dr. Sickles noted that pain is a powerful motivator for patients to take their medication. Accordingly, Dr. Sickles testified that, although there is evidence that Patient 4 was a noncompliant patient, that is not necessarily a red flag concerning how the patient was using his pain medication. (Tr. at 835-836)

111. Dr. Kirkland testified that her diagnoses of Patient 4's medical problems had been correct. Dr. Kirkland further testified that the treatment she provided for those diagnoses had been appropriate and correct. Finally, Dr. Kirkland testified that specialists and studies had confirmed the appropriateness of the treatment she had provided Patient 4. (Tr. at 1096)

Patient 5

112. Patient 5 is a female born September 30, 1955. (St. Ex. 5 at 1) Patient 5 was first seen in Dr. Kirkland's practice by Dr. Kirkland's husband on September 6, 1994. (Tr. at 117)

Dr. Kirkland testified that her husband's note for the September 6, 1994, visit states,

Positive pain in the lower back with radiation to the right posterior knee. X-rays done in Tennessee were okay. The patient was treated with physical therapy and medication. Okay until she moved to Dayton recently and increasing pain. Tender—Tender in the LS area. Moves slowly. Positive straight-leg raising on the right. Absent right ankle jerk. And the left ankle jerk was okay. And the knees were okay. The K—the knees, ankle jerks were three plus.

(St. Ex. 5 at 3a; Tr. at 117-118) The note further states that Patient 5 had "chronic back" and "2 bulging discs." (St. Ex. 5 at 3a)

At that visit, Dr. Kirkland's husband ordered an injection of Decadron, bed rest, hot packs, and ultrasound. He prescribed, among other things, Vicodin #30 to be taken every 6 hours. (St. Ex. 5 at 3a; Tr. at 118)

Dr. Kirkland first saw Patient 5 the following visit on September 13, 1994. (St. Ex. 5 at 3a)

113. From September 13, 1994, through February 16, 1996, Dr. Kirkland issued twenty-three prescriptions to Patient 4 for Vicodin, to be taken every six hours as needed, usually in quantities of forty or fifty tablets. The diagnoses during this time included back strain, sciatica, fractured ribs, back pain, and L/S strain. Occasionally, the only diagnosis noted was abdominal pain. (St. Ex. 5 at 3a-6a)

A note dated March 12, 1996, states that a police officer had called and informed Dr. Kirkland that Patient 5 had stolen and forged prescriptions for Percocet from another physician. Dr. Kirkland sent a letter to Patient 5 that day and notified Patient 5 that she was terminating services for Patient 5. (St. Ex. 5 at 2, 6b)

114. Dr. Winter testified that she does not believe that a diagnosis of back strain justifies the medication that Dr. Kirkland prescribed. Moreover, Dr. Winter testified that there is a notation that Patient 5 had had a myelogram five years earlier, but no diagnosis from that myelogram is documented and no copy of the report is in the medical record. In addition, Dr. Winter testified that there is nothing in the medical record to confirm the notation made by Dr. Kirkland's husband on September 6, 1994, that Patient 5 had two bulging discs. (St. Ex. 5 at 3a; Tr. at 306-307)

Dr. Winter further testified that she believes that Dr. Kirkland's prescribing of Vicodin had been excessive both for the condition that it was prescribed for, and because it was continuous. (Tr. at 307)

115. On December 5, 1994, Patient 5's only complaints were stomach cramps, cough, and runny nose for one month, and the only diagnosis rendered was abdominal pain. Dr. Kirkland prescribed Vicodin #50 to be taken every 6 hours as needed. (St. Ex. 5 at 4a)

Dr. Winter testified that Vicodin is not an appropriate medication to treat abdominal pain. The abdominal pain had been going on for one month, and the cause was unknown. Dr. Winter further testified that narcotics are not prescribed for abdominal pain unless the cause is known. (Tr. at 307-308)

Further, the December 5, 1994, entry states that Patient 5 would be leaving until the first of the year and needed her medications. (St. Ex. 5 at 4a) However, Dr. Winter noted that Patient 5 visited Dr. Kirkland again on December 13, 19, and 29, 1994. (St. Ex. 5 at 4b; Tr. at 308-309)

116. On December 19, 1994, Patient 5 saw Dr. Kirkland and complained of having been physically assaulted by her husband on December 16, 1994. She complained of injuries to ribs nine and ten on her right side, to her left elbow, and left temporal area. She further complained that her husband is an alcoholic and "on all kinds of pills." Dr. Kirkland noted that the patient informed her that she had been to an emergency room in Tennessee but had "no films" with her. Dr. Kirkland diagnosed fractured ribs, and prescribed, among other things, Vicodin #50 to be taken every six hours. (St. Ex. 5 at 4b)

Dr. Winter testified that Vicodin may be an appropriate medication for such injuries "[i]f they were severe and well evaluated." However, Dr. Winter testified that she could find no evaluation other than "elbow tender," nor could she find any reports of x-rays that the patient reported had been taken. (St. Ex. 5 at 4b; Tr. at 309-310)

Dr. Kirkland testified that she had not performed an x-ray on Patient 5's ribs, but that Patient 5 had told her that "they were injured. And she was tender." (Tr. at 129-130)

117. Dr. Winter testified that she believes that Dr. Kirkland had not appropriately evaluated Patient 5's complaints of back pain and other injuries, and that she had treated them only with narcotic medication and Soma. Dr. Winter further testified that she could not determine from the medical record whether Dr. Kirkland had assessed Patient 5's response to the controlled substances prescribed. (Tr. at 311)
118. Dr. Winter testified that Dr. Kirkland "did not use appropriate evaluation in selecting her medications for this patient." Dr. Winter testified that she bases this opinion upon Dr. Kirkland's use of Vicodin to treat Patient 5's back pain. (Tr. at 305-306)
119. Dr. Kirkland testified that she had first seen Patient 5 for back pain. The patient gave a history at that time of having two bulging discs, and having been seen in the past by a neurosurgeon. Dr. Kirkland further testified that Patient 5 had "complained of lower back pain with radiation to her right posterior knee." (Tr. at 1146)

Dr. Kirkland testified,

At this time, she had documented disease. She had tenderness in the mid-lumbar spine and lower -- LS area. She was moving slowly, as documented by the notes. She had a positive straight-leg raise and an absent ankle jerk on the right, which to me would indicate she had some nerve problem. And she was treated. She -- hot packs, ultrasound, a shot of Decadron, a muscle relaxant, and pain medicine was ordered for this patient. She was advised to stay in bed for two days.

(Tr. at 1146) Dr. Kirkland further testified that Patient 5 had documented back pain, and "documented nerve damage from the very first visit." (Tr. at 1147)

120. Dr. Kirkland testified that she believes that Patient 5 had legitimate disease, "as noted from the very first visit." Dr. Kirkland further testified that she now believes that Patient 5 was drug-seeking, but had not known that earlier "because she had documented problems to have the drugs." (Tr. at 130-132)

Dr. Kirkland testified that she had discussed with Patient 5 the addictive nature of Vicodin, although such discussion is not documented in the medical record. (Tr. at 132-133)

Dr. Kirkland further testified that her diagnoses and treatment of Patient 5 had been correct and appropriate. (Tr. at 1149-1150)

121. Dr. Sickles testified that, in his opinion, Dr. Kirkland's treatment of Patient 5 had conformed to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Sickles further testified that Dr. Kirkland had used reasonable

care discrimination and acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. (Tr. at 884-885)

Dr. Sickles stated that Patient 5 had presented to Dr. Kirkland with a history of chronic back pain. Moreover, Dr. Sickles testified that the medications and dosages prescribed by Dr. Kirkland were appropriate and within therapeutic ranges. (Tr. at 885-886)

122. Concerning patients who are discovered to be obtaining medication from multiple sources, Dr. Sickles testified that determining the legitimacy of patient's complaints can be difficult. Dr. Sickles further testified that such patients can have legitimate pain complaints, but seek to abuse their medication. Moreover, Dr. Sickles testified that it is almost impossible for physicians to know when a patient is obtaining medication from multiple providers. (Tr. at 887)

Dr. Sickles stated that Dr. Kirkland had determined to discontinue services to Patient 5 when she learned that Patient 5 was obtaining medication from additional sources. Dr. Sickles testified that it also would have been an option to confront the patient, reassess the relationship, and continue treating her. (Tr. at 887-888)

Patient 6

123. Patient 6 is a male born May 10, 1953. (St. Ex. 6 at 1) Dr. Kirkland testified that she had first seen Patient 6 in March 1984. (St. Ex. 6 at 7b; Tr. at 136)

124. On December 6, 1993, Patient 6 saw Dr. Kirkland for the first time since November 1987. At that time, Dr. Kirkland diagnosed hypertension, and prescribed, among other things, Ativan 1 mg #30, to be taken at bedtime. There were no complaints or findings documented relating to that prescription. (St. Ex. 6 at 6a)

Dr. Kirkland acknowledged that she had not documented the reason for the Ativan prescription on December 6, 1993. However, Dr. Kirkland further testified that she did so the following visit on December 14, 1993. At that time, Dr. Kirkland documented that Patient 6 had stress related to a divorce. Dr. Kirkland testified that Patient 6 had been anxious and depressed because his wife had had an affair and was divorcing him. Dr. Kirkland acknowledged, however, that she had not included anxiety as a diagnosis. (St. Ex. 6 at 5b; Tr. at 138-140)

125. Beginning January 10, 1994, Dr. Kirkland continuously prescribed Xanax to Patient 6 in varying dosages and dosing frequencies. Diagnoses recorded were stress, hypertension, and/or anxiety. (St. Ex. 6 at 2b-7b)
126. Dr. Winter noted that Dr. Kirkland had treated Patient 6 from 1984 until 1987, followed by a six-year gap. When Patient 6 returned to Dr. Kirkland's practice on December 6, 1993, Dr. Kirkland prescribed Ativan 1 mg #30 to be taken at bedtime. Dr. Winter testified that she could not determine from the medical record the reason for prescribing Ativan to

Patient 6. She stated that Ativan could be used as an adjunct for treating hypertension in some cases, but that that is not a common use for it. (St. Ex. 6 at 6a; Tr. at 313-314)

127. Dr. Winter described what the standard of care requires to justify a prescription for Xanax to treat stress,

The standard of care would involve some information about the stress itself, what it is like, describing the stress; what physical symptoms it brings on, if any, with the patient; the duration; previous history of stress and how those were managed; as well as a good physical exam, eliminating some of the other causes of any physical symptoms that might be interpreted as stress.

(Tr. at 316)

128. On April 8, 1996, Dr. Kirkland documented that Patient 6 had been using cocaine for a year, and had been hospitalized and released the previous week. Dr. Kirkland further documented that Patient 6 was in withdrawal, although the signs and symptoms that led to that conclusion were not documented. Dr. Kirkland further documented a telephone conversation she had had that day with a Dr. Al-Samkari, the physician who had treated Patient 6 during his hospitalization, and noted that he had advised her to give Patient 6 Valium if Patient 6 had withdrawal. The medical record indicates that Dr. Kirkland instead prescribed Xanax 0.5 mg #10, to be taken three times per day, and to follow up on Thursday. (St. Ex. 6 at 2b)

A discharge summary from Miami Valley Hospital indicates that Patient 6 had been admitted on April 1, 1996, and discharged on April 4, 1996. The diagnoses noted were “[d]epression secondary to chemical dependency, cocaine and Xanax abuse; cocaine and Xanax abuse, addiction; [and] avoidant personality disorder.” (St. Ex. 6 at 15) Moreover, the history states, among other things, that the patient had a

history of cocaine abuse, inadvertent withdrawal, and depression with suicidal ideation. He went through a similar cycle in 1994 at which time the Kettering Police took a gun from him that he intended to use to kill himself. He promised at that time to seek treatment, but did not. * * * His physical examination was performed shortly after admission by Dr. Al-Samkari who also performed a chemical dependency evaluation, finding him drug dependent on cocaine, with drug withdrawal symptoms related to cocaine and Xanax.

(St. Ex. 6 at 14) Moreover, the discharge summary indicates that Patient 6 had been detoxified using Valium, that Xanax was discontinued, Prozac 20 mg was continued, and Trazodone or Desyrel 50 mg daily was added to help Patient 6 sleep. The summary indicates that Patient 6 did well during his hospitalization. (St. Ex. 6 at 14-15)

129. On April 11, 1996, Patient 6 saw Dr. Kirkland and she prescribed Xanax 0.5 mg #10, to be taken twice per day. (St. Ex. 6 at 2b)

Dr. Kirkland testified that she never prescribed Xanax to Patient 6 again after April 11, 1996. (St. Ex. 6 at 2a; Tr. at 146)

Patient 6 saw Dr. Kirkland on three more occasions. At one visit on May 9, 1996, Dr. Kirkland noted that Patient 6 had been hospitalized for “another cocaine relapse. Subsequently, on June 3, 1996, Patient 6 complained of back pain and requested Percocet or Vicodin; Dr. Kirkland prescribed Motrin. Patient 6’s final visit was June 10, 1996. (St. Ex. 6 at 2a)

130. When asked why she had prescribed Xanax to Patient 6 on April 8, 1996, Dr. Kirkland testified that she had called Dr. Al-Samkari and told him that Patient 6 “was going into withdrawal.” Dr. Kirkland testified that the symptoms of Patient 6’s withdrawal were that “the patient was diaphoretic and he was shaking.” Dr. Kirkland acknowledged that those symptoms had not been recorded in the medical record, but that she can remember seeing the patient in her office. (Tr. at 143-144) Dr. Kirkland further testified,

Patient 6 had been given a prescription for the Xanax back in March 18th of ‘96. When he went home, since the trazodone wasn’t working, he resumed his Xanax. And so in order for me to prevent the withdrawal, I gave him medication for three days, slowly decreasing the medication over five days, and then I never gave him any more medication.

(Tr. at 144-145) Dr. Kirkland further acknowledged that this explanation had not been documented in the medical record. (Tr. at 145)

131. Dr. Winter testified that she finds Dr. Kirkland’s treatment on April 8, 1996, to be problematic because, four days after Patient 6’s release from detoxification and treatment, Dr. Kirkland documented that Patient 6 was in withdrawal and prescribed Xanax 0.5 mg #10 to be taken three times per day. Dr. Winter testified that, at that point, Patient 6 should have completed detoxification and not been in physical withdrawal. Dr. Winter testified that she is concerned “because there’s no documentation of what signs of withdrawal he is showing; how is this decision determined.” (Tr. at 319-322)

Dr. Winter testified that the fact that Dr. Kirkland has more than twenty years of practice experience does not mean that she can recognize the symptoms of withdrawal when she sees them. Dr. Winter testified that many experienced physicians have never seen a patient in withdrawal, or may have seen it only on a limited basis during their training. Dr. Winter further testified that, in any case, there must be an evaluation and documentation of that evaluation. Dr. Winter testified that, with regard to Patient 6, there was no explanation of how the patient was evaluated. Moreover, Dr. Winter testified that the notation of

withdrawal is a diagnosis, and there is no supporting documentation of patient symptoms or other evaluation to support that diagnosis. (Tr. at 729-741) Finally, Dr. Winter testified,

This question of whether the patient is in withdrawal is key. Either she prescribes an addicting substance to a recently detoxified patient, which runs a tremendous risk of restarting that addiction roaring, or she attempts to manage what she feels is a withdrawal on her own as an outpatient after hospitalization. I—I can't see that that can—that management can be justified.

(Tr. at 741-742) Dr. Winter added that she believes that Dr. Kirkland's intentions had been good.

It is clear that she was planning to decrease the amount of Xanax. She has decreased it from his previous dose. And then at the next visit she decreases it further. I have no problem with the intention to decrease and, you know, attempt to help with managing withdrawal.

However, I have tremendous problem with this diagnosis of withdrawal almost immediately after hospitalization.

* * *

If * * * we were to assume that he physically was in withdrawal, appropriate options might have been to give Valium, as I believe was recommended. The reason for that is that Valium is a different drug from Xanax. He was addicted to Xanax. His body will recognize that immediately and make that with—withdrawal and recovery all that much harder.

Or she can return him to the hospital for supervised withdrawal. Those are two better options than to give the patient quantities of—any quantity of the drug that he was previously addicted to.

(Tr. at 742-743)

132. Dr. Winter testified that, in her opinion, Dr. Kirkland did not appropriately prescribe Xanax to Patient 6, or appropriately monitor such prescriptions for Patient 6. (Tr. at 312)

Dr. Winter further testified that, in her opinion, Dr. Kirkland's management, documentation, and treatment of Patient 6 was inadequate. Dr. Winter noted that Dr. Kirkland had monitored Patient 6's hypertension, but not his depression and anxiety. (Tr. at 323)

133. Dr. Sickles testified that, in his opinion, Dr. Kirkland's treatment of Patient 6 had conformed to the minimal standard of care of similar practitioners under the same or

similar circumstances. Dr. Sickles further testified that Dr. Kirkland had used reasonable care discrimination and acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. (Tr. at 880)

Dr. Sickles further testified that Xanax had been an appropriate medication for Dr. Kirkland to use to treat Patient 6's diagnoses of anxiety and depression. Dr. Sickles testified that Patient 6 had also received Prozac or Zoloft as well. Dr. Sickles noted that, when cocaine addiction was identified, Patient 6 went through treatment and was weaned off Xanax with Valium. When Patient 6 presented to Dr. Kirkland's office following his discharge from treatment and was felt to be in withdrawal, Dr. Kirkland contacted the treating physician at the hospital who recommended Valium. Dr. Kirkland instead decided to give Patient 6 two small doses of Xanax. Dr. Sickles testified that he believed that Dr. Kirkland's use of Xanax to treat Patient 6's withdrawal had been appropriate and within the standard of care. (Tr. at 881-882)

Moreover, Dr. Sickles testified that it is a dilemma for a physician to be presented with an addict who was potentially in withdrawal, such as Patient 6. Dr. Sickles testified that the physician must weigh the chance that the patient is trying to get more Xanax versus the risk to the patient's health if he/she is actually going through benzodiazepine withdrawal, which could potentially be fatal. Dr. Sickles further testified that Dr. Kirkland's giving the patient two small prescriptions of Xanax was appropriate. (Tr. at 882-883)

Finally, Dr. Sickles testified that a family practice physician should be able to recognize the symptoms of withdrawal. With regard to Dr. Kirkland's documentation concerning that diagnosis, Dr. Sickles testified,

I think family physicians should be able to recognize those signs and symptoms. By putting that diagnosis, you make the assumption obviously that she's done some assessment to come to that conclusion or—or diagnosis that the patient's having problems in terms of that. So I'm, again, to some degree, I guess, dependent on Dr. Kirkland's assessment that she was accurate in coming to that conclusion.

(Tr. at 883) However, Dr. Sickles acknowledged that Dr. Kirkland's records for Patient 6's visit on April 8, 1996, indicated that Patient 6's heart had normal sinus rhythm. Dr. Sickles further testified that he would not expect a patient who was in withdrawal to have a normal heart rate. (St. Ex. 6 at 2b; Tr. at 998)

134. Dr. Kirkland testified that she had first seen Patient 6 in March 1984. Dr. Kirkland further testified that "[i]t was not until * * * January of '94 that the patient was started on Xanax. Again, it was a small dosage, .5 milligrams three times a day. * * * The patient was under considerable stress and anxiety, as noted in the chart. He was undergoing a divorce." Dr. Kirkland further testified that she had started Patient 6 on an antidepressant because he had been depressed. (Tr. at 1140)

Dr. Kirkland further testified that, in the beginning, the prescriptions had not been given on an ongoing basis. Dr. Kirkland testified that she had followed Patient 6 closely and saw him monthly for his prescriptions. (Tr. at 1140-1141)

Dr. Kirkland testified that Patient 6's blood pressure was elevated, and that that condition had been aggravated by his stress. (Tr. at 1141)

Dr. Kirkland testified that in November 1995, Patient 6 had been depressed and crying. Dr. Kirkland testified that he had not been suicidal at that time. Dr. Kirkland testified that "he seemed to be able to cope or at least able to work with his Xanax." (Tr. at 1141)

135. Dr. Kirkland testified that in April 1996 Patient 6 had informed her for the first time that he had been using cocaine, and had just been released from the hospital. Dr. Kirkland testified that she had believed at that time that Patient 6 was in withdrawal, and called the family practice physician who had treated Patient 6 in the hospital for cocaine dependency. Dr. Kirkland testified,

I relayed to him that the patient was in withdrawal. He suggested we could give him something like Valium to help him through the withdrawal. However, this was the medication that the patient had been discharged on, the Valium. And if it had been effective and if the patient had been taking it, he wouldn't have been in withdrawal in my office, is the way I felt. This was the way I looked at it.

* * * So I elected to give him something that I thought would work, something he had been on before, but something in a lower dose. And my intention was to taper him off of this medication over the next few days.

I was concerned enough about the patient that I saw him back a couple days later. This patient received two prescriptions, both for a minimal amount of pills and in decreasing doses over the next few days.

(Tr. at 1143-1144)

Dr. Kirkland further testified concerning the observations that had led her to believe that Patient 6 had been in withdrawal,

Well, the patient was, like I had said earlier, diaphoretic. You see patients sweating sometimes when they're in withdrawal and they're sort of shaky. And the patient appeared to me to be in withdrawal.

There can be life-threatening consequences if you don't treat something like this. And in my best judgment and my best clinical observation, this is how the patient should have been treated. Not treating him would have been far more risky.

(Tr. at 1144) Dr. Kirkland added that, had Patient 6 been experiencing withdrawal and gone untreated, he could have died. (Tr. at 1144-1145)

136. Dr. Kirkland testified that her diagnoses of Patient 6's conditions had been correct and appropriate, and confirmed by specialists and objective signs. Dr. Kirkland further testified that her treatment of Patient 6's conditions had been appropriate. (Tr. at 1145-1146)

Patient 7

137. Patient 7 is a female born June 24, 1949. (St. Ex. 7b at 1) Dr. Kirkland began treating Patient 7 in November 1983. (Tr. at 148)

Dr. Kirkland's Prescribing of Narcotic Pain Medication to Patient 7

138. Dr. Kirkland first prescribed narcotic pain medication to Patient 7 on December 3, 1984. At that time, she prescribed Tylenol No. 3 #30, to be taken every four to six hours as needed for a diagnosis of abdominal pain of unknown etiology. (St. Ex. 7b at 6a) Thereafter, Dr. Kirkland did not prescribe any more narcotic pain medication until October 1985. (St. Ex. 7b at 6a-6b)

139. In October 1985, Patient 7 was involved in a serious automobile accident involving head trauma for which she was hospitalized for several days. (St. Ex. 7b at 6b)

Dr. Kirkland testified that Patient 7 was admitted to St. Elizabeth Hospital on October 10 and discharged October 17, 1985. Dr. Kirkland's medical record indicates that Patient 7 suffered a head contusion, and a parietal hematoma. (St. Ex. 7b at 6b; Tr. at 148-150)

Dr. Kirkland further testified that she had been the physician who admitted Patient 7 to the hospital. Moreover, Dr. Kirkland testified that the discharge summary that she had dictated stated that Patient 7's accident had caused "shifting of the structures in her head [as shown] on the CAT scan and swelling in the brain." (St. Ex. 7a at 150; Tr. at 151-153)

Dr. Kirkland testified that Patient 7 has had "24-hour chronic headaches since the accident." (Tr. at 151)

140. In addition to headaches, Dr. Kirkland also treated Patient 7 for repeated episodes of syncope, which was diagnosed as seizure disorder following an August 1987 hospitalization. Following that hospitalization, Dr. Kirkland prescribed medication such as Dilantin and Tegretol for Patient 7's seizure disorder. Moreover, throughout her care of Patient 7, Dr. Kirkland referred Patient 7 to specialists, and ordered diagnostic tests, such as skull x-rays and CT scans, concerning Patient 7's headaches and seizures. (St. Ex. 7a and 7b)

141. On October 22, 1985, Patient 7 saw Dr. Kirkland for the first time following her automobile accident. Patient 7 complained of headache, and Dr. Kirkland prescribed Darvocet N-100 #100, to be taken every six hours as needed. (St. Ex. 7b at 6b)

Although Patient 7 occasionally complained of headache from time to time, as well as episodes of syncope and further head contusions, it was not until May 14, 1987, that Dr. Kirkland next prescribed narcotic pain medication to Patient 7. On that day, she prescribed Percodan #30 to be taken every six hours as needed for a diagnosis of head contusion. Subsequently, on July 16, 1987, Dr. Kirkland ordered an IM injection of Demerol 50 mg/Phenergan 25 mg for a diagnosis of headache. On September 18, 1987, she ordered an IM injection of Demerol 75 mg/Phenergan 50 mg for a complaint of severe headache and a diagnosis of seizure disorder. On October 12, 1987, Dr. Kirkland again prescribed Percodan #30; there are no findings or diagnosis for that prescription. On May 3, 1988, she again prescribed Percodan #30 and ordered an IM injection of Demerol 50 mg with Phenergan. The complaint was seizure and severe headache, Dr. Kirkland noted a bruise over the left eye, and diagnosed seizure disorder. Subsequently, on August 22, 1988, she prescribed Percodan #50 and ordered an IM injection of Demerol 75 mg with Phenergan. The diagnosis was "migraine." (St. Ex. 7b at 6b-11b)

Dr. Kirkland continued to prescribe narcotic pain medication to Patient 7 on a regular basis through January 15, 1998, usually Percodan or Percocet, but sometimes Darvocet N-100, Fiorinal No. 3, Vicodin ES, or Duragesic Patch 25 mg. Moreover, Dr. Kirkland continued to administer frequent injections of Demerol and Phenergan or Vistaril through January 19, 1998. The dose of Demerol increased to 100 mg for the first time on October 24, 1991, and remained there. Moreover, the frequency of the Demerol injections increased over time:

- In 1987, two injections were ordered.
- In 1988, two injections were ordered.
- In 1989, two injections were ordered.
- In 1990, five injections were ordered by Dr. Kirkland; Patient 7 received a total of six from the practice.
- In 1991, six injections were ordered.
- In 1992, fifteen injections were ordered.
- In 1993, thirteen injections were ordered by Dr. Kirkland; Patient 7 received a total of seventeen from the practice.
- In 1994, twenty-four injections were ordered by Dr. Kirkland; Patient 7 received a total of thirty from the practice.
- In 1995, twenty-two injections were ordered by Dr. Kirkland; Patient 7 received a total of thirty-five from the practice.
- In 1996, twenty-one injections were ordered by Dr. Kirkland; Patient 7 received a total of twenty-nine from the practice.
- In 1997, twenty-two injections were ordered by Dr. Kirkland; Patient 7 received a total of thirty-four from the practice.

(St. Ex. 7b at 9a-57b) Patient 7 often received multiple injections monthly, and the injections for Demerol were often given the same day as prescriptions for oral narcotic pain medication. (St. Ex. 7b at 9a-57b) For example, in July 1994, Patient 7 received injections of Demerol 100 mg with Phenergan on July 7, 21, 27, and 28. Further, Patient 7 received prescriptions for Percodan #50 on July 7 and July 21. (St. Ex. 7b at 35b-36a) Sometimes the injections were given on consecutive days, as on July 27 and 28, 1994; April 18 and 19, 1995; and June 29 and 30, 1995. (St. Ex. 7b at 36a, 40a, 41b) Furthermore, on one day, September 29, 1994, Patient 7 received two injections of Demerol 100 mg/Phenergan 50 mg from Dr. Kirkland's practice; the first entry that day appears to have been written by Dr. Kirkland's husband, and the second was ordered by Dr. Kirkland, for a complaint and diagnosis of migraine and "never got rid of HA." (St. Ex. 7b at 36b) Finally, Demerol injections were frequently ordered with no documentation of an examination or diagnosis. This includes injections ordered on October 10, 1991; January 2, April 16, and August 27, 1992; and July 27 and 28, 1994. (St. Ex. 7b at 23b, 24b, 25b, 26b, and 36a)

142. In her written report, Dr. Winter stated, in part, as follows concerning Dr. Kirkland's treatment of Patient 7,

This patient suffered from multiple headaches. These were ultimately felt to result from her cervical disease and were appropriately evaluated by consultants. However, Dr. Kirkland provided only narcotic prescriptions or injections for management. Prescriptions included Percodan, Darvocet, Tylenol #3, Fiorinal #3, Percocet, Lorcet Plus, Vicodin ES and Duragesic patch. She received multiple injections of Demerol with Phenergan or Vistaril, often several times monthly, and frequently without documentation of the diagnosis or physical exam. This excessive use of narcotics was unwarranted for this patient's continuing pain. There was no apparent trial of prophylaxis for her headaches until 11/93.

(St. Ex. 12 at 15)

143. As an example, on October 17, 1989, Patient 7 received an injection of Demerol 75 mg and Phenergan 50 mg. No basis for that injection is noted in the medical record. (St. Ex. 7b at 15b)
- Dr. Winter testified that Dr. Kirkland's documentation for that injection would not comply with the Board's rules. (St. Ex. 7b at 15b; Tr. at 345-346)
 - Dr. Kirkland testified that the basis for the injection was recorded elsewhere in her medical record, in that the patient "had had eight major head traumas. She came into the office several times with lacerations all the way to the skull, drenched in blood. My records had a picture of her in one instance." (Tr. at 161) When asked how another physician could tell what that injection had been given for, Dr. Kirkland replied that one would have to look at the whole record. (Tr. at 162-163)

- Dr. Sickles testified that he was unable to tell except by inference from prior visits why the injection had been given. Dr. Sickles acknowledged that that entry contains no documentation of an examination or evaluation of the patient, nor of any reason for the utilization of Demerol at that visit. (Tr. at 959-961)

Dr. Sickles testified concerning whether he would document injections in a similar fashion,

No, this would not be typical of how we would document our charts with patients. Although we don't administer injectable narcotics in our office, either, so it's a bit of a different scenario.

But if a patient comes in for a noncontrolled injection, typically if they don't see the physician, there's still a notation by the nurse as to the diagnosis at least and the medications that are being administered.

(Tr. at 961-962) Dr. Sickles further testified that he does not administer controlled substance injections in his office "[b]ecause the bookkeeping that's required either by the University or State or somebody is prohibitive for us to keep the logs necessary to keep them on site." (Tr. at 962)

144. Concerning the use of Percodan to treat migraine headaches, Dr. Winter testified that, while Percodan does help relieve migraine headaches, other medications are better. Dr. Winter further testified,

In 1988, there were plenty of other migraine medicines that had been around a while. Cafegot, Sansert had been around. Nonsteroidal anti-inflammatories help a lot with analgesics, such as Tylenol. Muscle relaxants along with a mild analgesic helped considerably.

In addition, this is a diagnosis of migraine, but nowhere previously in the chart has the headache been evaluated as far as its characteristics. I could not find in the chart any headache evaluation, which should include a good, thorough description of what the headaches are like, the triggering factors, how it occurs, timing; all kind of details that help determine what type of headache this is.

(Tr. at 339-340)

145. Dr. Sickles testified that it had been appropriate for Dr. Kirkland to treat Patient 7 with narcotic pain medication.

Narcotic pain medication basically is an appropriate intervention for severe headaches of any kind; certainly migraines can fall into that category. In this particular case, I think they—there potentially were other causes for her

headaches besides what I would call true migraines. She certainly had a history of the cervical or neck problems, as well, that could have contributed to her headaches, as well. And, again, the use of abortive therapy with narcotic pain medications for, again, any kind of severe pain, I think, is appropriate.

(Tr. at 807)

Dr. Sickles further testified that Dr. Kirkland had employed treatment modalities other than narcotic pain medication in her treatment of Patient 7. Dr. Sickles testified that she had referred Patient 7 to specialists regarding her seizures and headaches, had tested and treated Patient 7 for allergies, prescribed anti-seizure medication to Patient 7, and utilized abortive therapy for her headaches. (Tr. at 807-808)

Moreover, Dr. Sickles testified that Dr. Kirkland had ordered appropriate diagnostic testing. Dr. Sickles testified that these included CT scans, and consultation with neurologists. (Tr. at 808-809)

Finally, Dr. Sickles testified that he found nothing in the medical record to suggest that Patient 7 had been feigning pain. Dr. Sickles testified that there were subjective and objective findings in the medical record that support Dr. Kirkland's diagnosis and treatment. (Tr. at 809)

146. Dr. Sickles testified that he disagrees with Dr. Winter's report that Dr. Kirkland had prescribed excessive quantities of narcotic pain medication to Patient 7. Dr. Sickles further testified that the dosages that Dr. Kirkland prescribed were consistent with the recommended dosages as stated in the PDR. (Tr. at 810-811)

Dr. Sickles disagreed with Dr. Winter's criticism that Dr. Kirkland had provided only narcotic pain medications to deal with Patient 7's headaches. Dr. Sickles testified that "in this case there were multiple attempts to try numerous different things" to treat Patient 7's pain. Dr. Sickles further testified that changing pain medications is appropriate only when you are "not achieving control with the ones you're utilizing." (St. Ex. 12 at 15; Tr. at 819-820)

Dr. Sickles further testified that when opioid medications are taken for pain, they rarely cause addiction. (Tr. at 817-818)

147. Dr. Sickles acknowledged that he did not find direct documentation where Dr. Kirkland had explored the nature and cause of Patient 7's headaches, or the triggers for those headaches. (Tr. at 957)
148. Dr. Kirkland testified that in June 1986 Patient 7 began having seizures, and further injured her head from falling on several occasions. By July 1990, she had injured her head nine times during these episodes, some of which required hospitalization. Her condition

deteriorated to the point where she had to leave her employment as a respiratory therapist and file for disability. (Tr. at 1071-1073)

Dr. Kirkland testified that Patient 7 continued having seizures in October and November 1990. Dr. Kirkland further testified that, around that time, Patient 7 began receiving injections of Demerol and Phenergan for her headaches. Dr. Kirkland testified that, “if she did not get the shot, she would get severe vomiting and she would start seizing. And this seemed to be the only thing to relieve her pain.” Moreover, Dr. Kirkland testified that she added “some oral medication with the hopes that we would not have to give her the shots, but this was not always the case because once she would start vomiting and seizing, she couldn’t keep the medication down.” (Tr. at 1074-1075)

149. Dr. Kirkland testified that, when she prescribed controlled substance medication to patients, she discussed with them the nature of the medication. “I told them what the — you know, what the drug was for. If it was controlled, I would tell them it’s controlled.” (Tr. at 1070-1071)

150. Dr. Kirkland testified that her treatment of Patient 7 included trials of a number of medications and modalities, diagnostic studies, and referrals to specialists. Dr. Kirkland further testified that none of these medications, surgeries, or modalities proved to be effective in controlling Patient 7’s headaches and seizures. (Tr. at 1069-1084)

Dr. Kirkland’s Use of Steroid Medication in Her Treatment of Patient 7

151. Dr. Kirkland ordered IM injections of steroid medication for Patient 7 as follows:

Date	Medication	Relevant Findings and/or Diagnosis
02/14/85	Celestone 2 cc	Allergies and phlebitis (?)
12/23/88	Celestone 2 cc	Allergies (by Dr. Kirkland’s partner)
01/06/89	Celestone 2 cc	Allergies
05/15/89	Celestone 2 cc	Sinusitis
04/18/91	Celestone 2 cc	Allergies
05/06/91	Celestone 2 cc	Allergies
08/15/91	Celestone 2 cc	Sinusitis
10/24/91	Celestone 2 cc	Complained of sinusitis
01/02/92	Celestone 2 cc	None
01/13/92	Celestone 2 cc	Allergies
02/18/92	Celestone 2 cc	None
03/02/92	Celestone 2 cc	“Allergy inj” (?)
04/06/92	Celestone 2 cc	Sinusitis
05/04/92	Celestone	Seizure (?)
07/07/92	Celestone 2 cc	Sinusitis
08/27/92	Celestone 2 cc	None

Date	Medication	Relevant Findings and/or Diagnosis
09/17/92	Celestone 2 cc	Allergies
09/29/92	Decadron 8 mg	Neck strain
10/01/92	Decadron 8 mg	None
03/25/93	Celestone 2 cc	Migraine (?)
05/25/93	Decadron 8 mg	Fibrositis
06/24/93	Kenalog 40 mg and Xylocaine	Complained of allergies
08/23/93	Celestone 2 cc	Sinusitis
11/15/93	Kenalog 40 mg and Xylocaine	Complained of pain in left arm (?)
03/15/94	Kenalog 40 mg and Xylocaine	Bursitis
04/25/94	Celestone 2 cc	Allergies
05/11/94	Celestone 2 cc	Allergies (by Dr. Kirkland's partner)
05/24/94	Kenalog 40 mg and Xylocaine	Bursitis
06/02/94	Depo-Medrol and Kenalog	Allergies
06/13/94	Depo-Medrol 80 mg and Kenalog 40 mg	Allergies
08/29/94	Celestone 2 cc	Allergies
09/15/94	Depo-Medrol and Kenalog	Allergies
12/27/94	Depo-Medrol and Kenalog	Migraine (?)
02/23/95	Depo-Medrol 80 mg and Kenalog 40 mg	Migraine (?)
04/27/95	Kenalog 10 mg and Xylocaine	Bursitis
07/23/96	Decadron 8 mg	Headache (?)
04/24/97	Depo-Medrol 80 mg	Allergies

(St. Ex. 7b at 6a-51b)

152. In her written report, Dr. Winter stated, in part, as follows,

[Patient 7] received numerous injections of steroids without adequate documentation of her current condition, physical exam and often lacking the diagnosis for treatment. There did not appear to be any concern for the long-term consequences of frequent steroid injections, which are generally limited to one per quarter by most family physicians.

(St. Ex. 12 at 15)

153. As an example, on January 6, 1989, Dr. Kirkland saw Patient 7 for a complaint concerning her sinuses. She diagnosed allergies, and, among other things, administered an IM injection of Celestone 2 cc. Patient 7 had previously received an injection of Celestone 2 cc to treat allergies on December 23, 1988. (St. Ex. 7b at 12b)

Dr. Winter testified that she could not discern from the record how the diagnosis of allergies had been arrived at for that visit. She testified that there had been no evaluation

documented, no history, and no physical examination, only a notation, “sinuses non tender.” Moreover, Dr. Winter testified that the shot of Celestone that was administered that day had been inappropriate. Dr. Winter testified that one shot per season is effective for patients who respond to that medication. (Tr. at 340)

154. With regard to the use of Decadron injections or other steroid injections given for pain, Dr. Winter testified that the standard of care for family practitioners is usually one injection per quarter. Dr. Winter testified that successive administrations over a period of several days is “not how it’s used in family practice.” (Tr. at 561-562)

Dr. Winter further testified concerning the reasons why steroid injections should be limited,

The long-term complications of—can be significant. Most commonly heard and discussed are the development of osteoporosis, and this patient did develop some signs of osteoporosis early on. However, more importantly would be suppression of the adrenal axis. And in a patient if their axis is suppressed, they have no appropriate physical way to respond to stress. And that can be very dangerous.

(Tr. at 326)

155. Dr. Sickles testified that he disagrees with Dr. Winter’s report concerning Dr. Kirkland’s use of steroids in treating Patient 7. Dr. Sickles testified that Dr. Kirkland’s use of steroids to treat both allergy symptoms and headaches had been appropriate. Dr. Sickles further disputed Dr. Winter’s assertion that the use of steroids is limited to one administration per quarter. Dr. Sickles acknowledged that that is true for intra-articular injections; however, “much, much higher doses” of IM injections would have to be given before potential side effects such as osteoporosis or Cushing’s disease would become a concern. Dr. Sickles further testified that the dosages given by Dr. Kirkland had actually been fairly low. (Tr. at 811-813)

156. Dr. Kirkland denied that the steroid injections that she had given to Patient 7 had been inappropriate. Dr. Kirkland testified that,

[Patient 7] did get temporary relief from the steroid shots. Not only did I recommend the steroid shots, the consultants that I sent her to recommended the steroids. She was given Decadron in my office, which is a short-acting steroid. It is not a long-acting steroid. It was given in much lower doses than what neurosurgeons use. It can be given daily. It can be given in higher amounts.

She was also given injections for her allergies no different than what she would have received at the allergist. And he had also evaluated her.

(Tr. at 1086)

Dr. Kirkland's Prescribing of Amoxicillin to Patient 7 After Patient 7 Began Receiving Allergy-Desensitizing Injections for Penicillium Mold

157. On February 6, 1989, Dr. Kirkland's office began administering allergy-desensitizing injections to Patient 7. The allergens in these injections included Penicillium mold. (St. Ex. 7b at 12b)

Dr. Kirkland prescribed amoxicillin on several occasions after the allergy-desensitizing injections began; namely, March 16 and May 15, 1989; May 23, 1991; April 6, July 7, September 10, October 26, and December 1, 1992; May 13, 1993; March 2 and December 5, 1995; January 4 and August 6, 1996; and March 11, 1997. (St. Ex. 7b at 13a-50b) Moreover, on January 23, 1990, Dr. Kirkland prescribed Augmentin. (St. Ex. 7 at 17a)

Note, however, that Patient 7 had also received penicillin prior to starting the allergy-desensitizing injections. For example, on March 11, 1986, Dr. Kirkland prescribed penicillin VK 250 mg #40 to be taken four times per day. (St. Ex. 7b at 7a)

158. Dr. Winter testified that she would be cautious in giving penicillin to a patient with a penicillin mold allergy "because the mold is what makes penicillin." (Tr. at 543) Dr. Winter acknowledged that amoxicillin and Augmentin are not made directly from penicillin mold. However, the chemical similarities "very likely could cause a similar reaction." (Tr. at 544)
159. Dr. Sickles testified that it was apparent that Patient 7 had tolerated amoxicillin prior to receiving any allergy injections for Penicillium mold. Dr. Sickles further testified that he is not surprised that there is no cross-reactivity between Penicillium mold and a synthetic, penicillin-like medication. (Tr. at 818-819)
160. Dr. Kirkland testified that Patient 7 had received allergy-desensitizing injections for Penicillium mold, not for the medication penicillin. Dr. Kirkland further testified that amoxicillin and Augmentin are synthetic, and are not actually made from Penicillium mold. Moreover, Dr. Kirkland testified that Patient 7 had received amoxicillin at her first visit to Dr. Kirkland's office. Finally, Dr. Kirkland testified that Patient 7 had previously received penicillin from her office with no ill effects. (Tr. at 171-172, 1085-1086)

Conclusions Regarding Dr. Kirkland's Care of Patient 7

161. Concerning whether Dr. Kirkland's treatment of Patient 7 conformed to the minimal standard of care, Dr. Winter testified,

[T]he medications selected to treat headaches and pain were almost exclusively narcotic medications until late in her course when some preventive medication was attempted. It was an excessive use of narcotics.

And it appeared unwarranted for her continuing pain. There was no apparent trial of prophylaxis of medicines for headaches until 1993.

The other concern regarding medications is that she received numerous injections of steroids without adequate documentation or physical exam. And there did not appear to be much concern for the long-term consequences of frequent steroid injections. This most physicians try to limit to one per quarter.

(Tr. at 325-326)

Dr. Winter further testified that, in her opinion, Dr. Kirkland had failed to use reasonable care discrimination or evaluation in determining the medications to use in treating Patient 7. (Tr. at 346-347)

162. Dr. Sickles testified that, in his opinion, Dr. Kirkland had conformed to the minimal standard of care in her treatment of Patient 7. Dr. Sickles further testified that Dr. Kirkland had used reasonable care discrimination and employed acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. Furthermore, Dr. Sickles testified that he believes that Dr. Kirkland's documentation had conformed to the minimal standard of care. (Tr. at 806-807, 822)
163. Dr. Sickles testified concerning the documentation required for repeated visits for treatment of chronic conditions. Dr. Sickles testified that there must be evidence in the medical record of the medical condition, and the reason for the treatment. Dr. Sickles stated that he does not believe that "the standard requires you to reiterate repetitively for an ongoing repetitive problem every time" the reasons for giving injections. (Tr. at 820-821)

Dr. Sickles further testified that he does not believe that, if a physician has included in the patient's medical record copies of consultation reports and diagnostic studies, it is still necessary for the physician to summarize that information in the progress notes.

Certainly, again, I think it's appropriate to note that a consultation was done or, you know, when you're sending a patient out, or if the patient comes back to discuss the results of their consultation, to have something in the note that we discussed their consult or something.

But I don't see any point to reiterating all the points that are already in a consultative letter that's—that's in the record. Again, it's there. It's information that's in the chart. Again, if there's some reference to it, I think that's perfectly appropriate; but I don't think you need to go back and rehash everything that's in it.

(Tr. at 823-824)

164. Dr. Sickles testified that he believes that Dr. Kirkland did appropriate follow-up care and physical examinations to monitor patients' chronic conditions. (Tr. at 821)
165. Dr. Kirkland testified that she had appropriately diagnosed the conditions that Patient 7 had suffered from. Dr. Kirkland further testified that her diagnoses had been confirmed by tests. Dr. Kirkland further testified that she had provided appropriate treatment for Patient 7, and that that treatment was confirmed and corroborated by the specialists with whom she discussed Patient 7's care. (Tr. at 1087)

Patient 7's Testimony

166. Patient 7 testified at hearing on behalf of Dr. Kirkland. Patient 7 testified that she has been a patient of Dr. Kirkland's since the early 1980s, and still sees Dr. Kirkland. (Tr. at 620-621)

Patient 7 testified that she had been in good health until she was involved in an automobile accident in 1985 or 1986, in which she suffered a head injury. Following the accident, her "health went to pot." She began having seizures and headaches, "[a]nd it's just been downhill from then with one thing or another." Patient 7 testified that she had worked as a respiratory therapist at St. Elizabeth Hospital in Dayton. After the accident, however, she was unable to remember things or to learn new things. This, coupled with her general poor health, necessitated her going on permanent disability. (Tr. at 622-623, 638)

167. Patient 7 testified that she began having seizures immediately following the accident. At first, she had grand mal seizures that increased in frequency for a time. Patient 7 stated that she now has them as often as every week or two, but can go as long as a month without having one. Patient 7 testified that, more recently, she started also having petit mal seizures, as often as four times per week. (Tr. at 624-625)
168. Patient 7 described her headaches as "[u]nbelievable." Patient 7 further testified that it is "the worst pain [she has] ever had in [her] life." Patient 7 further testified, "if I didn't have pain medicine, didn't get it under control, I couldn't stand it. It felt like my head was going to explode." (Tr. at 623-624) Moreover, Patient 7 testified that, since her accident, she has had such headaches at least once per week. (Tr. at 624)
169. Patient 7 testified that Dr. Kirkland had discussed with her the addiction potential of the pain medication that was being prescribed. Patient 7 further testified that the subject was brought up "a few times" during the course of that therapy. (Tr. at 626)

Patient 7 testified that, at some point, she had begun receiving Demerol injections for her headaches. Patient 7 further testified that, if she had not gotten some relief from her headaches, she started vomiting, and was unable to keep her seizure medication down. She would then start having seizures. (Tr. at 626)

Patient 7 testified that Dr. Kirkland had tried to reduce her intake of pain medication. Patient 7 noted that she also suffers from constipation secondary to adhesions, and that some of the alternative medications exacerbated that problem. Moreover, some of the other medications that she tried were ineffective in controlling the pain. (Tr. at 627)

170. Patient 7 testified that Dr. Kirkland had referred her to other physicians, including neurologists, orthopedic surgeons, and a pain specialist, Dr. Dahlquist. Patient 7 testified that her experience with the pain specialist was less than positive and, after a few visits, Patient 7 declined to return. (Tr. at 628-630)

Patient 7 further testified that Dr. Kirkland had told her that she wanted to keep Patient 7 on the lowest possible dose of pain medication. Moreover, Patient 7 testified that Dr. Kirkland would not give her pain medication without first seeing her. (Tr. at 627-628)

171. Patient 7 testified that she no longer receives pain medication from Dr. Kirkland, but that she receives it from another physician. Patient 7 testified that she takes the same pain medicine as before, plus Gabitril, which Patient 7 stated treats pain, and a muscle relaxer. (Tr. at 631-632)

172. Patient 7 denied that she is allergic to penicillin. (Tr. at 623)

173. Patient 7 testified that she does have some memory problems. (Tr. at 632)

174. Patient 7 testified that she has seen a lot of physicians over the last fifteen years. Patient 7 testified that she would rate the care that she received from Dr. Kirkland as excellent. Patient 7 described Dr. Kirkland as a fine physician who is compassionate and dedicated to her patients. (Tr. at 628, 636)

Patient 8

175. Patient 8 is a female born November 9, 1942. (St. Ex. 8 at 1) Dr. Kirkland testified that she first saw Patient 8 in November 1984. (Tr. at 173)

176. Dr. Kirkland prescribed narcotic pain medication to Patient 8 as follows:

Date	Medication	Relevant Findings and/or Diagnosis
02/28/85	Darvocet N-100 #30 q 6	No findings or diagnosis
03/04/85	Darvocet N-100 #30, 1 refill, q 6	Head contusion
09/23/85	Darvocet N-100 #30 q 6 prn	Abdominal pain
11/19/85	Darvocet N-100 #60 q 6 prn	Arthritis
05/20/86	Darvocet N-100 #30 q 6 prn	None relevant (hypertension, hives)
06/24/86	Darvocet N-100 #60 q 6	Menopause(?)
01/08/88	Percocet 5 mg #60 q 6	No findings or diagnosis

Date	Medication	Relevant Findings and/or Diagnosis
03/22/88	Percocet 5 mg #15 q 6	No findings or diagnosis
09/26/89	Vicodin #6 q 6 prn	“Consult repair”
04/09/90	Darvocet N-100 #100 q 4-6 prn	No findings or diagnosis
05/21/90	Darvocet N-100 #100 q 6	No findings or diagnosis
07/17/90	Darvocet N-100 #120, 2 refills, q 6 prn	None relevant (hypertension)
10/09/90	Darvocet N-100 #120, 2 refills, q 6 prn	None relevant (hypertension)
06/18/91	Darvocet N-100 #120, 2 refills, q 6	No findings or diagnosis
11/01/91	Darvocet N-100 #20 q 6	No findings or diagnosis
01/16/92	Darvocet N-100 #120, 2 refills, q 6	Complained of headache, diagnosed chest pain
06/02/92	Darvocet N-100 #120, 2 refills, q 6 prn	None relevant
07/21/92	Esgic Plus q 4-6 prn, unspecified number of samples	Complained of abdominal discomfort
08/11/92	Lortab 7.5 mg #30 samples q 6 prn	No findings or diagnosis
11/23/92	Lortab 7.5 mg #100, 1 refill, q 6 prn	None relevant
02/09/93	Lortab 7.5 mg #100, 1 refill, q 6	Peripheral neuropathy, menopause
06/08/93	Lortab 7.5 mg #100, 2 refills, q 6	None relevant
08/31/93	Lortab 7.5 mg #120, 2 refills, q 6	Arthritis
12/02/93	Lortab 7.5 mg #120, 2 refills, q 6	Sinusitis(?)
02/07/94	Lortab 7.5 mg #120 q 6	None relevant
03/29/94	Lortab #200 q 4 prn	None relevant (hypertension, menopausal edema)
05/05/94	Lortab #50 q 6	No findings or diagnosis
05/10/94	Vicodin ES #50, 5 refills, q 6 prn	Arthritis
05/24/94	Lortab #100 q 4-6	No findings or diagnosis
07/05/94	Lortab #50 q 4-6	No findings or diagnosis
07/19/94	Lortab #200 q 6	Menopause(?)
08/22/94	Lortab #120, 2 refills, q 6 prn	Fibrositis, arthritis
11/17/94	Lortab #120, 2 refills, q 6 prn	Menopause(?)
02/13/95	Lortab #120, 2 refills, q 6	None relevant (bronchitis)
03/13/95	Lortab #120 q 6	Menopause(?)
04/24/95	Lortab #120 q6	Arthritis
05/22/95	Lortab #120, 2 refills, q 6	Arthritis
08/21/95	Lortab #360 q6	Menopause(?)
12/04/95	Lortab #360 q6	Arthritis
02/26/96	Lortab #120 q6	None relevant
03/18/96	Lortab #120 q6	None relevant (asthma, anemia)
04/15/96	Lortab #120 q6	Sinusitis(?)
05/20/96	Lortab #120 q6	Arthritis
06/10/96	Lortab #120 q6	Arthritis

Date	Medication	Relevant Findings and/or Diagnosis
07/08/96	Lortab #120 q6	Arthritis
08/05/96	Lortab #120 q6	Arthritis
09/03/96	Lortab #120 q6	Arthritis
09/30/96	Lortab #120 q6	Arthritis
10/28/96	Lortab #120 q6	Arthritis
11/25/96	Lortab #120 q6	Arthritis
12/23/96	Lortab #120 q6	Arthritis
01/20/97	Lortab 7.5 mg #120 q6	Arthritis
02/17/97	Lortab 7.5 mg #120 q6	Arthritis
04/21/97	Lortab 7.5 mg #120 q6	Arthritis
05/19/97	Lortab 7.5 mg #120 q6	Arthritis
06/16/97	Lortab 7.5 mg #120 q6	Arthritis
07/14/97	Lortab 7.5 mg #120 q6	Arthritis
08/11/97	Lortab 7.5 mg #120 q6	Arthritis
09/08/97	Lortab 7.5 mg #120 q6	Arthritis
10/06/97	Lortab 7.5 mg #120 q6	None relevant (acute gastritis)
11/03/97	Lortab 7.5 mg #120 q6	Arthritis
12/01/97	Lortab 7.5 mg #120 q6	Arthritis
12/29/97	Lortab 7.5 mg #120 q6	Arthritis

(St. Ex. 8b at 3b-32a)

Examples of Dr. Kirkland's Prescribing of Narcotic Pain Medication to Patient 8

177. Dr. Kirkland first prescribed narcotic pain medication to Patient 8 on February 28, 1985. At that time, Dr. Kirkland prescribed Darvocet N-100 #30 to be taken every six hours. Nothing other than the prescription, the date, and the name of a pharmacy is recorded. (St. Ex. 8b at 27a)

- Dr. Kirkland acknowledged that she would have to go back through the medical record to determine why that prescription had been issued. (St. Ex. 8b at 27a; Tr. at 173-174) After reviewing the record, Dr. Kirkland testified that an earlier note dated February 19, 1985, indicates that Patient 8 had been treated for a head contusion with a prescription for Feldene. Dr. Kirkland testified that she had tried Patient 8 on the Feldene, but it had not been effective for her head pain. Then she had told Patient 8 on February 25, 1985, to use plain Tylenol, which had also been ineffective. Dr. Kirkland testified that she had next prescribed the Darvocet. (St. Ex. 8b at 26b-27a; Tr. at 174-177)

Note that, although the February 28, 1985, entry states that Patient 8's head was "still painful," none of the progress notes document that Feldene or Tylenol had been ineffective. (St. Ex. 8b at 26b-27a)

- Dr. Winter testified that the only reason apparent from the medical record for the prescription was a head contusion that the patient suffered on February 13, 1985. Dr. Winter further testified that Darvocet does not seem appropriate for a head contusion that should have been healing, having occurred two weeks earlier. (St. Ex. 8b at 26b-27a; Tr. at 351-353)

178. A diagnosis of arthritis was documented on November 19 and December 3, 1985. The note for the November 19, 1985, visit states, "[Follow-up]—wants something for arthritis," and "[2.] Loss of memory—for about ten days. Sometimes disoriented." Exam findings state, "Fundi benign." Other than the patient's weight and blood pressure, no other findings or complaints are noted. Dr. Kirkland diagnosed, among other things, arthritis. (St. Ex. 8b at 27b)

The note for the December 3, 1985, visit states, "[Follow-up] on memory loss – doing a little better. Arthritis acting up with this cold weather." Other than the patient's blood pressure, no other complaints or findings are noted. Dr. Kirkland diagnosed arthritis. (St. Ex. 8b at 28a)

- Dr. Winter testified concerning the November 19, 1985, entry that there was nothing in the medical record to support a diagnosis of arthritis. "There's no evaluation of—physical evaluation of where you have the arthritis, what's the history, what brings it on." (Tr. at 354)

Dr. Winter further noted that on December 3, 1985, the diagnosis of arthritis again appears, and a rheumatoid survey was ordered, which was appropriate. Dr. Winter further testified that a notation that Patient 8's arthritis gets worse in cold weather is also helpful. (St. Ex. 8b at 28a; Tr. at 354-355)

179. On June 24, 1986, Patient 8 complained of "Hot flashes and moody for 1 month, tired a lot. Inj?" No other complaints or findings are documented, except for the patient's blood pressure. Dr. Kirkland diagnosed menopause, and prescribed, among other things, Darvocet N 100 #60 to be taken every six hours. (St. Ex. 8b at 29a)

- Dr. Winter testified that Darvocet is not an appropriate medication for menopause. Dr. Winter further testified that the earlier diagnosis of arthritis, as documented on November 19 and December 3, 1985, and on February 18, 1986, did not justify the prescription for Darvocet on June 24, 1986. (St. Ex. 8 at 28a, 28b, 29a; Tr. at 353-355)

When asked if a physician who is treating a patient for a chronic condition needs to document that condition at every visit, Dr. Winter replied that if the physician is

treating that condition in some way or prescribing medication for it, then the physician needs to document it. Dr. Winter acknowledged that, if the patient has a chronic condition for which he/she always receives the same medication, it is okay to simply state, "Refill routine meds," or something to that effect. However, she added that "narcotics are not generally considered routine medicines." (Tr. at 355-356)

- Dr. Kirkland denied that she had prescribed Darvocet to Patient 8 for menopause; rather, she had prescribed it for the patient's arthritis. Dr. Kirkland testified that she had diagnosed arthritis previously on February 18, 1986. (St. Ex. 8b at 28b; Tr. at 177)

Note that Dr. Kirkland's progress note for February 18, 1986, documents the patient's weight and blood pressure, and states, "Checkup— Chest clear. Heart NSR. Abd benign," and a diagnosis of arthritis. No other complaints or findings are documented. (St. Ex. 8b at 28b)

180. On January 8, 1988, Dr. Kirkland prescribed Percocet 5 mg #60 to be taken every six hours. No reason for the prescription was recorded that date. (St. Ex. 8b at 31b)

- Dr. Kirkland first testified that she had prescribed the Percocet to Patient 8 because the patient's arthritis got worse. However, after further review of the medical record, and noting a January 21, 1988, report of a consult of Patient 8 with Deepak Kumar, M.D., a colon and rectal surgeon. Dr. Kirkland testified that it had been prescribed for abdominal pain and arthritis. (St. Ex. 8a at 70; Tr. at 177-179)

181. On August 11, 1992, Dr. Kirkland gave Patient 8 samples of thirty tablets of Lortab 7.5 mg to be taken every six hours as needed. No basis for the prescription was documented. (St. Ex. 8b at 17b)

182. Dr. Kirkland prescribed Lortab 7.5 mg #100 with one refill, to be taken every six hours, on September 1, 1992, and again on November 23, 1992. No basis for either prescription was documented in the medical record. (St. Ex. 8b at 17b)

183. On May 5, 1994, Dr. Kirkland called in a prescription for Lortab #50 to be taken every six hours. No basis for the prescription was recorded. (St. Ex. 8b at 16a)

- Dr. Winter testified that Lortab is not a medication that can be given simply as if it were a refill of chronic medications. Dr. Winter testified that the Board's rules "require some evaluation and follow-up." (Tr. at 362)
- Dr. Kirkland testified that the August 11 and September 1, 1992; and the May 5, 1994, prescriptions had been issued for the patient's ongoing problem with arthritis. Dr. Kirkland further testified that that condition was documented in her chart in a letter dated January 16, 1986, from Harvey M. Ellman, M.D., a rheumatologist. (St. Ex. 8a at 86-87; Tr. at 182)

In his letter, Dr. Ellman stated, in part, that

[t]he exact cause of her symptoms is not entirely clear. I was somewhat concerned about the possibility of rheumatoid arthritis based on the long history of symmetrical polyarthritis associated with prolonged morning stiffness, however there are very few physical findings to support that diagnosis. In addition, her sed rate is normal and latex fixation negative. Therefore I feel that we should call this polyarthritis of unknown cause and observe her closely for future developments that might help diagnostically. I am, however, suspicious that this represents seronegative rheumatoid disease. I took the liberty of starting her on Meclomen 50 mg tid. This can be increased to a maximum of 100 mg qid if necessary.

(St. Ex. 8a at 87)

Dr. Kirkland further testified that Patient 8's arthritis had gotten worse since Dr. Ellman's evaluation; she had swelling in her legs, ulcerations on her legs, pain everywhere, and was using a cane. (Tr. at 182)

Further Evidence Concerning Dr. Kirkland's Prescribing of Narcotic Pain Medication to Patient 8

184. With regard to Patient 8's diagnosis of arthritis, Dr. Kirkland testified that, around November 1985, she had referred Patient 8 to Dr. Ellman. (Tr. at 1131-1132) Dr. Kirkland further testified that Patient 8 had complained of numbness in her hands for seven or eight years, for which she had been tried "on multiple anti-inflammatory drugs without relief." (Tr. at 1132)

Dr. Kirkland testified that, in April 1986, she referred Patient 8 to Daniel E. Braunlin, M.D., a physical medicine and rehabilitation specialist, for physical therapy. Dr. Kirkland further testified that Dr. Braunlin provided her with a home cervical traction unit, which Patient 8 used. Dr. Kirkland testified that three years later, in 1989, Patient 8 saw Daniel G. Camacho, M.D., an orthopedic surgeon, for wrist pain. Dr. Kirkland testified that Dr. Camacho performed arthroscopy and discovered that Patient 8 had crystals in her right wrist. (St. Ex. 8a at 81-82; Tr. at 1133-1134)

Dr. Kirkland testified that, in February 1990, Patient 8 was seen by Dr. Kumar, who started her on "Darvocet during that hospitalization for some abdominal problem." Dr. Kirkland further testified that, around this time, Patient 8 also had a CT scan of her head and an EEG. (Tr. at 1134)

Dr. Kirkland testified that, in February 1993, Patient 8 complained of left arm numbness. Dr. Kirkland further testified that “[s]he had an EMG done, which was abnormal. She had some mild chronic ulnar entrapment.” (Tr. at 1134)

Dr. Kirkland testified that, in September 1994, Patient 8 “saw her fourth doctor for arthritis or bone problems,” Pietro Seni, M.D., an orthopedic surgeon. Dr. Kirkland further testified that Dr. Seni attributed her “multiple arthralgias and multiple pain” to her muscles, and had nothing to offer her in the way of treatment. Moreover, Dr. Kirkland testified that Dr. Seni recommended that Patient 8 see a rheumatologist. “She also had documented disease on x-ray at this time. In August of ’94 she had an abnormal x-ray which showed degenerative changes in her spine with disc—disc space narrowing.” (Tr. at 1135)

Dr. Kirkland testified that Dr. Seni had sent Patient 8 to B. Burt Rahavi, M.D., a rheumatologist. Dr. Kirkland further testified that, after she received a letter from Dr. Rahavi concerning Patient 8, in which he had recommended, among other things, weaning Patient 8 from narcotic pain medications, she had discussed Dr. Rahavi’s findings and recommendations with Patient 8. “The patient was not happy at all and not very believing of what Dr. Rahavi had to say. She did not have a very pleasant visit with him.” Patient 8 declined to see Dr. Rahavi any further. (Tr. at 1137-1138)

Dr. Kirkland testified that an LS spine x-ray performed October 6, 1997, “revealed problems with her back. She had moderate degenerative narrowing L4-5. She had diffuse and mild degenerative spurring of the lumbar spaces. And so she had problems with her back.” (Tr. at 1138) However, note that, although an x-ray report dated October 6, 1997, concluded, “Moderate degenerative narrowing of L4-5[.]” and “Diffuse and mild degenerative spurring of the lumbar interspaces[.]” a report of CT scan of Patient 8’s spine dated the following day, October 7, 1997, concluded that “[t]he facet joints are normal[.]” and “[t]he lumbar spinal canal shows a normal AP and lateral diameter. There is no evidence of spinal stenosis.” The impression noted in that report stated, “Normal CT of the lumbosacral spine and intravertebral discs from L1 to S1.” (St. Ex. 8b at 35-37)

Dr. Kirkland stated that, in addition to arthritis, Patient 8 suffers from asthma, which is treated by Fred A. Wagshul, M.D. Dr. Kirkland testified that Patient 8’s asthma is severe enough to require Prednisone. Dr. Kirkland testified that Dr. Wagshul was aware of the pain medication that Patient 8 was using. (Tr. at 1134-1135)

Dr. Kirkland further testified that Patient 8 had not been a good candidate for steroid injections in her back because she had been taking “a significant amount of steroids for her asthma.” Dr. Kirkland further testified that Patient 8 was not a good candidate for any kind of patch because she was allergic to tape. Accordingly, Dr. Kirkland testified that she kept Patient 8 on pain medication “[a]nd it was very effective. This lady was able to function. She was able to work until recently * * *. And * * * she is seeing a pain specialist that has her on actually more medication than what I had her on.” Dr. Kirkland testified that Patient 8 now sees another physician for pain control, since Dr. Kirkland no longer prescribes pain medication. (Tr. at 1138-1139)

185. An October 10, 1994, letter, Dr. Rahavi, stated, in part,

Assessment: At this time, the problem seems to be chronic pain in the lower back and lower extremities of undetermined etiology. The extent of the complaint is out of proportion to physical findings. At the first glance, it appears that the problem is Chronic Pain Syndrome, something like what we normally see in patients with Fibromyalgia. Also, chronic use of addicting analgesics makes me more suspicious of this type of problem rather than a primary organic lesion. The fact that I do not find a specific physical abnormality also adds more suspicion for such problem. [Patient 8] is insisting that she would like to find out why she can not walk or why she is hurting all of the time. She was told that we will try to find out if there is any physical reason for her problem and then at that time we would be in the position to comment about a specific treatment. At this time, I am not sure if we will find anything, but we will give it the benefit of the doubt. Therefore, we will plan to repeat some of the laboratory tests such as CBC, Chemistry Profile, Sed Rate, and CPK. Also, x-ray examination of both hips will be obtained. She is referred for an EMG of both lower extremities.

From a treatment standpoint, I suggested that she continue Dolobid. I expressed a deep concern about a continuation of addicting analgesics, especially at an excessive dose. She states that she cannot go on without those. She was told at this time, I will just focus on diagnostic evaluation and leave any decisions about medications to her primary care physician. But, I would definitely be in favor of tapering the Vicodin down. If the examination fails to reveal a definite cause of her pain that could be treated, then one would need to focus on the possibility of Fibromyalgia/Chronic Pain Syndrome and treat her with tricyclic antidepressants. Another alternative would be referral to a chronic pain clinic if no definite lesion is found.

(St. Ex. 8b at 59-60)

By letter dated October 24, 1994, to Dr. Seni, Dr. Rahavi stated that he had performed further evaluation and had discussed the results of that evaluation with Patient 8. Dr. Rahavi further stated, in part,

It is my impression that [Patient 8] suffers from chronic pain syndrome which, in my opinion, is best handled by a pain clinic. She would require a global approach to her problem since there is no specific organic or medical problem that can be detected. Quite often, a global management would involve treating her physically and psycho-socially. As outlined in the previous letter, I would be uncomfortable with keeping her on controlled analgesic substances.

I understand that at this point, she is not being followed actively in your office. Therefore, I will communicate with Dr. Jeanne Kirkland, who is her primary care physician, with respect to her continued care. I feel in difficult cases like her, who are on controlled substances, it would be best that one physician be in charge of the medications in order to be able to control the amount of medication that they get.

(St. Ex. 5b at 58)

On November 7, 1994, Patient 8's first visit after having seen Dr. Rahavi, Dr. Kirkland noted, "Unhappy with Dr. Rahavi—no help w/ consult." Nothing further was documented in the progress notes concerning Dr. Rahavi's recommendations. (St. Ex. 8b at 5b)
Dr. Kirkland continued to prescribe narcotic pain medication at that visit and thereafter. (St. Ex. 8b at 3b-11b)

186. With regard to Dr. Kirkland's response, or lack of response, to Dr. Rahavi's consultation, Dr. Winter testified,

The standard of care is certainly to give it attention, to review what the physician says, to weigh for yourself how much in there seems to apply and is practical to do for your patient. You're certainly not obligated to do what any consultant says, but it needs to be weighed seriously in your management of that patient.

In addition, the—in a patient like this who states that they do not want to see a consultant of any kind after that first visit, you would probably want to know why. And a quick, easy answer might be, 'Well, he didn't do anything for me.' 'What did he do?' 'What did you talk about?' Because that's a lot of information.

When your patient comes back, you have not yet received the consultation forms in most cases from the consulting physician. Occasionally they will call you and discuss something that they feel is very important with you in person. But in most cases, you're seeing the patient before you review the consultant's report.

So if there is a disconnect there between your patient and a consultant, I think it's important as best you can to discern why. And, you know, one hypothetically might have gotten the information, 'Well, he wanted to take me off the pain medicines and try 'such-and-such' instead.' And that would give you a clue into some of the patient's feelings and concerns.

(Tr. at 376-377)

187. With regard to Dr. Rahavi's report, Dr. Sickles testified that he would agree with Dr. Rahavi's assessment that Patient 8 had chronic pain syndrome. Dr. Sickles further testified that he does not necessarily agree with Dr. Rahavi's suggestion that Patient 8 should have been weaned off of narcotic pain medication. Moreover, Dr. Sickles testified,

In patients that have chronic pain syndromes, oftentimes narcotics are one of the few things you've got to offer to control their pain.

* * * [W]hile it's an option, I don't think it's necessarily the best option for a patient that has, you know, a longstanding history of chronic pain with multiple other attempts at other treatments and medications all without success.

(St. Ex. 8b at 58-60; Tr. at 875-876)

188. Dr. Kirkland testified as follows concerning Dr. Rahavi's report,

He stated that the patient was practically in tears, and the pain in her lower extremities was incapacitating and was affecting her overall life and sleep. This is what she had told him.

Now, keep in mind, Dr. Rahavi had only seen this patient one time.³ She had seen four previous specialists besides me. I had been following this lady since 1984; so I had been following her five years by this time.

And he suggested trying this lady on Elavil and tapering her off her Vicodin. She couldn't tolerate the Elavil. We had tried her on this at a later date and it didn't agree with her. And she was not able to taper off her Vicodin.

And—And in a second letter that he sent me, he sort of backed off a little bit and said that one doctor should be prescribing her medication. My experience at this time with pain clinics had not been very good from other patients that I had treated. And so she was not sent to a pain clinic.

I—Never did I think that this patient was drug seeking. She had documented disease. She was in pain. She had seen four other doctors that had confirmed all of the findings that we had had at this time. And so she was kept on her pain medication. I had also considered her—starting her on an arthritis medicine called Ridaura at this time.

³ Dr. Kirkland later corrected her testimony and noted that Dr. Rahavi had seen Patient 8 on two occasions. (Tr. at 1162-1163)

Then in October of '97, the patient had an LS spine x-ray done which revealed moderate degenerative narrowing of the lumbar L4-L5.

(Tr. at 1135-1136) Dr. Kirkland further testified that she does not consider Dr. Rahavi's report to have been a comprehensive assessment of Patient 8's condition "[b]ecause it was incorrect." Furthermore, Dr. Kirkland testified that every other physician who had seen Patient 8 prior to Dr. Rahavi, including Dr. Seni, who had referred Patient 8 to Dr. Rahavi, had found that Patient 8 had severe pain. (St. Ex. 8b at 63-64; Tr. at 183-184, 187)

Finally, Dr. Kirkland testified that she had offered alternative modalities to Patient 8 to treat her pain, but none except pain medications were effective. (Tr. at 189-190)

Conclusions Regarding Dr. Kirkland's Care of Patient 8

189. Dr. Winter testified that, in her opinion, Patient 8 "was prescribed excessive quantities of narcotics for chronic pain, and was not offered other more appropriate modalities for her chronic pain, such as exercise, ice or heat, strengthening, as she should have been." (Tr. at 350) Dr. Winter further testified,

I feel that medications were prescribed without adequate thought and evaluation. I feel that the treatment was lacking in not pursuing other types of medications to be used. It wasn't until much later in the course when she finally made her way to a rheumatologist that more light was shined on this. And I feel that in a patient with no obvious physical signs of organic disease, that much more attention should have been paid to the emotional, and how do you say, soft tissue aspects of pain, which is where Dr. Rahavi ultimately was pursuing and pushing that patient.

(Tr. at 374-375)

190. Concerning Dr. Kirkland's employment of reasonable care discrimination or accepted scientific methods in the selection of drugs or other modalities in the treatment of disease, Dr. Winter testified, "I think she failed to apply appropriate discrimination in choosing medications for this patient, and also did not do appropriate follow-up in management of those narcotic medications." (Tr. at 377)
191. Dr. Sickles testified that, in his opinion, Dr. Kirkland's treatment of Patient 8 had conformed to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Sickles further testified that Dr. Kirkland has used reasonable care discrimination and acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. (Tr. at 873)

Dr. Sickles testified that Dr. Kirkland had made an effort to control Patient 8's "arthritis-type symptoms without exacerbating her gastrointestinal symptoms at the same time." Dr. Sickles further testified that Dr. Kirkland had referred Patient 8 to specialists to

determine a cause for Patient 8's symptoms and for possible treatment. Dr. Sickles further testified that the medical record indicated that Patient 8 was somewhat disabled by her symptoms and had to use a cane or walker. Dr. Sickles testified that this suggests that she was "having some legitimate problems even if, from an objective standpoint of diagnostic testing at least, there [were not] severe things that you could put your finger on." Dr. Sickles testified that Patient 8's condition led to the use of narcotic pain medication that the medical record indicated did help her to function better. (Tr. at 874)

Dr. Sickles testified that he believes that the dosages of medication that Dr. Kirkland prescribed to Patient 8 were appropriate and within the standard of care. (Tr. at 875)

192. Dr. Kirkland testified that her diagnoses of Patient 8's conditions had been correct and appropriate. Dr. Kirkland further testified that her diagnoses had been confirmed by discussions with specialists and by objective findings. Moreover, Dr. Kirkland testified that her treatment of Patient 8's conditions had been appropriate, and had been confirmed by discussions with specialists and by objective findings. (Tr. at 1139-1140)

Patient 8's Testimony

193. Patient 8 testified at hearing on behalf of Dr. Kirkland. Patient 8 testified that she is a patient of Dr. Kirkland's and that she has been seeing Dr. Kirkland since around 1984. Patient 8 testified that she suffers from or has suffered from osteoarthritis (which she said has had since she was fourteen), fibromyalgia, Raynaud's disease, high blood pressure, asthma, anxiety, depression, carpal tunnel syndrome, impaired renal function, hiatal hernia, and acid reflux. Patient 8 further testified that she is disabled, and has not worked since February 2002. (Tr. at 661-662, 668)

Patient 8 testified that Dr. Kirkland prescribed pain medication "because my system will not accept pills hardly. * * * And we finally set it on Lortab because it's the only one my system will accept. And to this day, it's the only one my system accepts." (Tr. at 662-663)

Patient 8 testified that Dr. Kirkland had discussed with her the addiction potential of her medication "[a]ny time that [she] had to have something else, another medication added on or something like that, with the potential of it all added together * * *." Patient 8 further testified that Dr. Kirkland referred her to specialists for her conditions. "I have ten different doctors right now." (Tr. at 664)

194. Concerning her visit to Dr. Rahavi, Patient 8 testified,

I went to a Dr. Rahavi, who did not know his business at all because if he had, he would know I had fibromyalgia because when—I was told that there was nothing wrong with me. When I walked in, I didn't walk in like a cripple or something like that. I walked in like I did today. And he had no interest in me whatsoever.

But he did run tests. And he came back and said there was nothing that showed I had anything. But I have been on anti-inflammatories ever since I was the age of 15. And every other doctor had found it.

(Tr. at 666)

195. Patient 8 testified that Dr. Kirkland had tried her on a variety of anti-inflammatory medications. Patient 8 further testified that Dr. Kirkland had referred her out for diagnostic studies. Moreover, Patient 8 testified that Dr. Kirkland had talked to her about decreasing her use of pain medication. (Tr. at 667, 671-675)

Patient 9

196. Patient 9 is a male born April 20, 1934. (St. Ex. 9 at 1) Dr. Kirkland testified that she had first treated Patient 9 on a couple occasions in 1983, and then began treating him again in 1993. (Tr. at 191-192)

197. Dr. Kirkland prescribed Ativan to Patient 9 as follows,

Date	Medication	Relevant Findings and/or Diagnosis
01/14/93	Ativan 1 mg #20 qd prn	Hypertension
03/22/93	Ativan 1 mg #20 qd	No findings or diagnosis
04/22/93	Ativan 0.5 mg #30 qd prn	Hypertension
05/20/93	Ativan 0.5 mg #30, 1 refill, qd	None relevant (dermatitis)
09/07/93	Ativan 0.5 mg #30 hs prn	Hypertension
12/16/93	Ativan 0.5 mg #30, 1 refill, hs prn	Hypertension
03/24/94	Ativan 0.5 mg #30, 1 refill, hs prn	Hypertension
06/07/94	Ativan 0.5 mg #30, 2 refills, hs prn	Hypertension
09/20/94	Ativan 0.5 mg #30, 2 refills, hs prn	Hypertension
12/20/94	Ativan 0.5 mg #30 hs prn	Hypertension
12/19/95	Ativan 0.5 mg #30 hs	Hypertension
03/07/96	Ativan 0.5 mg #30 hs	Hypertension
06/13/96	“Ativan cont.”	Hypertension

(St. Ex. 9 at 2a-5a) Dr. Kirkland continued to see Patient 9 through at least December 11, 1997, the last visit on record. However, she prescribed no Ativan to Patient 9 after March or June 1996. (St. Ex. 51-5b)

198. In her written report, Dr. Winter stated, in part, “There was no documentation of the diagnosis or rationale for the prescription of Ativan, which was given continuously throughout his care.” (St. Ex. 12 at 19) Dr. Winter further stated that Dr. Kirkland had appropriately managed Patient 9’s elevated alkaline phosphatase, abnormal EKG, and kidney stones through referrals to specialists. Moreover, Dr. Winter stated that

Dr. Kirkland appropriately managed Patient 9's back pain, and did not prescribe narcotic pain medication. (St. Ex. 12 at 19)

At hearing, Dr. Winter testified that "throughout the patient's care, there was no documentation of the diagnosis, the rationale, or follow-up of the use of Ativan in this patient. The great majority of the other aspects of his care were fine." (Tr. at 379)

199. On January 14, 1993, Dr. Kirkland prescribed, among other things, Ativan 1 mg # 20 to be taken once per day. This was Dr. Kirkland's first prescription of Ativan to Patient 9. The only diagnosis noted is hypertension. At that visit, Patient 9's blood pressure had been 210/110. (St. Ex. 9 at 2b)
200. Concerning Patient 9's January 14, 1993, visit, Dr. Winter testified that Dr. Kirkland had failed to document the reason that Patient 9 had been given Ativan, or her plan for its use. Dr. Winter further testified that, in order to follow the Board's prescribing rules, one would need a physical examination, an appropriate diagnosis, the purpose for prescribing the drug, how the drug fits into the management of the patient's diagnosis, and follow-up. Moreover, Dr. Winter testified that, had Dr. Kirkland's documentation been appropriate, it might have been reasonable to prescribe Ativan for Patient 9's hypertension if the hypertension had a "strong anxiety component." Dr. Winter further testified that its use for that purpose must be monitored. Finally, Dr. Winter added,

But for me evaluating this patient, the link needs to be made for me, rather than me guessing is this what the Ativan is used for. If there was a statement in there 'because patient is very anxious, I will attempt to bring down his anxiety and stabilize his blood pressure using Ativan as an adjunct,' I think that would be reasonable.

(Tr. at 381-382)

Dr. Winter noted that Dr. Kirkland had also prescribed Zestril for Patient 9's blood pressure. (Tr. at 381)

201. Dr. Winter testified that, with regard to Dr. Kirkland's prescribing of Ativan to Patient 9, her treatment constituted a failure to use reasonable care discrimination in the selection of drugs or other modalities in the treatment of disease. (Tr. at 383)

Further, when asked if it was within the standard of care to use Ativan to control high blood pressure related to anxiety, Dr. Winter testified that it is useful only for unique situations. Moreover, Dr. Winter testified, "My concern about the medical care rendered in this case is mostly of a documentation problem because a not-common method of blood pressure management was attempted to be used in this case. And the fact that it is a controlled drug imposes additional documentation requirements." (Tr. at 534-535)

202. Dr. Sickles disagreed with Dr. Winter's written report in which she stated that Dr. Kirkland had prescribed Ativan to Patient 9 continuously throughout his care. Dr. Sickles testified that Dr. Kirkland had prescribed Ativan on an episodic basis to Patient 9, and not as an ongoing, daily medication. Dr. Sickles further testified that Dr. Kirkland had prescribed a "[f]airly low dose" of Ativan to Patient 9. (Tr. at 805)
203. Dr. Sickles testified that Ativan can be prescribed for the management of stress and anxiety, but is also used "as an adjunct in therapy for hypertensive individuals whose hypertension seems to be affected by stressful life situations and so forth. And it appeared that that was the case with this patient." (Tr. at 803)
204. Dr. Sickles testified that, in his opinion, Dr. Kirkland had conformed to the minimal standard of care in her treatment of Patient 9. Dr. Sickles further testified that Dr. Kirkland had used appropriate scientific methods in prescribing medication to Patient 9. (Tr. at 802-803)
205. Dr. Sickles testified concerning Patient 9's April 22, 1993, visit, that he could not tell from that entry why Ativan had been prescribed. "For that particular visit, I can't say with certainty whether she used it as an adjunct in treating his hypertension or if she was using it to treat an undocumented diagnosis of anxiety." (Tr. at 956)
206. Dr. Kirkland noted that on January 14, 1993, Patient 9 had presented with extremely high blood pressure. Dr. Kirkland testified that patients with such high blood pressure are eight times more likely to suffer a stroke or heart attack than someone in the general population. (Tr. at 1064-1065)
- Dr. Kirkland further testified that she had prescribed Ativan to Patient 9 because Patient 9 "was an anxious individual." Dr. Kirkland further testified that he would get anxious when he came to see her, and at other times as well. Dr. Kirkland stated that she had prescribed Ativan to Patient 9 with the hope that it would help to reduce his blood pressure, which was not well controlled with antihypertensive medication. Finally, Dr. Kirkland testified that "[t]here definitely is a relationship" between anxiety and high blood pressure. (Tr. at 195-196, 1065-1066)
207. Dr. Kirkland testified that Patient 9 had numerous other health problems besides anxiety and high blood pressure, including an enlarged heart with an ejection fraction of fifteen percent, severe heart disease with a pacemaker and defibrillator, kidney stones, arthritis, and peptic ulcer disease. (Tr. at 1066-1067)
208. Dr. Kirkland testified that she believes that her diagnoses of Patient 9's medical problems had been appropriate, and had been confirmed by specialists. Dr. Kirkland further testified that her treatment of Patient 9 with Ativan for anxiety associated with high blood pressure had been appropriate and proper treatment. (Tr. at 1069)

209. Patient 9 testified at hearing on behalf of Dr. Kirkland. Patient 9 testified that he is a patient of Dr. Kirkland's. Patient 9 further testified that he has been seeing Dr. Kirkland since around 1982. (Tr. at 928-929)

Patient 9 testified that he suffered from very high blood pressure, and had constant panic and anxiety attacks when he would sit or rest. "I just felt like a bunch of pins would hit me in the chest right up to my head and I just couldn't sit still." Patient 9 further testified that the Ativan that Dr. Kirkland prescribed for him helped. Patient 9 testified that he took it every day at first but, after a while, only took it if he needed it. (Tr. at 929-933)

Patient 9 testified that he believes that Dr. Kirkland is a great doctor, and that she had saved his life multiple times. (Tr. at 933-934)

Patient 10

210. Patient 10 is a female born February 20, 1953. (St. Ex. 10 at 1)

Dr. Kirkland's Utilization of Stadol and Narcotic Pain Medication in Her Treatment of Patient 10

211. Dr. Kirkland first saw Patient 10 on May 5, 1988. At that time, Patient 10 was a patient of another physician for whom Dr. Kirkland's practice provided coverage. In her note for that visit Dr. Kirkland recorded the patient's weight and blood pressure, "c/o migraine HA [with] vomiting & nausea. [Follow-up] pulled muscle in neck tx x Dr. Ryan. [Decreased] ROM. Tender muscles [left] neck." Dr. Kirkland diagnosed "Migraine." She ordered, among other things, an IM injection of Stadol 4 mg with Phenergan. (St. Ex. 10 at 4a)

The following day, May 6, 1988, Dr. Kirkland again ordered an IM injection of Stadol 4 mg with Phenergan for a diagnosis of migraine. There are no subjective or objective findings in that entry. (St. Ex. 10 at 4a)

In late 1989 or early 1990, Patient 10 became a regular patient of Dr. Kirkland's practice. Beginning with the December 4, 1989, visit, Dr. Kirkland ordered frequent IM injection of Stadol 4mg with Phenergan or Vistaril, usually for complaints of migraine headache, through November 20, 1997, the last such injection on record ordered by Dr. Kirkland. Often, multiple injections were given per month. For example, in February 1993, Dr. Kirkland ordered such injections on February 1, 2, 13, and 19, 1993. Similarly, between March 13 through April 18, 1995, Dr. Kirkland ordered such injections on five occasions. Lastly, between October 29 and November 20, 1997, Dr. Kirkland ordered such injections on five occasions. (St. Ex. 10 at 6a-30b. For examples of these injections, see St. Ex. 10 at 15b-16a, 21b-22a, 30a-30b.)

While the stated diagnosis underlying these injections was most often headache or migraine, on some occasions no diagnosis was documented. This occurred on: May 7, September 1, and December 15, 1992, plus an undated entry documenting an injection

ordered between one ordered on August 31 and another ordered on September 1, 1992; September 13, 1993; and November 21, 1994. (St. Ex. 10 at 13a, 14a, 15a, 17a, 20b)

Further, on some occasions an injection for Stadol 4 mg with Phenergan or Vistaril was ordered when the only diagnosis documented was seemingly inappropriate. For example,

- On December 13, 1990, the only diagnosis documented was acute viral syndrome. (St. Ex. 10 at 8b)
- On February 21, 1991, the only diagnosis was depression. (St. Ex. 10 at 9b)
- On February 11, 1991, the only diagnosis was sinusitis. (St. Ex. 10 at 9b)
- On September 9, 1991, the only diagnosis was insomnia. (St. Ex. 10 at 11a)
- On September 10, 1991, and April 17, 1995, the only diagnosis was bronchitis. (St. Ex. 10 at 11b and 22a)

212. Dr. Winter described Stadol as follows,

Stadol has not been a controlled drug, it—when it first came out. It was very exciting because it was promoted as a non-narcotic analgesic which was effective in migraine headaches and severe pain. * * *

At first we thought it was great because it did a very nice job of resolving pain. However, it did not take long before we found that it behaved exactly like a narcotic, even though it's not officially called a narcotic. People developed a tolerance to it very, very quickly. And I have seen several patients who I believe truly were addicted to it.

(Tr. at 385-396)

Examples of Dr. Kirkland's Treatment of Patient 10 with IM Injections of Stadol

213. On September 9, 1991, Patient 10 complained of sinus congestion and cough for five days. She also reported that she was upset because her son had taken LSD and was receiving counseling. Dr. Kirkland diagnosed insomnia. Among other things, she ordered an IM injection of Stadol 4 mg with Phenergan. (St. Ex. 10 at 11a)
- Dr. Winter testified that Stadol with Phenergan is not an appropriate medication for insomnia. Dr. Winter testified that it is a short-acting pain medication, and that “[t]he patient will be awake in the evening.” Dr. Winter further testified that it is not an appropriate medication for sinus congestion and cough, either. (Tr. at 397-398)
214. An entry dated August 31, 1992, states that Patient 10 had complained of not sleeping well. Dr. Kirkland diagnosed migraine and ordered an injection of Stadol 4 mg with Vistaril 50 mg. An entry dated the following day, September 1, 1992, states that Dr. Kirkland ordered an injection of Stadol 4 mg with Vistaril. Nothing else was documented in that entry. Moreover, prior to the September 1, 1992, entry, and following the August 31, 1992,

entry, there is an undated entry documenting another injection of Stadol and Phenergan. (St. Ex. 10 at 14a)

- Concerning the undated entry, Dr. Winter testified,

Initially, I thought that belonged to the entry before. But at the entry before, 8-31 of '92, another injection of Stadol and Vistaril were given. So here is one, here is another one at some date. And then the very next date, 9-1 of '92, another injection. And this is very unclear because there aren't any more days after 8-31.

* * *

So if this is true, she received three Stadol injections in two days.

(Tr. at 399-400) Dr. Winter testified that this causes concern for her "simply because it's being used so often and the problem being treated is not really evaluated."

(Tr. at 400)

Dr. Kirkland's Prescribing of Narcotic Pain Medication to Patient 10

215. In addition to the Stadol injections, Dr. Kirkland began providing Patient 10 with prescriptions for Tylenol No. 3 on September 27, 1990. On that date, Dr. Kirkland issued a prescription for Tylenol No. 3 #50 to be taken every six hours as needed. Nothing was documented except the date, the prescription, and "Rx." (St. Ex. 10 at 8a) These prescriptions continued on a periodic basis with increasing frequency. By February 1993, Dr. Kirkland began issuing prescriptions to Patient 10 for Tylenol No. 3 on a regular and continuous basis. During this period, the most frequently prescribed quantity was either 100 or 120 pills, usually to be taken every six hours as needed. Generally, the stated diagnosis was headache or migraine, and/or lumbosacral strain or back pain. Sometimes no diagnosis was documented. These prescriptions continued through January 15, 1998, the last visit on record. On a few occasions, Dr. Kirkland issued prescriptions for Vicodin, Vicodin ES, Percodan, or Percocet. (St. Ex. 10 at 8a-31a)

Examples of Dr. Kirkland's Treatment of Patient 10 with Narcotic Pain Medication

216. On August 25, 1994, Patient 10 reported that she had an abscessed tooth and her lower back was tender. Among other things, Dr. Kirkland prescribed Percodan #20 to be taken every six hours. (St. Ex. 10 at 19b-20a)

- When Dr. Kirkland was questioned concerning the prescription for Percodan, she stated that that had evidently been prescribed for the patient's back pain and abscessed tooth. When asked if the patient should have gone to the dentist concerning tooth pain, Dr. Kirkland replied, "They don't prescribe pain medicine."

* * * And she already had the Tylenol and it wasn't working. She only got 20 pills.”
(Tr. at 216-217)

- Dr. Winter testified that patient complaints concerning dental pain are a red flag, and should be recognized as a potential sign of abuse. “Patients often know to come in and complain of an abscess or dental problem to get short-term pain medications.”
(Tr. at 396)

Dr. Winter further testified that dentists are allowed to prescribe controlled substances for pain. (Tr. at 396-397)

217. On February 21, 1995, Dr. Kirkland saw Patient 10 for complaints and a diagnosis that relate only to vaginitis. She prescribed, among other things, Tylenol No. 3 #100 to be taken every six hours. (St. Ex. 10 at 21b)

- Dr. Winter testified that Tylenol No. 3 is not an appropriate medication for vaginitis.
(Tr. at 408)

Dr. Kirkland's Diagnosis of Migraine Headaches, and Alleged Failure to Consider Non-Narcotic Medications or Elimination of Triggers in Her Treatment of Patient 10's Migraine Headaches

218. In her written report, Dr. Winter stated that, although Patient 10 was treated for years with IM injections of Stadol and prescriptions for narcotic pain medication for a diagnosis of migraine headaches, Dr. Kirkland's medical records do not reflect that that diagnosis was based upon a description of Patient 10's symptoms or by an expert evaluation. (St. Ex. 10; St. Ex. 12 at 22)

Dr. Winter further stated in her written report that Dr. Kirkland's management of the patient for a diagnosis of migraines had not been appropriate. Dr. Winter stated that “multiple other non-narcotic medications are available[.]” Further, she stated that, for patients suffering from frequent episodes, it is essential to “focus on eliminating triggers” and the prevention of the onset of the headaches. (St. Ex. 12 at 21-22)

Note that Inderal was prescribed beginning on November 5, 1992, but on December 29, 1992, Patient 10 complained that the Inderal was making her headaches worse. (St. Ex. 10 at 14b-15b) On February 1, 1993, Patient 10 was again started on Inderal, with the note, “Discuss Inderal taking – helping panic attacks.” (St. Ex. 10 at 15b) Inderal was then prescribed through July 13, 1993. There is no reason documented why it was thereafter discontinued. (St. Ex. 10 at 16b)

Also note that Elavil was prescribed throughout Dr. Kirkland's care of Patient 10 until January 28, 1997. It was discontinued that day with the explanation, “Elavil was for sleep—not helping.” (St. Ex. 10 at 7a-28b)

219. Dr. Kirkland testified that she had sent Patient 10 to a pain specialist and headache expert, a Dr. Rohera, during the course of her treating Patient 10. Dr. Kirkland further testified that she documented that Patient 10 had had vomiting and nausea with the headaches, as well as tenderness in her neck and decreased range of motion. Moreover, Dr. Kirkland testified that she had had discussions with Patient 10 concerning triggers for her headaches. Dr. Kirkland testified that triggers that she discussed with Patient 10 that seemed to cause her headaches had included monosodium glutamate, wine, and dental procedures. Finally, Dr. Kirkland testified that she also told Patient 10 to avoid caffeine. (Tr. at 202-203, 1130-1131)

Note that Dr. Kirkland's medical record for Patient 10 does not include a report from a Dr. Rohera, or from any other pain or headache specialist. Further note that Dr. Kirkland's medical records do not reflect any discussions with Patient 10 concerning the elimination of triggers for her migraines, although the following entries may have documented the existence of possible triggers for Patient 10's migraines:

- An entry dated July 22, 1987, during which Patient 10 was evidently seen by Dr. Kirkland's husband, states that Patient 10 had had a migraine headache and vomiting for two days. It further states, "ate Chinese food and 3-4 hours later vomited 10 times[.]" (St. Ex. 10 at 2a)
- An entry dated January 15, 1990, during which Patient 10 was seen for migraine, states, "under a lot of stress right now." (St. Ex. 10 at 6a)
- An entry dated December 4, 1989, during which Patient 10 was seen for migraine, states, "Has been under a lot of stress & drinking Etoh [with] no Elavil." (St. Ex. 10 at 7a)
- An entry dated October 22, 1992, states that Patient 10 had had migraine, vomiting, and diarrhea since that morning, and "thinks it is [secondary] to wine." (St. Ex. 10 at 14b)
- An entry dated October 3, 1995, states that Patient 10 had had a migraine for one day, and had been "working a lot on computer." (St. Ex. 10 at 23b)
- An entry dated March 21, 1997, stated that Patient 10 had had her home sprayed for termites and that the "odor has triggered HA." (St. Ex. 10 at 28a)
- An entry dated October 29, 1997, states that Patient 10 complained of a headache "possibly from dental work this AM." (St. Ex. 10 at 30a)

220. Dr. Kirkland testified that she had tried unsuccessfully to control Patient 10's headaches with Midrin, with Elavil, with BuSpar, with Pamelor, and with Cataflam. Dr. Kirkland further testified that she had referred Patient 10 to a psychiatrist to help her deal with her stress. (Tr. at 208-209, 1121-1122, 1126, 1128)

Note that Dr. Kirkland's medical record for Patient 10 indicates that Dr. Kirkland prescribed Elavil for an extended period of time. She also prescribed Pamelor on one occasion on July 24, 1991, evidently for sleep problems. In addition, she prescribed Cataflam on one occasion on August 29, 1994. However, the Hearing Examiner was unable to find any prescriptions for Midrin or BuSpar issued to Patient 10 by Dr. Kirkland. (St. Ex. 10)

Dr. Kirkland further testified that in December 1997 Patient 10's headaches had increased in frequency. She tried Patient 10 on Imitrex, and Stadol nasal spray. Dr. Kirkland further testified that she had tried to get Patient 10 weaned off of Tylenol No. 3, "but that seemed to be the only thing that was effective for her." (Tr. at 1129)

An entry dated December 5, 1997, states that Patient 10 had complained of her migraines increasing in frequency, but Dr. Kirkland's husband evidently saw Patient 10 at that visit. It appears that Dr. Kirkland's husband probably prescribed Imitrex, although the list of prescriptions is nearly illegible. The subsequent entries dated December 18 and 23, 1997, and January 15, 1998, in which Patient 10 was seen by Dr. Kirkland, do not address the success or failure of Imitrex, if indeed it had been prescribed. In any case, the Hearing Examiner could find no prescriptions for Imitrex issued to Patient 10 by Dr. Kirkland in December 1997. (St. Ex. 10 at 30b-31a)

221. Dr. Sickles noted that Dr. Kirkland had prescribed Tylenol No. 3 to Patient 10 for headaches and back pain, but had also used or attempted other modalities. Dr. Sickles testified that Dr. Kirkland used ultrasound, antidepressants such as Elavil and Zoloft, Calan, and Imitrex. Dr. Sickles noted that, ultimately, Patient 10 ended up going back to Tylenol No. 3. (Tr. at 867)

Note that Dr. Kirkland's medical records for Patient 10 indicate that she prescribed Elavil and Zoloft, and that she prescribed Calan for Patient 10 on December 29, 1992. She also ordered ultrasound treatments. However, the Hearing Examiner could find no prescription for Imitrex issued to Patient 10 at any time by Dr. Kirkland, although her husband probably issued such a prescription on December 5, 1997. (St. Ex. 10)

222. Dr. Sickles acknowledged that there was no documentation in the medical record that Dr. Kirkland had discussed with Patient 10 the triggers for her headaches, or that Dr. Kirkland had investigated that cause of Patient 10's headaches. (Tr. at 992)

Drug-Seeking Behavior by Patient 10

223. On February 1, 1991, Dr. Kirkland's husband prescribed to Patient 10, among other things, Tylenol No. 3 #30. A subsequent entry dated February 4, 1991, states that the patient had reported that her purse had been stolen along with her medication. Dr. Kirkland prescribed,

among other things, Tylenol No. 3 #30. (St. Ex. 10 at 9a)

- Concerning the February 1, 1991, notation that the patient had informed Dr. Kirkland that her purse and medication had been stolen, Dr. Kirkland testified that she had discussed that issue with Patient 10. Dr. Kirkland testified that she was satisfied that that was legitimate, and was not drug-seeking behavior. (St. Ex. 10 at 9a; Tr. at 1125) Note, however, that no such discussion was documented in the medical record. (St. Ex. 10 at 9a-9b)

224. An entry dated May 15, 1991, states, “Dr. Bean’s office nurse called, she states [Patient 10] has been getting pain meds from 3 other doctors besides our office. Dr. Bean has discontinued giving any more pain meds.” (St. Ex. 10 at 10b) At Patient 10’s next visit, on June 3, 1991, no discussion with the patient concerning that issue is documented, nor is any discussion with the other physicians involved. Moreover, at that time Dr. Kirkland prescribed Tylenol No. 3 #100. (St. Ex. 10 at 10b)

- Concerning the May 15, 1991, telephone call from Dr. Bean’s office, Dr. Winter testified that “this is a large—more than a red flag. This is a parade.” Dr. Winter further testified that she did not see this addressed in the medical record. Moreover, “[i]t would be the standard of care to address this report, and for most physicians to refuse to prescribe any further medications because it’s very obvious pain medication shopping.” (Tr. at 395)
- Concerning the May 15, 1991, notation of the call from Dr. Bean’s office, Dr. Kirkland testified, “The whole purpose of making notes like this in the record is to be able to talk to the patients about it. And I did talk to her about it, as verified [by Patient 10’s testimony].” Dr. Kirkland further testified, “Any time a patient’s taking medication from other doctors, I tell them that it’s not appropriate; that they are only to get medication from one doctor.” Moreover, Dr. Kirkland testified that Patient 10 responded appropriately to her discussion. (St. Ex. 10 at 10b; Tr. at 1123-1125) Note, however, that no such discussion was documented in the medical record. (St. Ex. 10 at 10b)

Dr. Kirkland further testified that she talked to Dr. Bean’s office, but acknowledged that she had not documented that discussion. (Tr. at 212)

- Dr. Sickles acknowledged that he had found no documentation that Dr. Kirkland had counseled the patient concerning obtaining medication from other physicians. (Tr. at 989)

225. On March 15, 1994, Dr. Kirkland prescribed, among other things, Tylenol No. 3 #120. A subsequent entry dated March 28, 1994, states that Patient 10 complained that she had “left Soma and Tylenol in a suitcase in Florida—little chance of recovery[.]” Dr. Kirkland

prescribed, among other things, Tylenol No. 3 #120. No discussion with the patient concerning possible drug-seeking behavior is documented. (St. Ex. 10 at 18b)

- Dr. Kirkland testified concerning the March 28, 1994, note that she did not think that Patient 10 had abused her medication. Dr. Kirkland further testified that she “had a long discussion with her the first time this happened.” Dr. Kirkland acknowledged, however, that this discussion had not been documented in the medical record. (Tr. at 213-215)

226. On August 14, 1994, Dr. Kirkland prescribed, among other things, Tylenol No. 3 #100. A note dated August 15, 1994, stated that the patient had lost her prescription. Dr. Kirkland prescribed Tylenol No. 3 #50. (St. Ex. 10 at 19b)

- Dr. Kirkland acknowledged that this had been the third time that Patient 10 had reported losing a prescription. (Tr. at 216)

227. On October 29, 1997, Dr. Kirkland saw Patient 10 for a complaint of migraine headache “possibly from dental work” that morning. Dr. Kirkland noted that Patient 10’s lower jaw was swollen and tender. Dr. Kirkland diagnosed headache, ordered an IM injection of Stadol 4 mg with Phenergan 50 mg, and prescribed Percocet #20 to be taken every six hours. (St. Ex. 10 at 30a)

- Dr. Winter testified, “If [a dental problem] typically requires pain medication, the dentists usually provide that. And we don’t know in this case whether the dentist did or not.” Dr. Winter further testified that there is no documentation that Dr. Kirkland had contacted the dentist. Moreover, Dr. Winter stated, “there had been so many red flags pop up already, that one should be cautious.” (Tr. at 411)

228. Dr. Winter testified that she saw nothing documented in Dr. Kirkland’s medical record for Patient 10 that indicated that Dr. Kirkland had ever addressed possible drug-seeking behavior. Dr. Winter further testified that it would be the standard of care to document how that issue had been addressed, even if Dr. Kirkland had not believed at the time that it was a problem. “It’s always wise to document when something is questionable.” (Tr. at 411-412)

229. Dr. Sickles testified concerning situations where a patient reports losing prescriptions on more than one occasion. Because of the potential that the patient could be lying, “it puts the physician in a position of trying to be a detective and determine what is the relationship with that patient and how trustworthy do they think that patient is.” Dr. Sickles testified that the standard of care requires the physician to discuss the issue with the patient, and to determine whether to continue to manage the patient or to terminate the patient. (Tr. at 871-872)

With regard to a patient whom the physician learns is obtaining medication from multiple sources, Dr. Sickles testified that the standard of care requires the physician to confront the

patient, inform the patient that that is unacceptable and that the patient needs to obtain his/her medication from one source, and determine whether that source would be that physician or another physician. (Tr. at 871)

230. Dr. Sickles noted that the medical record indicates that Patient 10 was intolerant of Vicodin and Percodan, which Dr. Sickles testified would be inconsistent with drug-seeking. Dr. Sickles testified that drug-seeking patients will typically state that they are intolerant of milder medications such as Tylenol No. 3 in attempt to get stronger drugs such as Vicodin and Percodan. (St. Ex. 10 at 1; Tr. at 868)

Documentation Concerning Codeine Allergy

231. A page of progress notes in Dr. Kirkland's medical record for Patient 10 containing entries dated July 22 and 23, 1987, bears the statement, "Allergic to codeine." Another page of progress notes containing entries dated February 5, May 5, and May 6, 1988, bears the statement, "Allergies – Codeine." Another progress note dated January 11, 1989, states, "Drug allergies: codeine, Demerol." All of these notes date from a time when Dr. Kirkland's practice was seeing Patient 10 while covering for another physician. (St. Ex. 10 at 2a-5a)

A later entry, dated January 15, 1990, states "NKA." (St. Ex. 10 at 6a)

Although Dr. Kirkland subsequently prescribed Tylenol No. 3 to Patient 10, there is no documentation in the patient record clarifying Patient 10's drug allergy status. (St. Ex. 10)

232. Dr. Winter testified that Dr. Kirkland's prescriptions for Tylenol No. 3 causes some concern because, elsewhere in the medical record, there is information that Patient 10 is allergic to codeine, which is an ingredient in Tylenol No. 3. If the patient had not actually been allergic to codeine, it was incumbent upon Dr. Kirkland to update the medical record accordingly. Dr. Winter further testified that this is true even if Dr. Kirkland's office was only covering for another physician at that time. "If you have a patient-doctor relationship, you must know that patient's allergies before you do any prescribing." Moreover, Dr. Winter testified that the patient-doctor relationship exists "[o]nce you have seen that patient and evaluated them[.]" Finally, Dr. Winter stated that it is very important for a physician to keep accurate information concerning a patient's drug allergies because medication allergies can "bring on anaphylaxis and kill" a patient. (Tr. at 388-390)
233. Dr. Kirkland testified that she had not written the notations indicating that Patient 10 was allergic to codeine, and that those notations had been wrong. Moreover, Dr. Kirkland testified that Patient 10 never had had any problem with codeine. (St. Ex. 10 at 6a; Tr. at 204-206)

Dr. Kirkland testified that, when she sees patients for other physicians, the progress notes for their visits are kept separately in another file, and no chart is started. Dr. Kirkland stated, however, that those pages had "[e]ventually" been added to the patient's chart.

Dr. Kirkland further testified that, when Patient 10 became her patient, Patient 10 had denied that she had any drug allergies. Moreover, Dr. Kirkland testified that Patient 10 had not, in fact, been allergic to codeine or had any problems with medications containing codeine. (Tr. at 1120-1122)

Dr. Kirkland's Management of Patient 10's Back Pain with Steroids

234. Dr. Kirkland ordered IM injections of steroid medication for Patient 10 as follows:

Date	Medication	Relevant Findings and/or Diagnosis
04/29/91	Celestone 2 cc	None relevant (migraine?)
12/14/92	Decadron 8 mg	Acute L/S strain
05/11/93	Celestone 2 cc	Allergy
06/07/93	Decadron 8 mg	Back pain
08/24/94	Decadron 8 mg	Prescribed by another physician
08/25/94	Decadron 8 mg	Complaint of tender lower back
12/05/94	Decadron 8 mg	Acute L/S strain
12/08/94	Decadron 8 mg	L/S strain
12/13/94	Decadron 8 mg	L/S strain
08/14/95	Depo-Medrol & Kenalog	Allergies
09/14/95	Depo-Medrol & Kenalog	None relevant (chest pain?)
01/28/97	Depo-Medrol 80 mg	None relevant (bronchitis?)
11/20/97	Celestone 2 cc	None relevant (pharyngitis & migraine?)

(St. Ex. 10 at 10a, 15a, 16b, 19b, 20a, 21a, 23a, 23b, 28b, 30b)

235. In her written report, Dr. Winter stated that Dr. Kirkland had managed Patient 10's back pain "almost exclusively with [steroid] injections and narcotic pain medication" and that such management "is largely ineffective and inappropriate." Dr. Winter further stated that better modalities "include nonsteroidal anti-inflammatory medication, exercise, ice or heat, and strengthening, possibly through physical therapy." Moreover, Dr. Winter stated, "Numerous injections of steroids were given for allergy and back pain, often only a few days apart. The quantity of steroid injections in a three month period far exceeds the single dose most experts consider safe and appropriate." (St. Ex. 12 at 21)

Examples of Dr. Kirkland's Ordering of Steroid Injections

236. On April 29, 1991, Dr. Kirkland saw Patient 10 for a follow-up visit concerning pharyngitis. She noted that Patient 10 had complained of earache, nausea, temperature at night, awaiting surgery, and migraine. She further noted that Patient 10 had taken two

Tylenol No. 3. Dr. Kirkland diagnosed migraine, and ordered, among other things, an IM injection of Celestone 2 cc. (St. Ex. 10 at 10a)

- Dr. Winter testified that the purpose of the Celestone injection was not documented. Dr. Winter speculated that it may have been given to treat the earache if Dr. Kirkland had suspected that the earache had been caused by allergies. (Tr. at 392-393)

237. On August 24, 1994, Patient 10 saw Dr. Kirkland's husband for a complaint of back pain. He ordered, among other things, an IM injection of Decadron 8 mg. Subsequently, on August 25, 1994, Patient 10 reported that her pain was no better, she had an abscessed tooth, and her lower back was tender. Dr. Kirkland ordered, among other things, an IM injection of Decadron 8 mg. (St. Ex. 10 at 19b-20a)

- Dr. Kirkland stated that she had given Patient 10 an injection of Decadron for her back pain, "to cut down on inflammation and swelling." (Tr. at 217)

238. On December 5, 8, and 13, 1994, Dr. Kirkland ordered IM injections of Decadron 8 mg. (St. Ex. 10 at 21a)

- Dr. Kirkland testified that those injections had been given to cut down on inflammation in the patient's back. Dr. Kirkland testified that she had documented back problems, including herniated discs. Dr. Kirkland further testified that she had also given ultrasound treatments to Patient 10 to help her back. (Tr. at 217)

239. On August 14, 1995, Dr. Kirkland saw Patient 10 for complaints of swelling in throat off and on for one month, and for medication refills. Dr. Kirkland diagnosed allergies. Among other things, she ordered an IM injection of Depo-Medrol with Kenalog. (St. Ex. 10 at 23a)

- Dr. Kirkland testified that the Depo-Medrol had been given to relieve Patient 10's allergy symptoms. (Tr. at 218)
- When asked if a Depo-Medrol injection is appropriate to treat a diagnosis of allergies, Dr. Winter replied,

Sometimes it is. However, in her case, you know, she's had fairly recent steroids and should be covered at this point already. For allergy, it only takes a low level of steroids in the system to work if they're going to work.

And if the swelling—here it does not appear to be appropriate because it does not—I don't see any evaluation of the swelling in the throat off and on for one month.

(Tr. at 408) Moreover, Dr. Winter testified that she cannot tell how the diagnosis of allergies was made. The only findings documented were “Chest-clear” and “Heart nsr.” (Tr. at 409)

240. Dr. Kirkland denied that she had given Patient 10 an excessive amount of steroids during the course of her treatment. (Tr. at 218-219)

241. Dr. Kirkland testified that back x-rays done on December 5, 1994, indicated that Patient 10 had degenerative disc disease. “So the patient had documented disease.” (Tr. at 1128)

An x-ray report dated December 6, 1994, concerning Patient 10’s lumbosacral spine, concludes, “Mild degenerative disc disease at L5-S1 with minimal spondylosis involving the lower lumbar spine.” (St. Ex. 10 at 61)

242. Dr. Winter testified concerning the x-ray report dated December 6, 1994, that indicates mild degenerative disc disease at L5-S1 with mild spondylosis, that “[g]enerally, this means nothing.” Dr. Winter further testified that that report would not justify the prescriptions that were issued to Patient 10 for back pain. (Tr. at 412-413)

Conclusions Regarding Dr. Kirkland’s Care of Patient 10

243. With regard to Dr. Kirkland’s selection of modalities to treat Patient 10’s back pain, Dr. Winter testified,

I think in this case, there was some help with that. Soma was prescribed on a frequent basis. That’s a muscle relaxant which does generally help with the back pain.

I feel that the patient missed out on a change in emphasis of the treatment. There should have been more—more emphasis in using anti-inflammatories, which actually reduce inflammation, with strengthening exercise, weight loss, than there were in this patient. I think by focusing on narcotic medications and steroid injections, they were missing some good opportunities to actually improve her—improve her function with the back pain.

(Tr. at 414-415)

However, with regard to Patient 10’s headaches, Dr. Winter testified that Dr. Kirkland had not treated Patient 10 appropriately. Dr. Winter noted that migraine headaches can be very complicated. However, Dr. Kirkland had failed to do any appropriate evaluation to determine whether Patient 10’s headaches really were migraine headaches, or if they were of some other type. Dr. Winter further noted that Elavil can be a useful medication for preventing certain types of headaches, but that it obviously “wasn’t doing the job by itself.” Dr. Winter testified that the patient would have benefited from a good evaluation of her

headaches, and from “the use of multiple other modalities of treating it; in particular, non-narcotic medications.” (Tr. at 415)

244. Dr. Winter testified that Dr. Kirkland’s treatment of Patient 10 fell below the minimal standard of care “regarding a number of problems, but most commonly with the excessive dosages of Stadol and of steroids for allergy and back pain.” (Tr. at 401)

With regard to Dr. Kirkland’s use of reasonable care or scientific methods in the selection of drugs or other modalities in the treatment of disease, Dr. Winter testified,

[Patient 10] received inappropriate drugs both by injection and by prescription for multiple medical problems, most predominantly migraine, which was treated predominantly with injections of Stadol and narcotic medications rather than any abortive or preventive measures or alternative pain measures.

The—Throughout the treatment period, frequent and increasing doses of these narcotics are prescribed. In addition, narcotic pain medications were used to assist with back pain, which appeared to be very mild by physical signs, and [she] did not pursue other modalities that would have been more appropriate. And I feel that Dr. Kirkland failed to attend to numerous red flags during this patient’s care * * *.

(Tr. at 384)

245. Dr. Sickles testified that, in his opinion, Dr. Kirkland’s treatment of Patient 10 had conformed to the minimal standard of care of similar practitioners under the same or similar circumstances. Dr. Sickles further testified that Dr. Kirkland had used reasonable care discrimination and acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. (Tr. at 866)
246. When asked if there were subjective and objective findings in the medical record that were consistent with Dr. Kirkland’s diagnoses, Dr. Sickles testified that migraine headaches “are almost an entirely subjective diagnosis. There’s very little other than a perceived perception of the patient’s pain based on facial expressions and things. There’s not going to be much in the way of objective findings for—for migraine headache type of problems.” (Tr. at 870)

With regard to Patient 10’s back pain, Dr. Sickles testified that there were abnormal findings on x-rays. Dr. Sickles further noted that the severity of a patient’s symptoms may not necessarily correlate with the severity of abnormalities that are apparent from x-rays or MRIs. (Tr. at 870)

247. Dr. Sickles testified that it had been appropriate for Dr. Kirkland to use injections of Stadol as an abortive medication for Patient 10’s headaches. (Tr. at 868-869)

248. Dr. Kirkland testified that, throughout her treatment of Patient 10, she had had discussions with Patient 10 concerning the risks and benefits of the controlled substances that were being prescribed. Dr. Kirkland testified that she does not believe that Patient 10 was drug seeking, or was addicted or dependent upon her medication. (Tr. at 1125-1126)
249. Dr. Kirkland testified that her diagnoses of Patient 10's conditions had been correct and appropriate. Dr. Kirkland further testified that specialists and objective studies had confirmed her diagnoses. Dr. Kirkland further testified that her treatment of Patient 10's conditions was corroborated by discussions with specialists and by studies. (Tr. at 1130-1131)

Testimony of Patient 10

250. Patient 10 testified that she has been a patient of Dr. Kirkland's since 1987. Patient 10 further testified that she had worked as a secretary and as a bartender. She is not currently employed, and is on total disability. Patient 10 testified that she stopped working on February 5, 2002. (Tr. at 643)

Patient 10 testified that she has been having migraine headaches since 1978. The frequency of her migraine headaches depends on her stress level and her blood pressure. She can go two or three months without a migraine, but sometimes she has them as frequently as three or four in one month. Her symptoms include a very bad headache and vomiting. (Tr. at 643-644)

When asked how long her migraine headaches last, Patient 10 replied,

Well, that would just depend. If I would see Dr. Kirkland and she would be able to give me something and I could go to bed for six or seven hours, I would be okay. But if I would try to go and do nothing about it, I might have a headache for like two days. And by the end of the second day, it would just be, you know, extremely bad.

(Tr. at 644-645)

251. Patient 10 testified that her back problems had started around 1988 or 1989. Patient 10 further testified that Dr. Kirkland had prescribed Tylenol No. 3 and Soma for her headache and back, and administered injections of Stadol to give her relief from her migraines. Patient 10 testified that she had received injections of Stadol when she was having a migraine attack. (Tr. at 643-646)

Patient 10 testified that Dr. Kirkland had also tried her on other medication, such as Elavil to aid sleep, Zoloft, and Flexeril. Patient 10 further testified that Dr. Kirkland had sent her to specialists, and for diagnostic studies such as CT scans and x-rays. Patient 10 stated that Dr. Kirkland had tried to find triggers for her migraines, and counseled her on exercise and weight loss. Moreover, Patient 10 testified that, on more than one occasion, Dr. Kirkland had discussed with her the addiction potential of the pain medication she was using.

Finally, Patient 10 testified that Dr. Kirkland had talked to her at each visit about reducing the amount of pain medication she used. However, Patient 10 testified that, because her back was so painful, she had been unable to do so. (Tr. at 646-649, 652-653)

252. Patient 10 testified that she had once received pain medication from another physician following a tonsillectomy and had failed to inform Dr. Kirkland. Patient 10 testified that Dr. Kirkland was very upset and informed her that that was unacceptable. Patient 10 further testified that Dr. Kirkland told her that she would discontinue seeing Patient 10 as her patient if it happened again. (Tr. at 658-659)

253. Patient 10 testified that she is not allergic to codeine. (Tr. at 653)

Additional Information

254. Dr. Winter testified that, in her opinion, the care that Dr. Kirkland rendered to Patients 1 through 10 fell below the minimal standard of care. Dr. Winter further testified that, in her treatment of those patients, Dr. Kirkland had failed to use reasonable care discrimination in the selection of drugs or other modalities for the treatment of disease. Moreover, Dr. Winter testified that Dr. Kirkland had failed to maintain patient records that reflected her evaluations and examinations of Patients 1 through 10. Furthermore, Dr. Winter testified that Dr. Kirkland had “[g]enerally” failed to document the purposes for which controlled substances were being utilized. Finally, Dr. Winter testified that, for her chart entries from 1986 through 1998, Dr. Kirkland had failed to follow the Board’s rules relating to the documentation required for prescribing controlled substances. (Tr. at 413-414, 416)

Dr. Winter further testified,

In general, I felt that there was a * * * general lack of concern in the prescribing of narcotic medications. The appearance, to me, was that of a naïveté in dealing with patients and their narcotic medications. In addition, I was also concerned because there seemed to be a lack of thoroughness in evaluating patients’ medical conditions and working toward improvement of their symptoms.

(Tr. at 237-238) Dr. Winter noted that Dr. Kirkland’s records did contain adequate patient histories; however, they did not consistently document thorough physical examinations. Moreover, Dr. Winter testified that, in many cases, she did not feel that adequate evaluations or diagnostic testing had been documented. Furthermore, Dr. Winter testified that, when Dr. Kirkland had been presented with patients who demonstrated signs of abuse or the potential for abuse of controlled substances, or when patients’ problems with controlled substances had been brought to her attention by consultants, Dr. Kirkland did not always respond appropriately. (Tr. at 238)

255. Concerning situations when the amount of a prescribed medication increases, Dr. Winter was asked if it is fair to assume that it was increased because the prior dose did not prove satisfactory. She replied that that cannot be assumed, and that the reason must be documented. Moreover, when asked if, when a medication is changed to a different medication, it is logical to conclude that the earlier medication was not proving effective, Dr. Winter replied,

I disagree. A lot—Medications are changed for many different reasons. In today's world, an insurance company tells you, 'We'll pay for this drug, we won't pay for that.' That is often the reason behind changes. A patient, you know, sometimes will find on his own that a particular drug is cheaper and would like to try that one. Or in some cases one is less effective. There are a great number of reasons for potential changes. And that is why we need to be clear on the documentation.

Also, a patient will occasionally tell you they don't tolerate a medication. It's important to know that for your records to understand the patient, as well as prevent future trials of that medication if that truly was the case.

(Tr. at 427-428)

256. Concerning patients with pain complaints, Dr. Winter acknowledged that some entries in Dr. Kirkland's medical record indicate that Dr. Kirkland had encouraged patients to reduce their intake of medication. However, Dr. Winter further testified that Dr. Kirkland had then continued to prescribe the same amounts of medication. "So, yes, it does show a good intention, but it does not show that the driver of the ship is steering the ship." Moreover, if a patient had followed Dr. Kirkland's advice and reduced the amount of medication used, then Dr. Kirkland should have "correspondingly decrease[d] the prescribed dosage." (Tr. at 429-430)

Conversely, Dr. Winter testified that, if a dosage of medication is not proving to be effective in controlling a patient's pain, it may make sense to increase the amount of medication prescribed if the reasons make sense and are appropriately documented. However, "[i]f the dosage is not covering the pain, then you should still be looking to find ways to manage that patient's pain, whether it's increasing the dosage, whether it's adding adjunctive medications, whether it's trying physical therapy or behavioral therapy. There are so many different things you can do." (Tr. at 430-431)

257. Dr. Sickles testified that he believes that Dr. Kirkland completed and maintained accurate medical records reflecting her examination, evaluation, and treatment of Patients 1 through 10. Dr. Sickles further testified that he believes that Dr. Kirkland's medical records accurately reflect the utilization of controlled substances in her treatment of these patients. Finally, Dr. Sickles testified that he believes that Dr. Kirkland's medical records indicate the diagnosis and purpose for which controlled substances were utilized, and additional information upon which the diagnoses were based. (Tr. at 888-889)

258. With regard to the issue of early refills of controlled substance prescriptions, Dr. Sickles testified that it is not uncommon for patients to request refills of pain medication too early. Dr. Sickles testified that, when that occurs, the standard requires that the physician be aware of the situation, and discuss with the patient why he/she is taking more medication than is being prescribed. Dr. Sickles testified that, many times, this indicates a need for the physician to either increase the dose to control the patient's pain, or to try a different medication. Dr. Sickles noted that dismissing the patient is another option that the physician could consider. However, Dr. Sickles testified that "it does put the physician in a position where they have to try and address that." (Tr. at 828-829)

With regard to the issue of dismissing a non-compliant or drug-seeking patient from the practice, Dr. Sickles testified that if he believes that a patient is simply manipulating him to obtain drugs, he dismisses the patient from his practice without hesitation. However, if he believes that a patient has legitimate pain concerns, he is reluctant to automatically dismiss the patient from his practice. Dr. Sickles further testified that to do so may be in the best interest of the physician sometimes, but does not address the problem of who is going to manage the patient's problems. Moreover, Dr. Sickles testified that it is for the physician to discuss his/her concerns with the patient, and how they are going to deal with the patient's non-compliance. (Tr. at 830-831)

259. Dr. Sickles noted that he cannot tell from Dr. Kirkland's medical records whether she had the necessary discussions with the patients concerning their requests for early refills of pain medication. However, Dr. Sickles testified that, as long as those discussions took place, then, in his opinion, Dr. Kirkland's continued prescribing to those patients had met the standard of care. (Tr. at 832-834)
260. Dr. Sickles testified that from his review of the patients' medical records, Dr. Kirkland's patients were taking therapeutic and appropriate doses of medication. Dr. Sickles further testified that he did not see any instance where Dr. Kirkland had prescribed medication beyond the recommended therapeutic dosage. (Tr. at 789-790, 835)
261. Dr. Sickles acknowledged that he had received written summaries from Dr. Kirkland concerning her care of Patients 1 through 10. Dr. Sickles further testified, however, that he had not relied on that information in forming his opinions concerning whether she had conformed to the standard of care. Nevertheless, Dr. Sickles testified that he made one assumption during his review of Dr. Kirkland's patients; namely,

the assumption that there were conversations with patients regarding the premature filling of their prescriptions.

That is the one assumption that I made. But it's not based on anything that Dr. Kirkland said in any of these documents. It's just based on an assumption that I made in order for me to assume that she was providing appropriate care to her patients.

(Tr. at 1010-1011) Dr. Sickles further testified that, if he had not been able to assume that, his opinion would have changed. (Tr. at 1011)

262. Dr. Kirkland testified that she refers her patients to specialists frequently “not only to confirm a diagnosis, but to help [her] in clinically managing the patient.” For example, Dr. Kirkland testified that she referred patients who had problems of an emotional or psychiatric nature to psychiatrists. Moreover, Dr. Kirkland testified that many insurance companies will not reimburse family physicians for treating patients with psychiatric problems, so those patients have to be referred out. However, Dr. Kirkland further testified that, lately, there are fewer psychiatrists in her geographic area to whom she can refer patients, so it is becoming harder to get patients in. (Tr. at 1030-1032)

Dr. Kirkland further testified that the number of physicians who specialize in pain control in her geographic area has also diminished. Dr. Kirkland testified that, currently, there are three pain specialists in Montgomery County, and one of them “absolutely will not prescribe pain medication; all he does is back injections.” (Resp. Ex. D; Tr. at 1032-1033)

263. Dr. Kirkland indicated that she does not believe that she needed to document the purpose of every single treatment as long as it was documented in the medical record at some previous time. (Tr. at 1154)
264. Dr. Kirkland testified that, when she had discussions with a patient concerning her suspicion that the patient may have been obtaining medication from more than one physician, she did not always document that discussion in the record. However, Dr. Kirkland testified, “[The] whole purpose of putting the note in the chart was to remind me to do this for the patient. Otherwise, why would I put the note in the chart. You know what I’m saying? I had to discuss it with the patient. It was part of the medical record. It was necessary to put it in the chart.” (Tr. at 1155-1156)
265. Dr. Kirkland testified that she currently treats no patients with controlled substances. “I have elected not to give out any controlled substances mainly because of why I’m here today.” Dr. Kirkland further testified that, during the time period that is relevant to this hearing, she had not had very many patients who had received controlled substance medication. For example, Dr. Kirkland testified that she could not recall any patient in her practice besides Patient 10 who had received injections of Stadol. Moreover, she testified that she could not recall any patient besides Patient 7 whom she had treated with Demerol. (Tr. at 1029-1030)

Dr. Kirkland testified that, as a result of her decision to discontinue prescribing controlled substances, she feels somewhat restricted in her ability to care for patients. “You know, the role of a family practice doctor is to take care of the whole patient. And that’s always what I have been taught. And I don’t feel like I can do that right now. So I’ve had to send all these people out to specialists. * * * And if that’s what I have to do, that’s what I have to do.” (Tr. at 1152)

266. Dr. Kirkland testified that she believes that her medical records for Patients 1 through 10 accurately reflect the utilization of any controlled substance used to treat each patient. Dr. Kirkland further testified that she recorded the name of the controlled substances utilized and the dosages. Moreover, Dr. Kirkland testified that her medical records indicate the diagnoses and purposes for which she utilized controlled substances. (St. Ex. 15; Tr. at 1039-1041)
267. Dr. Kirkland testified that, for all of the patients for whom she prescribed controlled substances, she closely monitored them with frequent visits to her office. Dr. Kirkland further testified that she had discussions with those patients concerning the nature of those medications, and the dosages. Moreover, Dr. Kirkland testified that she prescribed medication to her patients only when she felt it was in the best interests of the patient's health. (Tr. at 1151)

FINDINGS OF FACT

1. In the routine course of her practice, Jeanne M. Kirkland, M.D., undertook the treatment of Patients 1 to 10, as identified in a confidential Patient Key. As demonstrated in her patient records, Dr. Kirkland excessively and inappropriately prescribed controlled substances and dangerous drugs to Patients 1 through 10 without performing appropriate histories and physical examinations, and/or without utilizing diagnostic testing or other methods of evaluating the validity of the patients' complaints or the nature or severity of the patients' reported pain, and/or without devising treatment plans, and/or without periodically reassessing the effectiveness or the treatment, and/or despite her knowledge that the patients were abusing controlled substances or exhibiting drug-seeking behavior, and/or despite recommendations by consultants that narcotic therapy be discontinued, and/or she failed to document the above actions. Further, Dr. Kirkland failed to provide and/or document primary treatment and/or preventive care for the medical conditions suffered by the patients, and she failed to respond and/or document her response to changes in the patients' conditions.

Examples of such prescribing and/or conduct include, but are not limited to, the following:

- a. Dr. Kirkland began treating Patient 1 in October 1988. In 1993, identifying anxiety as a problem, she prescribed Valium and Ativan to Patient 1. Although Dr. Kirkland continuously prescribed Valium and Ativan, she failed to perform and/or document an appropriate evaluation, diagnosis, assessment of symptoms, or reassessment of the treatment and/or consider appropriate alternate therapy. Dr. Kirkland continued to prescribe these medications to Patient 1, often overlapping sequential prescriptions.

Beginning in January 1994, Dr. Kirkland treated Patient 1 for injuries and pain by inappropriately prescribing Tylenol No. 3, which gradually developed into continuous, excessive prescribing of Vicodin without performing and/or documenting an

appropriate evaluation of the patient at regular intervals. On Patient 1's final visit in or about January 1998, despite previously advising the patient to decrease her use of pain medications, Dr. Kirkland issued a prescription for her usual dosage of Vicodin.

- b. Dr. Kirkland began treating Patient 2 in January 1986. There is a considerable amount of evidence that Patient 2 suffered from bona fide chronic pain. There is also ample evidence that Dr. Kirkland attempted or recommended numerous modalities to address Patient 2's pain besides narcotic pain medication, including antidepressant medication, ultrasound, physical therapy, referrals to surgeons and other specialists, and referrals to pain specialists and pain clinics.

The evidence indicates that in January 1991, she began to prescribe Valium and narcotic pain medication to Patient 2, but failed to document her assessment of the medical condition for which the Valium was prescribed. Moreover, the doses of Valium and narcotic pain medication prescribed to Patient 2 gradually increased over time.

After evaluating Patient 2, a specialist in neurosurgery recommended that Patient 2 be weaned from all narcotics. Nevertheless, Dr. Kirkland continued to inappropriately prescribe Percocet and other narcotic medications in increasing doses. Furthermore, during the course of her treatment of Patient 2, even though Patient 2 displayed drug-seeking behavior, exhibited signs of drug dependency, and demonstrated compromised judgment, Dr. Kirkland failed to modify her treatment protocol until August 1994. In August 1995, Dr. Kirkland terminated the physician/patient relationship with Patient 2 by letter informing him that she had discovered that Patient 2 had been receiving Methadone prescriptions from another physician.

- c. Dr. Kirkland first began treating Patient 3 in August 1981. She treated Patient 3 for complaints of headaches, and anxiety and/or depression, with a prescription of Tylenol No. 3 for the headaches, and prescriptions of Xanax or Ativan for the mood disorders. By letter dated May 3, 1988, Patient 3's psychiatrist reported to Dr. Kirkland that he had prescribed Xanax to Patient 3, that he was concerned over suspicions reported by Patient 3's family and friends that she was not taking the medication properly, and that a schedule to taper her off Xanax had been established. In response, Dr. Kirkland briefly attempted to reduce the dose of Xanax prescribed; however, she resumed prescribing the higher doses of Xanax despite the psychiatrist's recommendation. She further continued to prescribe Xanax and Vicodin despite Patient 3's drug-seeking behavior. Moreover, despite having made appropriate referrals for physical therapy, and for orthopedic and neurological consultations for her complaints of back pain, Dr. Kirkland continued to inappropriately treat Patient 3 with narcotic pain medications.

Dr. Kirkland inappropriately prescribed to Patient 3 excessive amounts of Xanax and Vicodin, and on multiple occasions failed to adequately document the prescriptions, instead noting only the date and medication in the patient file. On several occasions,

she failed to document whether the patient had had an office visit or had called the office requesting a prescription.

- d. Dr. Kirkland began treating Patient 4 in July 1994. She inappropriately prescribed excessive and increasing doses of Vicodin for chronic back pain to Patient 4. However, Dr. Kirkland failed to evaluate and/or continue to assess and/or failed to document her evaluation and continued assessment of his back pain and arthritis, and failed to undertake any additional pertinent studies. Moreover, Dr. Kirkland failed to offer other modalities of treatment for chronic back pain and arthritis, although there is evidence that she referred him for physical therapy after he was injured in a fall. Furthermore, in late 1995, Dr. Kirkland attempted to limit Patient 4 to a lower dosage of Vicodin, but abandoned this attempt by June 1996, and continued prescribing Vicodin at the previous dosage and dosing frequency, despite some indications of drug-seeking behavior.

Furthermore, the evidence is sufficient to support a finding that Dr. Kirkland failed to acknowledge or respond, or to document an acknowledgement or response, to Patient 4's elevated GGT levels, which indicated possible excessive alcohol intake. Although persuasive evidence was presented that this factor does not, by itself, prove that Patient 4 was abusing alcohol, under the circumstances of this case, because the patient was receiving continuing prescriptions for narcotic pain medication, it was incumbent upon Dr. Kirkland to note the possibility that Patient 4 might be abusing alcohol and investigate further.

- e. Dr. Kirkland treated Patient 5 from September 1994 through March 1996. Dr. Kirkland frequently saw Patient 5 in office visits and inappropriately prescribed Vicodin without adequate documentation of an evaluation and assessment of the patient's medical conditions, the patient's response to treatment, or any consideration about the appropriateness of the amount of Vicodin being prescribed.
- f. Dr. Kirkland began treating Patient 6 in March 1984. Her treatment of Patient 6 included inappropriately prescribing large and frequent doses of Xanax for diagnoses of anxiety and depression without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Additionally, Dr. Kirkland failed to adequately document and/or monitor Patient 6's progress or lack of progress with this medication.

Moreover, Dr. Kirkland continued inappropriately prescribing Xanax to Patient 6 despite signs of drug dependency. Specifically, after having been apprised that Patient 6 had received treatment for cocaine addiction and Xanax abuse, Dr. Kirkland prescribed a small amount of Xanax in decreasing dosages to Patient 6. Dr. Kirkland did this to forestall what she had evidently interpreted to be withdrawal symptoms, but without documenting any of the symptoms that led her to that conclusion. The evidence is sufficient to support a finding that that such treatment was inappropriate.

- g. Dr. Kirkland began treating Patient 7 in November 1983. As a result of cervical disease, an automobile accident, and repeated head trauma secondary to syncope, Patient 7 suffered from multiple headaches. However, Dr. Kirkland inappropriately and excessively prescribed Percodan, Darvocet, Tylenol No. 3, Fiorinal No. 3, Percocet, Vicodin ES, and Duragesic Patch. Such prescribing was unwarranted for this patient's continuing pain in the absence of trials of other modalities such as prophylactic medication, which was not tried until November 1993. In addition, Dr. Kirkland inappropriately authorized multiple injections of Demerol with Phenergan or Vistaril, often several times monthly, to Patient 7, and frequently without documentation of a diagnosis or physical exam.

Moreover, without adequate documentation of her current condition, a physical exam, and often lacking a diagnosis to justify the treatment, Dr. Kirkland prescribed numerous injections of steroids; however she failed to consider and/or document any consideration of the long-term consequences of frequent steroid injections.

- h. Dr. Kirkland began treating Patient 8 in June 1988. In her treatment of Patient 8, Dr. Kirkland inappropriately prescribed continuous and excessive quantities of Lortab, or occasional prescriptions for Vicodin, Darvocet and Esgic Plus, for Patient 8's complaints of pain. Nevertheless, Dr. Kirkland failed to document any significant clinical or physical findings in an appropriate pain evaluation and assessment. Further, after an evaluation of Patient 8's pain, a rheumatologist reported that he had a deep concern about continued prescribing of narcotic pain medication, recommended that the Vicodin be tapered down, and recommended alternative therapies. However, Dr. Kirkland continued to inappropriately prescribe excessive amounts of Lortab. Moreover, in the patient record, Dr. Kirkland failed to acknowledge the rheumatologist's recommendations, and failed to discuss and/or document a discussion with Patient 8 regarding those recommendations.
- i. During the course of treating Patient 9, Dr. Kirkland issued frequent prescriptions of Ativan to Patient 9 without documenting the diagnosis or rationale for the prescriptions.
- j. Dr. Kirkland began treating Patient 10 in May 1988. During the course of her treatment of Patient 10, Dr. Kirkland inappropriately ordered for Patient 10 excessive IM injections of Stadol with Phenergan or Vistaril for complaints of migraine. Further, she failed to establish a diagnosis of migraine either by description of symptoms or expert evaluation. Moreover, Dr. Kirkland ordered IM injections of Stadol with Phenergan or Vistaril when such injections were not appropriate to treat the documented diagnoses, such as acute viral syndrome, depression, sinusitis, insomnia, and bronchitis.

Additionally, Dr. Kirkland treated Patient 10's migraines with Tylenol No. 3 from September 1990 through January 1998, the last visit on record. Moreover, a 1989 entry in the patient record indicates that Patient 10 was allergic to codeine; however,

Dr. Kirkland subsequently prescribed Tylenol No. 3 without clarifying the patient's allergy status. Furthermore, in her management of Patient 10's migraine headaches, Dr. Kirkland failed to consider eliminating triggers, which could prevent the onset of a migraine.

Moreover, throughout the treatment period, Dr. Kirkland inappropriately prescribed frequent and increasing doses of Tylenol No. 3, and occasional prescriptions for Percodan, and Vicodin, or Vicodin ES. Despite the fact that Dr. Kirkland noted indications of drug-seeking behavior, including a report from another physician's office that Patient 10 had received medication from three other physicians, Dr. Kirkland failed to discuss and/or document any discussion with Patient 10 about this situation and continued to inappropriately prescribe narcotic pain medications without interruption.

Furthermore, Dr. Kirkland prescribed multiple injections of steroids for allergy and back pain, often only a few days apart. The quantity of steroid injections that the patient received in a three-month period was excessive.

Finally, Dr. Kirkland had treated the patient's back pain almost exclusively with injections and narcotic pain medications and failed to consider and/or document alternative modalities for the treatment of the patient's back pain.

2. In the routine course of her practice, Dr. Kirkland undertook the treatment of Patients 1 through 10, as identified in a confidential Patient Key. After November 17, 1986, in her treatment of Patients 1 through 10, Dr. Kirkland routinely failed to maintain records that accurately reflected her evaluation, examination, and the utilization of controlled substances in the treatment of those patients, and the diagnoses and purposes for which the controlled substances were being utilized.
3. The evidence is insufficient to support the following allegations:
 - a. With regard to Patient 2, the notice of opportunity for hearing alleged that, on or about September 29, 1994, Dr. Kirkland had informed Patient 2 that she would no longer prescribe Prozac, Sinequan and Valium for him, because she had been aware that he was receiving these medications concurrently from another physician. However, in October 1994, Dr. Kirkland inappropriately prescribed Prozac, Sinequan and Methadone.

The evidence is insufficient to support this allegation because the October 4, 1994, note upon which this allegation is based does not appear to document prescriptions being issued to Patient 2. Rather, it is simply a record of the medications that Patient 2 was receiving from another physician.

- b. With regard to Patient 2, the notice of opportunity for hearing alleged that, on or about October 17, 1994, Dr. Kirkland had referred Patient 2 to a specialist for

Methadone maintenance and documented in the medical records that Patient 2's treatment with Methadone was to be assumed by the specialist. Nevertheless, Dr. Kirkland continued to prescribe Methadone to Patient 2 after his treatment began with the Methadone specialist.

Note that the State declined to present evidence supporting this allegation. See Procedural Matters 5, above.

- c. With regard to Patient 4, the notice of opportunity for hearing alleged that Dr. Kirkland failed to acknowledge and respond and/or document an acknowledgement and response to the consistently and significantly abnormal laboratory values in the management of Patient 4. Although Patient 4's total cholesterol values were significantly elevated while on medication, Dr. Kirkland failed to respond appropriately. Additionally, Patient 4 had elevated red blood cell indices which indicated possible excessive alcohol intake in a patient who excessively used narcotics.

First, with regard to cholesterol values, Dr. Winter stated that Patient 4's continued high total cholesterol values while receiving cholesterol-lowering medication should have alerted Dr. Kirkland to the issue of non-compliance with prescribed medication, and that this issue was not addressed. However, other evidence was persuasive that cholesterol pain medication can be very expensive, and that high cholesterol values are asymptomatic from a patient's perspective. On the other hand, pain medication is less expensive and pain is a powerful motivator to take pain medication. Accordingly, no finding is made that Patient 4's failure to comply with cholesterol therapy should have caused Dr. Kirkland to suspect that he might abuse his pain medication.

Further, the allegation concerning elevated red blood cell indices was not persuasively supported by evidence. Evidence was presented that the abnormal red blood cell indices present in this case were mildly elevated and were not indicative of alcoholism.

- d. With regard to Patient 7, the notice of opportunity for hearing alleged that, despite the fact that Dr. Kirkland prescribed allergy-desensitizing injections for Penicillin to Patient 7, she also prescribed several oral courses of Amoxicillin and Augmentin concurrent with the injections, which would have been inappropriate if she actually had been allergic to Penicillin.

The evidence is insufficient to support his allegation because Patient 7 had received allergy-desensitizing injections for Penicillium mold, not the medication penicillin. Moreover, Patient 7 had previously received penicillin and amoxicillin without adverse effect prior to the initiation of allergy-desensitizing injections.

- e. With regard to Patient 9, the notice of opportunity for hearing alleged that Dr. Kirkland had prescribed Ativan to Patient 9 continuously throughout his care.

Although the evidence is sufficient to find that such prescriptions had been frequent, the evidence is insufficient to support a finding that they were continuous. For example, Dr. Kirkland did not prescribe Ativan to Patient 9 from December 1994 through December 1995. Moreover, Dr. Kirkland last prescribed Ativan to Patient 9 in March or June 1996, although the record reflects that she continued to see him as a patient through at least December 1997.

- f. With regard to Patient 10, the notice of opportunity for hearing alleged that, during a representative period of six months from January 1992 through June 1992, Dr. Kirkland prescribed at least ten injections of Stadol to Patient 10.

Note that the State declined to present evidence supporting this allegation. See Procedural Matters 5, above.

- g. With regard to Patient 10, the notice of opportunity for hearing alleged that Dr. Kirkland had failed to consider other non-narcotic medications in her treatment of Patient 10's migraine headaches.

The evidence is insufficient to support a finding that Dr. Kirkland had failed to consider alternative medications. The medical record indicates that Dr. Kirkland had prescribed at one time or another Inderal, Cataflam, and Elavil to Patient 10, although the documentation is less than precise concerning the purposes for these medications.

CONCLUSIONS OF LAW

1. The conduct of Jeanne M. Kirkland, M.D., as set forth in Findings of Fact 1 and 2, constitutes “[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code, as in effect prior to March 9, 1999.
2. The conduct of Dr. Kirkland as set forth in Findings of Fact 1 and 2 constitutes “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.
3. There was conflicting testimony at hearing concerning the standard for medical documentation; specifically, the adage that if something is not documented in the medical record, it is deemed not to have occurred. Dr. Winter testified that that adage has applied for at least the past twenty years. Dr. Sickles testified that his position as a witness in medical malpractice cases has been that the court can look beyond the medical record, and that he would consider the statements of the physician and the patient in addition to the medical record to determine what transpired.

This Board has determined in the past that that if something is not documented in the medical record, it did not occur. Testimony offered in this case to the contrary is not persuasive. First, medical records are not kept simply for medico-legal purposes. They are also kept to ensure continuity of care for patients. If a treating physician dies or becomes unavailable, a subsequent treating physician would not be able to contact him or her to determine the course of the patient's previous treatment. Moreover, the subsequent treating physician cannot be expected to rely on the patient for that information, because the patient could well provide unreliable information, intentionally or unintentionally. Patients may also be uncommunicative due to illness or infirmity.

Furthermore, the memories of physicians and patients are fallible. Busy physicians cannot be expected to remember the details of treatment rendered in the past to one patient out of the hundreds or thousands that they may have treated during the intervening period. Moreover, patients vary in their degree of understanding of medical treatment, and cannot be relied upon to provide the level of technical information that may be necessary to reconstruct a course of treatment.

In addition, the reliability of testimony of physicians and patients could potentially be tainted by self-interest.

Finally, with regard to the prescribing of controlled substances, Rule 4731-11-02(D), Ohio Administrative Code, requires physicians to complete and maintain accurate medical records. Rule 4731-11-02(D), Ohio Administrative Code, states as follows,

A physician shall complete and maintain accurate medical records reflecting the physician's examination, evaluation, and treatment of all the physician's patients. Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based.

Ohio Adm.Code 4731-11-02(D), as in effect since September 1, 2000. (Note that the only change from the earlier version of this rule, as in effect from November 17, 1986, through August 31, 2000, was to make the language gender-neutral.)

Accordingly, the conduct of Dr. Kirkland as set forth in Findings of Fact 2 constitutes "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(D), Ohio Administrative Code. Moreover, pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

* * * * *

The evidence shows that Dr. Kirkland's medical practice with regard to her treatment of Patients 1 through 10 was deficient, primarily in her prescribing of controlled substance medication. Some of the deficiencies noted were doubtless the result of poor recordkeeping, which in many instances was abysmal.

A period of years has passed since the last occurrence upon which this action was based. One might have hoped that Dr. Kirkland would have come to realize during that time that there had been deficiencies in her practice. However, even though she has voluntarily ceased prescribing controlled substances, she did not do so because she has recognized the problems in her practice. Instead, she maintains that her treatment had been appropriate.

Accordingly, the Proposed Order suspends Dr. Kirkland from practice until she completes courses approved by the Board on the topics of medical recordkeeping and controlled substance prescribing. Following reinstatement, Dr. Kirkland would be subject to probationary conditions that include a requirement that she keep a log of controlled substances prescribed, dispensed, or administered. Moreover, her practice will be monitored to assure that it presents no harm to the public.

PROPOSED ORDER

It is hereby ORDERED that:

- A. **SUSPENSION OF CERTIFICATE:** The certificate of Jeanne M. Kirkland, 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. Kirkland's certificate to practice medicine and surgery until all of the following conditions have been met:
 1. **Application for Reinstatement or Restoration:** Dr. Kirkland shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
 2. **Controlled Substances Prescribing Course:** At the time she submits her application for reinstatement or restoration, Dr. Kirkland shall provide acceptable documentation of successful completion of a course dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which they are completed.

3. **Medical Records Course**: At the time she submits her application for reinstatement or restoration, Dr. Kirkland shall provide acceptable documentation of satisfactory completion of a course on maintaining adequate and appropriate medical records, such course to be approved in advance by 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.
 4. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. Kirkland 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/her fitness to resume practice.
- C. **PROBATION**: Upon reinstatement or restoration, Dr. Kirkland's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least five years:
1. **Obey the Law**: Dr. Kirkland 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. Kirkland shall submit quarterly declarations under penalty of Board disciplinary action or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which 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. Kirkland 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 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. **Controlled Substances Log**: Dr. Kirkland shall keep a log of all controlled substances she prescribes, orders, administers, or personally furnishes. Such log shall be submitted in a format approved by the Board thirty days prior to Dr. Kirkland's personal appearance before the Board or its designated representative, or as otherwise directed by the Board. Further, Dr. Kirkland shall make her patient records with regard to such controlled substances available for review by an agent of the Board upon request.

5. **Monitoring Physician:** Within thirty days of the date of Dr. Kirkland's reinstatement or restoration, or as otherwise determined by the Board, Dr. Kirkland shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Kirkland and who is engaged in the same or similar practice specialty. The Board shall not consider any individual who is related to or formerly related to Dr. Kirkland, either by blood or marriage, to serve in this capacity.

The monitoring physician shall monitor Dr. Kirkland and her medical practice, and shall review Dr. Kirkland'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. Kirkland and her medical practice, and on the review of Dr. Kirkland's patient charts. Dr. Kirkland 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. Kirkland's quarterly declaration.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Kirkland must immediately so notify the Board in writing. In addition, Dr. Kirkland 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. Kirkland shall ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefore.

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

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



R. Gregory Porter, Esq.
Hearing Examiner



State Medical Board of Ohio

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

EXCERPT FROM THE DRAFT MINUTES OF OCTOBER 13, 2004

REPORTS AND RECOMMENDATIONS

Ms. Sloan announced that the Board would now consider the findings and orders appearing on the Board's agenda. She asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the matters of: Ghassan Haj-Hamed, M.D.; Sam Hill, D.O.; Barry Alan Fultz, M.T.; Sandra Kay Harewood, M.D.; Jeanne M. Kirkland, M.D.; Michael Paul Parker, M.D.; Jinka R. Sathya, M.D.; Animesh Chandulal Shah, M.D.; Hisham H. Soliman, M.D.; and Mary Mei-Ling Yun, M.D. A roll call was taken:

ROLL CALL:	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Ms. Sloan	- aye

The motion carried.

Ms. Sloan 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. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Ms. Sloan	- aye

Ms. Sloan 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.

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

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

Dr. Davidson returned to the meeting at this time and advised that she received, read, and considered the hearing records, the proposed findings, conclusions, and orders, and any objections filed in the Reports and Recommendations appearing on today's agenda. She further advised that she does understand 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

.....
JEANNE M. KIRKLAND, M.D.

.....
DR. EGNER MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF JEANNE M. KIRKLAND, M.D. DR. BHATI SECONDED THE MOTION.

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

Vote:	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- nay
	Dr. Buchan	- aye
	Dr. Kumar	- abstain
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Ms. Sloan	- aye

The motion carried.



State Medical Board of Ohio

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

May 14, 2003

Jeanne M. Kirkland, M.D.
6464 Munger Road
Dayton, Ohio 45459

Dear Doctor Kirkland:

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

In the routine course of your practice, you undertook the treatment of Patients 1 to 10, as identified on the attached confidential Patient Key. (The Patient Key is to be withheld from public disclosure).

- (1) As demonstrated in your patient records, you excessively and inappropriately prescribed controlled substances and dangerous drugs to Patients 1 to 10 without performing appropriate histories and physical examinations, and/or without utilizing diagnostic testing or other methods of evaluating the validity of the patients' complaints or the nature or severity of the patients' reported pain, and/or without devising treatment plans, and/or without periodically reassessing the effectiveness or the treatment, and/or despite your knowledge that the patients were abusing controlled substances or exhibiting drug-seeking behavior, and/or despite recommendations by consultants that narcotic therapy be discontinued, and/or you failed to document the above actions. Further, you failed to provide and/or document primary treatment and/or preventive care for the medical conditions suffered by the patients, and you failed to respond and/or document your response to changes in the patients' conditions.

Examples of such prescribing and/or conduct include, but are not limited to, the following:

- (a) You began treating Patient 1 in October 1988. In 1993, identifying anxiety as a problem, you prescribed Valium and Ativan to Patient 1. Although you continuously prescribed Valium and Ativan, you failed to perform and/or document an appropriate evaluation, diagnosis, assessment of her symptoms, reassessment of the treatment and/or consider appropriate alternate therapy. You continued to prescribe these medications to Patient 1, often overlapping sequential prescriptions.

Mailed 5/15/03

Due to a kidney transplant and immunosuppression, Patient 1 should not have been prescribed nonsteroidal pain medication. However, in or about 1994, you treated Patient 1 for injuries and pain by inappropriately prescribing Tylenol #3, which gradually developed into continuous, excessive prescriptions of Vicodin without performing and/or documenting an appropriate evaluation of the patient at regular intervals. On Patient 1's final visit in or about January 1998, despite advising the patient to decrease her pain medications, you issued prescriptions for her standard dosages of Valium and Vicodin.

- (b) You began treating Patient 2 in January 1986. In or about 1991, you prescribed Valium and narcotic pain medication in gradually increasing doses to Patient 2 but failed to document your assessment of the medical condition for which the Valium was prescribed. After an evaluation of Patient 2, a specialist in neurosurgery recommended that Patient 2 be weaned from all narcotics, however you continued to inappropriately prescribe Percocet and other narcotic medications in increasing doses. During the course of your treatment, even though Patient 2 had displayed drug-seeking behavior, exhibited signs of drug dependency and had compromised judgment, you failed to modify your treatment protocol until in or about 1994.

In or about September 29, 1994, you informed Patient 2 that you would no longer prescribe Prozac, Sinequan and Valium for him, because you were aware that he was receiving these medications concurrently from another physician. However, in October 1994, you inappropriately prescribed Prozac, Sinequan and Methadone. On or about October 17, 1994, you referred Patient 2 to a specialist for Methadone maintenance and documented in the medical records that Patient 2's treatment with Methadone was to be assumed by the specialist. Nevertheless, you continued to prescribe Methadone to Patient 2 after his treatment began with the Methadone specialist. In August 1995, you terminated the physician/patient relationship with Patient 2 by letter informing him that you were aware that he was receiving Methadone prescriptions from other physicians.

- (c) You began treating Patient 3 in August 1981. You treated Patient 3 for complaints of headaches and anxiety and/or depression with prescriptions of Tylenol #3 for the headaches and Xanax and Ativan for the mood disorder. Patient 3's psychiatrist reported to you that he had prescribed Xanax to Patient 3, that he was concerned over suspicions reported from family and friends that she was not taking the medication properly and that a schedule to taper her off Xanax was established with Patient 3. You briefly attempted to reduce the dosage, however you resumed prescribing the higher doses of Xanax and Vicodin despite the psychiatrist's report and recommendation and Patient 3's drug-seeking behavior. Further, despite referring Patient 3 to a specialist for

her complaints of back pain, you continued to inappropriately treat her with narcotic pain medications.

You inappropriately prescribed to Patient 3 excessive amounts of Xanax and Vicodin, and failed to adequately document the prescriptions instead only noting the date and medication in the patient file. On multiple occasions, you failed to document whether the patient had an office visit or called the office requesting a prescription.

- (d) You began treating Patient 4 in October 1994. You inappropriately prescribed excessive and increasing doses of Vicodin for chronic back pain to Patient 4. However, you failed to evaluate and/or continue to assess and/or you failed to document your evaluation and continued assessment of his back pain and arthritis, and you failed to undertake any additional pertinent studies. You failed to offer other modalities of treatment for these problems. In early 1996, you attempted to limit Patient 4 to a set dosage of Vicodin, but abandoned this attempt by July 1996, with the inappropriate resumption of increased prescriptions and increased dosages of Vicodin, despite indications of his drug-seeking behavior.

You failed to acknowledge and respond and/or document an acknowledgement and response to the consistently and significantly abnormal laboratory values in the management of Patient 4. Although Patient 4's total cholesterol values were significantly elevated while on medication, you failed to respond appropriately. Additionally, Patient 4 had elevated red blood cell indices and a frequently elevated GGT, which indicated possible excessive alcohol intake in a patient who excessively used narcotics.

- (e) You treated Patient 5 from September 1994 to March 1996. You frequently saw Patient 5 in office visits and inappropriately prescribed multiple prescriptions for Vicodin without adequate documentation of an evaluation and assessment of the patient's medical conditions, her response to treatment, or any consideration about the appropriateness of the amount of Vicodin being prescribed.
- (f) You began treating Patient 6 in March 1984. Your treatment of Patient 6 included inappropriately prescribing large and frequent doses of Xanax for his diagnoses of anxiety and depression without performing and/or documenting an appropriate evaluation and assessment of the patient's symptoms. Additionally, you failed to adequately document and/or monitor Patient 6's progress or lack of progress with this medication. You continued inappropriately prescribing controlled substances despite signs of drug dependency.

- (g) You began treating Patient 7 in November 1983. As a result of cervical disease, Patient 7 suffered from multiple headaches, however, you inappropriately and excessively prescribed Percodan, Darvocet, Tylenol #3, Fiorinal #3, Percocet, Lorcet Plus, Vicodin ES, and Duragesic Patch, which were unwarranted for this patient's continuing pain. In addition, you inappropriately authorized multiple injections of Demerol with Phenergan or Vistaril, often several times monthly to Patient 7, and frequently without documentation of the diagnosis or physical exam. Without adequate documentation of her current condition, physical exam and often lacking the diagnosis to justify the treatment, you also prescribed numerous injections of steroids, however you failed to consider and/or document any consideration of the long-term consequences of frequent steroid injections. Additionally, despite the fact that you prescribed allergy-desensitizing injections for Penicillin to Patient 7, you also prescribed several oral courses of Amoxicillin and Augmentin concurrent with the injections, which would have been inappropriate if she actually had been allergic to Penicillin.
- (h) You began treating Patient 8 in June 1988. In your treatment of Patient 8, you inappropriately prescribed continuing and excessive quantities of Lortab, Lorcet, Vicodin, Darvocet and Esgic Plus for Patient 8's complaints of pain, and you failed to document any significant clinical or physical findings in an appropriate pain evaluation and assessment. After an evaluation of Patient 8's pain, a rheumatologist reported that he had a deep concern about a continuation of addicting analgesics, especially at an excessive dose, recommended that the Vicodin be tapered down, and recommended alternative therapies. However, you continued to inappropriately prescribe excessive amounts of Lortab, Vicodin, Darvocet and Esgic Plus. In the patient record, you failed to acknowledge the report and recommendations and failed to discuss and/or document a discussion with Patient 8 regarding the report.
- (i) You prescribed Ativan to Patient 9 continuously throughout his care, without documenting the diagnosis or rationale for the prescriptions.
- (j) You began treating Patient 10 in July 1987. You inappropriately prescribed to Patient 10 excessive injections of Stadol for complaints of migraine. For example, during a representative period of six months from January 1992 through June 1992, you prescribed at least ten injections of Stadol to Patient 10. You failed to establish a diagnosis of migraine either by description of symptoms or expert evaluation. Additionally, you treated Patient 10's migraines with Tylenol #3 from May 1990 through the remainder of her care with you which ceased in or about January 1998. In an entry in 1989, the patient record indicates that Patient 10 was allergic to Codeine, however, you continued to prescribe Tylenol #3 without clarification of her allergy status. In your management of Patient 10's migraine headaches, you failed to consider

other non-narcotic medications, and you failed to consider eliminating triggers, which could prevent the onset of a migraine. You also prescribed Stadol for inappropriate symptoms, such as nausea, aching, viral syndrome, earache, and sinus congestion.

Throughout the treatment period, you inappropriately prescribed frequent and increasing doses of Tylenol #3, Percodan, Vicodin, and Vicodin ES. Despite the fact that you noted indications of drug-seeking behaviors, including a report from another physician's office that Patient 10 received medication from four other physicians, you failed to discuss and/or document any discussion with Patient 10 about this situation and continued to inappropriately prescribe narcotic pain medications without interruption.

You prescribed numerous injections of steroids for allergy and back pain, often only a few days apart. The quantity of steroid injections that the patient received in a three-month period was excessive. You treated the patient's back pain almost exclusively with injections and narcotic pain medications and failed to consider and/or document alternative modalities for the treatment of the patient's back pain.

- (2) Additionally, when treating Patients 1 through 10 after November 17, 1986, you routinely failed to maintain records which accurately reflected your evaluation, examination, and the utilization of controlled substances in the treatment of those patients, and the diagnoses and purposes for which the controlled substances were being utilized.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[f]ailure to use reasonable care discrimination in the administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code (as in effect prior to March 9, 1999).

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions occurring on or after November 11, 1986, as alleged in paragraph (2) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02(D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio

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

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

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

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

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, effective March 9, 1999, 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,



Anand G. Garg, M.D.
Secretary

AGG/blt
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5148 1288
RETURN RECEIPT REQUESTED