



State Medical Board of Ohio

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November 10, 2004

Alberto Leon, M.D.
446 Kinsey Road
Xenia, OH 45385

Dear Doctor Leon:

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 November 10, 2004, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

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

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of 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.
Lance A. Talmage, M.D.
Secretary *(LAT)*

LAT:jam
Enclosures

CERTIFIED MAIL NO. 7000 0600 0024 5149 8996
RETURN RECEIPT REQUESTED

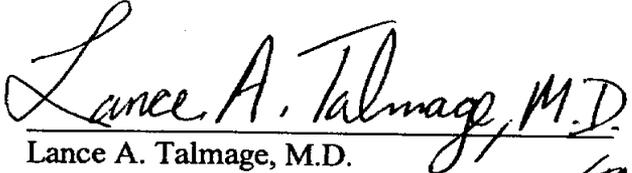
Cc: Eric J. Plinke, Esq.
CERTIFIED MAIL NO. 7000 0600 0024 5149 8972
RETURN RECEIPT REQUESTED

MAILED 12-03-04

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 November 10, 2004, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Alberto Leon, 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)

November 10, 2004

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

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ALBERTO LEON, M.D.

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ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on November 10, 2004.

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

It is hereby ORDERED that:

- A. **SUSPENSION OF CERTIFICATE:** The certificate of Alberto Leon, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for an indefinite period of time, but not less than two years.
- B. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Leon's certificate to practice medicine and surgery until all of the following conditions have been met:
 1. **Application for Reinstatement or Restoration:** Dr. Leon shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
 2. **Controlled Substances Prescribing Course:** At the time he submits his application for reinstatement or restoration, Dr. Leon 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 period(s) in which they are completed.

3. **Medical Records Course**: At the time he submits his application for reinstatement or restoration, Dr. Leon 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 period(s) in which they are completed.
4. **Chronic Benign Pain Assessment**: Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Leon shall submit to the Board for its prior approval the name and curriculum vitae of a physician of Dr. Leon's choice who specializes in pain management.

Upon approval by the Board, Dr. Leon shall obtain from the approved physician an assessment of Dr. Leon's current status. Prior to the initial assessment, Dr. Leon shall furnish the approved physician copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions, and any other documentation from the hearing record which the Board may deem appropriate or helpful to that approved physician.

Upon completion of the initial assessment, Dr. Leon shall cause a written report to be submitted to the Board from the approved approved physician. The written report shall include:

- a. A detailed report of the evaluation of Dr. Leon's current status and condition;
- b. A detailed plan of recommended treatment, if any, based upon the approved physician's informed assessment of Dr. Leon's current needs;
- c. A statement regarding any recommended limitations upon his practice, and
- d. Any reports upon which the treatment recommendation is based, including reports of physical examination and psychological or other testing.

Should the Board approved physician recommend treatment, and upon approval by the Board, Dr. Leon shall undergo and continue treatment weekly or as otherwise directed by the Board. Dr. Leon shall comply with his treatment plan, including taking medications as prescribed for his condition.

Dr. Leon shall continue in treatment until such time as the Board determines that no further treatment is necessary. To make this determination, the Board shall require reports from the approved physician. The reports shall contain information describing Dr. Leon's current treatment plan and any changes that have been made to the treatment plan since the prior report; Dr. Leon's compliance with the treatment plan; Dr. Leon's status; Dr. Leon's progress in treatment; and results of any laboratory or other studies that have been conducted since the prior report. Dr. Leon 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. Leon's quarterly declaration.

In addition, Dr. Leon shall ensure that his approved physician immediately notifies the Board of Dr. Leon's failure to comply with his treatment plan and/or any determination that Dr. Leon is unable to practice due to his condition.

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

5. **Additional Evidence of Fitness To Resume Practice:** In the event that Dr. Leon has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.
- C. **PROBATION:** Upon reinstatement or restoration, Dr. Leon'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. Leon 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. Leon 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 Dr. Leon's

certificate is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances:** Dr. Leon shall appear in person for an interview before the full Board or its designated representative during the third month following the month in Dr. Leon's certificate is restored or reinstated, 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. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Leon 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.
 5. **Terms, Conditions, and Limitations Continued from Suspension Period:** Dr. Leon shall continue to be subject to the terms, conditions, and limitations specified in Paragraph B.4. of this Order.
- Practice Plan:** Within thirty days of the date of Dr. Leon's reinstatement or restoration, or as otherwise determined by the Board, Dr. Leon shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Leon's activities will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. Leon shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. Leon submits his practice plan, he shall also 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 or Supervising Member will give preference to a physician who practices in the same locale as Dr. Leon and who is engaged in the same or similar practice specialty.

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

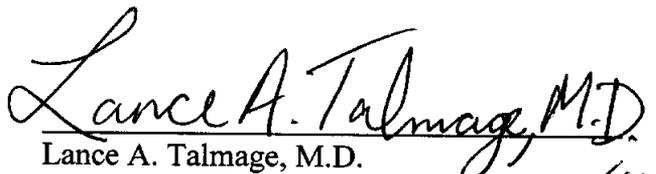
In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Leon must immediately so notify the Board in writing. In addition, Dr. Leon shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Leon 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. **Controlled Substances Log**: Dr. Leon shall keep a log of all controlled substances he prescribes, orders, administers, or personally furnishes. Such log shall be submitted in a format approved by the Board thirty days prior to Dr. Leon's personal appearance before the Board or its designated representative, or as otherwise directed by the Board. Further, Dr. Leon shall make his patient records with regard to such controlled substances available for review by an agent of the Board upon request.

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

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

(SEAL)


Lance A. Talmage, M.D.
Secretary

November 10, 2004

Date

2004 OCT 15 P 1: 27

**REPORT AND RECOMMENDATION
IN THE MATTER OF ALBERTO LEON, M.D.**

The Matter of Alberto Leon, M.D., was heard by R. Gregory Porter, Esq., Hearing Examiner for the State Medical Board of Ohio, on February 5 and August 19, 2004.

INTRODUCTION

I. Basis for Hearing

A. By letter dated July 9, 2003, the State Medical Board of Ohio [Board] notified Alberto Leon, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on allegations concerning his inappropriate prescribing of controlled substances to five patients, and his diverting for his own use some or all of the controlled substances that he had prescribed to three of those patients. The Board further alleged that Dr. Leon's conduct constitutes:

- “[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,’ as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Trafficking in Drugs, Section 2925.03, Ohio Revised Code[;] * * * Deception to Obtain a Dangerous Drug, Section 2925.22, Ohio Revised Code[; and/or] * * * Illegal Processing of Drug Documents, Section 2925.23, Ohio Revised Code, as current and prior versions of that statute have been in effect.”
- “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,’ as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code, General Provisions, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000. 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.”
- “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,’ as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-08, Ohio

Administrative Code, Utilizing Controlled Substances for Self and Family Members, as in effect from November 11, 1998, through March 14, 2001.”

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

- B. On July 27, 2003, the Board received a written hearing request from Eric J. Plinke and John J. Carney, Esqs., on behalf of Dr. Leon. (State’s Exhibit 1B-1)
- C. On February 5, 2004, a hearing was held concerning the issues raised in the Board’s July 9, 2003, notice of opportunity for hearing. At the close of the hearing, the hearing record was held open to permit the Respondent to submit additional evidence and for the parties to file written closing arguments. (See the Hearing Transcript at pages 211-212.)
- D. By letter dated April 14, 2004, the Board notified Dr. Leon that, pursuant to Section 3719.121(C), Ohio Revised Code, the Board had immediately suspended his certificate to practice medicine and surgery in the State of Ohio. The Board further notified Dr. Leon that continued practice of medicine or surgery would be considered practicing medicine without a certificate in violation of Section 4731.41, Ohio Revised Code.

In addition, the Board notified Dr. Leon that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on an allegation that, on or about February 18, 2004, in the Court of Common Pleas, Butler County, Ohio, Dr. Leon entered pleas of guilty to four felony counts of Deception to Obtain a Dangerous Drug, in violation of Section 2925.22(A), Ohio Revised Code. Thereafter, on or about February 25, 2004, in response to Dr. Leon’s motion seeking intervention in lieu of conviction for these charges, the court filed an “Entry Finding Eligibility for Intervention in Lieu of Conviction and Ordering Period of Rehabilitation” that granted his motion for intervention in lieu of conviction, stayed further criminal proceedings, and ordered him to complete an indefinite period of rehabilitation of at least one year.

The Board alleged that Dr. Leon’s pleas of guilty and/or the judicial finding of eligibility for intervention in lieu of conviction constitute “[a] plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony,” as that clause is used in Section 4731.22(B)(9), Ohio Revised Code.

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

- E. On April 22, 2004, the Board received a written hearing request from Eric J. Plinke, Esq., on behalf of Dr. Leon. (State's Exhibit 1X)
- F. On April 23, 2004, the Respondent filed a motion to consolidate the two matters concerning Dr. Leon. On May 24, 2004, the State filed a Memorandum in Opposition to Respondent's Motion to Consolidate. On May 28, the Respondent filed a Supplemental Memorandum in Support of Motion to Consolidate Hearings. On June 7, 2004, the Hearing Examiner filed an Entry granting the Respondent's motion to consolidate the hearings. An additional day of hearing in this matter was held on August 19, 2004. (States Exhibits 1Z through 1BB and 1EE through 1II)

II. Appearances

- A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Gregory A. Perry, Assistant Attorney General.
- B. On behalf of the Respondent: Eric J. Plinke, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

- A. Presented by the State
 - 1. Elaine Jones
 - 2. Detective Dennis M. Luken
 - 3. Alberto M. Leon, M.D., as upon cross-examination.
- B. Presented by the Respondent
 - Alberto M. Leon, M.D.

II. Exhibits Examined

- A. Presented by the State
 - 1. State's Exhibits 1A through III: Procedural exhibits.
 - * 2. State's Exhibit 2: Patient key.
 - * 3. State's Exhibit 3: Prescription profile of Patient 1 compiled by Elaine Jones.

- * 4. State's Exhibit 4: Spreadsheet / prescription profile of Patient 1 created by Detective Dennis M. Luken, with dates of multiple written prescriptions highlighted.
- * 5. State's Exhibit 5: Spreadsheet / prescription profile of Patient 3 created by Detective Luken, with dates of multiple written prescriptions highlighted.
- * 6. State's Exhibit 6: March 12, 2003, statement of Alberto M. Leon, M.D., witnessed by Ms. Jones and Detective Luken.
- * 7. State's Exhibit 7: February 11, 2003, statement of Patient 1 to the Pharmacy Board.
- * 8. State's Exhibit 8: Spreadsheet / prescription profile of Patient 1 created by Detective Luken. (Note: This exhibit is the same as State's Exhibit 4, but without highlighted dates).
- * 9. State's Exhibit 9: Spreadsheet / prescription profile of Patient 3 created by Detective Luken, with information sorted by doctor.
- * 10. State's Exhibit 10: Prescription profile of Patient 2 from Rite Aid in Xenia, Ohio.
- * 11. State's Exhibit 11: Certified copies of prescriptions and prescription profiles.
- * 12. State's Exhibit 12: Copies of prescriptions for Patient 2.
- * 13. State's Exhibit 15: Medical records maintained by James Binski, M.D., concerning Dr. Leon.
- 14. State's Exhibit 16: Copy of a Prosecutor's Reporting Form filed with the Board on March 23, 2004, by the Butler County [Ohio] Prosecuting Attorney's office.
- 15. State's Exhibit 17: Certified copies of documents maintained by the Butler County [Ohio] Common Pleas Court in *State of Ohio v. Alberto Antonio Leon*, Case Number CR-03-11-1732.
- * 16. State's Exhibit 18: Copy of a June 3, 2000, letter to the Board from Richard N. Whitney, M.D., Shepherd Hill.
- 17. State's Exhibit 19: Copy of Section 2951.041, Ohio Revised Code, Intervention in Lieu of Conviction.

B. Presented by the Respondent

- * 1. Respondent's Exhibit A: Copy of a February 4, 2004, letter to Eric Plinke, Esq., from Joseph P. Turcer, CCDC III-E, LSW, Program Director of The Woods at Parkside. [The Hearing Examiner redacted a Social Security number from this document post hearing.]
- * 2. Respondent's Exhibit B: Copy of Treatment Contract between Dr. Leon and Parkside Behavioral Healthcare, Inc., executed by Dr. Leon on February 2, 2004.
- 3. Respondent's Exhibit C and H: Copies of documents maintained by the Butler County Court of Common Pleas in *State v. Leon*.
- 4. Respondent's Exhibit D: Copies of releases executed by Dr. Leon authorizing the disclosure of medical records to the Board.
- * 5. Respondent's Exhibit E: Excerpt of medical records concerning Dr. Leon prepared by Richard T. Laughlin, M.D.
- 6. Respondent's Exhibit F: Copy of Dr. Leon's February 5, 2004, Voluntary Surrender of Controlled Substances Privileges.
- * 7. Respondent's Exhibit G: Copy of a February 27, 2004, letter to Mr. Plinke from Edna Jones, M.D., Medical Director, The Woods at Parkside, Columbus, Ohio.

C. Admitted by the Hearing Examiner Post Hearing pursuant to Rule 4731-13-33, Ohio Administrative Code

Board Exhibits A and B: Excerpts from the 55th (2001) and 57th (2003) editions of the Physicians' Desk Reference concerning Endocet and Xanax.

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

PROCEDURAL MATTERS

Following the August 19, 2004, hearing, the hearing record in this matter was held open for the submission of additional documents. The last document was received on October 1, 2004, and the hearing record closed at that time.

SUMMARY OF THE EVIDENCE

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

Background Information

1. Alberto Leon, M.D., testified that he had obtained his medical degree in 1980 from the Ohio State University College of Medicine. Dr. Leon further testified that he had completed an internship at Mt. Carmel Hospital in Columbus, Ohio, and a residency in emergency medicine at the University of Kentucky in Lexington, Kentucky. Moreover, Dr. Leon testified that he is board certified in emergency medicine, and was most recently recertified in 2000. (Hearing Transcript [Tr.] at 87-88, 203-204)

Dr. Leon testified that he is licensed to practice medicine in the State of Ohio, and that he currently resides in Xenia, Ohio. Dr. Leon also testified that he is not currently employed, and had last worked as a physician in November 2003. Dr. Leon further testified that his last employment had been at Greene Memorial Hospital, where he had worked in the emergency department on a part-time basis. (Tr. at 85-86)

2. Dr. Leon testified that he had worked full-time in the emergency department at Middletown Regional Memorial Hospital [Middletown Hospital] from 1993 until the end of 2002. Dr. Leon further testified that his group had left Middletown Hospital at the end of 2002 for reasons unrelated to the present matter. (Tr. at 88)

Dr. Leon testified that, until 2002, he had worked approximately 60 to 70 hours per week on average. Dr. Leon further testified that it was a rotating schedule that included days, evenings, and nights. (Tr. at 88-89)

Ohio State Board of Pharmacy Investigation

3. Elaine Jones testified on behalf of the State. Ms. Jones testified that she is a compliance specialist with the Ohio State Board of Pharmacy [Pharmacy Board], and that she is trained as a pharmacist. Ms. Jones further testified that she has worked for the Pharmacy Board since 1996. (Tr. at 9)

Ms. Jones testified that the Pharmacy Board had investigated Dr. Leon's prescribing of controlled substance medication, and that she had been involved in that investigation. Ms. Jones testified that her investigation had begun following a telephone call that she received on February 10, 2003, from the human resources director at Middletown Regional Hospital [Middletown Hospital] in Middletown, Ohio. The human resources director

reported that a nurse from that hospital's emergency department—identified as Patient 1 in this matter—had been seen selling Vicodin and Percocet at a party. The human resources director further reported to Ms. Jones that a pharmacist had previously reported to the hospital that Dr. Leon had written a prescription for Percocet #90 to that same nurse, that the pharmacist had contacted Dr. Leon to confirm the prescription, and that Dr. Leon had acknowledged to the pharmacist that the prescription was correct. The human resources director further expressed concern that the nurse may have been stealing medication from the hospital. (Tr. at 10-12)

Ms. Jones testified that she had obtained a patient profile concerning Patient 1 from a Walgreens pharmacy in Middletown that lists, among other things, the prescriptions provided to her by Dr. Leon that she had filled at that pharmacy. On February 11, 2004, Ms. Jones went to the hospital to talk to Patient 1. They met in a conference room accompanied by Fay Smiley, a representative from the hospital's human resources department. (Tr. at 12-13)

Ms. Jones testified that Patient 1 had denied stealing any medication from the hospital. Rather, she told Ms. Jones that she had obtained prescriptions from Dr. Leon for Vicodin and Percocet. Ms. Jones further testified that Patient 1 had told her that Dr. Leon "would write prescriptions two at a time, and [that] all the ones written for 90 tablets went to him and the others were hers." Ms. Jones noted that Vicodin is a Schedule III controlled substance, and contains hydrocodone; and that Percocet is a Schedule II controlled substance, and contains oxycodone. (Tr. at 13-14)

Ms. Jones stated that Patient 1 had told her that both she and Dr. Leon had worked in the emergency department at Middletown Hospital. Patient 1 also told Ms. Jones that the situation had begun when Patient 1 had asked Dr. Leon for medication for jaw pain. Further, Ms. Jones testified that, after a couple of prescriptions, Dr. Leon had asked her to return some of the medication to him. Moreover, Ms. Jones testified,

[The prescriptions] were written in [Patient 1's] name. [Dr. Leon] would give her two prescriptions in her name. She would go to two different pharmacies, and she had one filled at one pharmacy and another one filled at another pharmacy. And the ones for 90 tablets she was supposed to bring back to him and the other she kept [for her own use or to sell].

(Tr. at 14-16) Ms. Jones testified that Patient 1 had told her that she had not paid Dr. Leon for the prescriptions. Ms. Jones further testified that Patient 1 had admitted selling medication. Finally, Ms. Jones testified that Patient 1 provided Ms. Jones with a written statement. (State's Exhibit [St. Ex.] 7; Tr. at 16, 23, 27-28)

Patient 1 averred as follows in her February 11, 2003, written statement,

I have been receiving prescriptions from Dr. Leon for Vicodin & Percocet. When I would receive these prescriptions from Dr. Leon it was only in agreement that I would fill a prescription for Vicodin for him as well for 90 Vicodin, i.e.: He would write two prescriptions in my name. One which was for 90 Vicodin. I have never abused drugs or stole drugs while at work. I have only sold these medications at random & never on a regular basis. I feel that I may need some counseling. I have never taken any drugs from Middletown Hospital or any other facility. I have never denied any patients medications. I am a single mother of one child with a mortgage to pay.

(St. Ex. 7)

4. Ms. Jones testified that Ms. Smiley had also informed her that there had been an incident in the emergency department where Dr. Leon and a different individual, Patient 3, had had a personal argument in front of other staff, which had resulted in both of them being reprimanded by the hospital. (Tr. at 16-17)
5. Ms. Jones testified that, after speaking to Patient 1 and Ms. Smiley, she had visited different pharmacies in the Middletown/Butler County area and obtained profiles of both Patient 1 and Patient 3. Ms. Jones also obtained the actual prescriptions that Dr. Leon had written to those patients. (Tr. at 18-19)

Ms. Jones testified that after gathering those documents, she had contacted Detective Dennis M. Luken of the Warren County Drug Task Force for assistance. Ms. Jones noted that some of the prescriptions had been filled at pharmacies within Detective Luken's jurisdiction. On March 10, 2003, Ms. Jones and Detective Luken went to Middletown Hospital to interview Patient 3. (Tr. at 19-20)

Ms. Jones testified that Patient 3 had been a nursing assistant in the emergency department of Middletown Hospital, and at that time had been a third-year nursing student. Ms. Jones testified that Patient 3 acknowledged that she had obtained prescriptions for Vicodin and Percocet from Dr. Leon, and had also obtained prescriptions for Vicodin from a physician in Dayton, Dr. Laws. Ms. Jones further testified that Patient 3 had stated that Dr. Leon had been aware that another physician was prescribing medication for her, but that Dr. Laws had not been aware that Dr. Leon was also prescribing medication for her. (Tr. at 19-21)

Ms. Jones testified that Patient 3 had informed her that she obtained the prescriptions from Dr. Leon simply by asking him for them. Patient 3 also told Ms. Jones that she had not paid Dr. Leon for the prescriptions. Moreover, Ms. Jones testified that Patient 3 had denied returning any medication to Dr. Leon. (Tr. at 21-23)

6. Ms. Jones testified that, on March 12, 2003, she and Detective Luken went to Dr. Leon's house to speak to him. Ms. Jones further testified that Dr. Leon had not been aware that they were coming. Dr. Leon was home and agreed to talk to them. (Tr. at 23-24)

Ms. Jones testified that she had shown to Dr. Leon the patient profiles, prescriptions, and a spreadsheet summarizing the prescriptions that Dr. Leon had written to Patient 1.

Ms. Jones testified that Dr. Leon had acknowledged that he had written those prescriptions. Ms. Jones further testified that Dr. Leon had indicated that he had not realized how many prescriptions he had written to Patient 1, and had been surprised by the number that he had actually written. Moreover, Ms. Jones testified that Dr. Leon indicated that he had begun giving prescriptions to Patient 1 because she had had "TMJ," and he had felt sorry for her. (Tr. at 24-25)

Ms. Jones testified that, when she told Dr. Leon that Patient 1 had stated that she had given some medication back to him, Dr. Leon had denied it at first. However, Dr. Leon later acknowledged that some hydrocodone had been returned to him on about ten occasions. (Tr. at 24-25)

Ms. Jones testified that Dr. Leon's statement that medication had been returned to him on about ten occasions is consistent with the patient profile. (Tr. at 25-26)

7. Ms. Jones testified that Dr. Leon had denied being aware that Patient 1 had had been selling medication. (Tr. at 27-28)
8. Ms. Jones testified that Dr. Leon denied having shared any of Patient 3's medication. (Tr. at 30)
9. Ms. Jones testified that Dr. Leon had acknowledged being aware that another physician had been treating Patient 3. Ms. Jones further testified that Dr. Leon told her that he had prescribed medication to Patient 3 because "she would tell him that her doctor was out of town or that she had lost her prescription * * *." (Tr. at 30)
10. Ms. Jones testified that she had also obtained a patient profile and prescriptions for another individual, Patient 2. Ms. Jones further testified that a pharmacist had brought Patient 2 to her attention, and that the pharmacist had "thought it was unusual that an emergency room physician would be writing long-term controlled substances for a patient. And the patient was Dr. Leon's girlfriend." Moreover, Ms. Jones testified that Dr. Leon had admitted to her that he had prescribed hydrocodone to Patient 2, and that he had used some of the medication that he had written for her. Ms. Jones further testified that Dr. Leon told her that he had married Patient 2 in October 2000. (Tr. at 32-33)
11. With regard to another individual, Patient 4, Ms. Jones testified that Dr. Leon had told her that Patient 4 was his ex-wife's cousin, and that she suffered from back problems.

Ms. Jones further testified that Dr. Leon had admitted writing prescriptions to Patient 4. (Tr. at 36-37)

12. With regard to another individual, Patient 5, Ms. Jones testified that Dr. Leon had told her that Patient 5 was Patient 4's girlfriend, and he had admitted writing hydrocodone prescriptions for her. (Tr. at 37)

13. Ms. Jones testified that she had asked Dr. Leon if he had any medical records for Patient 1 through 5, and he stated that he did not. Ms. Jones testified that Dr. Leon was an emergency room physician, and had not had his own office. Ms. Jones further testified that "[t]hese were not people that he saw in the emergency room. These were acquaintances." (Tr. at 38)

14. Ms. Jones testified that Dr. Leon had told her that the reason he had been taking medication was because he had been injured in a motorcycle accident in 1997. Dr. Leon also told her that he had continuing problems with pain in his right leg as a result, and had had to work on his feet for twelve-hour shifts. Ms. Jones further testified that Dr. Leon had shown his leg to her and Detective Luken, and that he had had visible scarring. (Tr. at 33-34, 43)

Ms. Jones testified that she had asked Dr. Leon why he had not just gone to his physician to get pain medication. Dr. Leon had replied that "[h]e didn't want to appear like a drug seeker." (Tr. at 44) Ms. Jones further testified that Dr. Leon had denied that he had used medication for purposes of getting intoxicated. (Tr. at 46)

15. Ms. Jones testified that Dr. Leon provided her with a written statement. (St. Ex. 6; Tr. at 30-31) In the March 12, 2003, written statement that he provided to Ms. Jones, Dr. Leon wrote,

I Dr. Albert Leon write this voluntary statement, I wrote the prescriptions for [Patient 1] for Hydrocodone and took some on approximately 10 occasions, I never sold any medication.

(St. Ex. 6)

16. Ms. Jones testified that Dr. Leon had been cooperative with her during her investigation. (Tr. at 42-43)

17. Ms. Jones testified that, after she had finished her investigation, she presented the information to the prosecuting attorney in Butler County for possible criminal charges. (Tr. at 39)

18. Dennis M. Luken testified that he is a Deputy in the Sheriff's Office of Warren County, Ohio. Detective Luken further testified that he currently works in the Warren-Clinton

County Drug and Strategic Operations Task Force. Detective Luken testified that his responsibilities include investigating the abuse of pharmaceutical drugs. (Tr. at 47)

Detective Luken testified that he became involved in the matter of Dr. Leon at the request of Ms. Jones. Detective Luken testified that some prescriptions filled by Patient 1, whom Ms. Jones had at that time been investigating, had been filled at pharmacies within Detective Luken's jurisdiction. Detective Luken testified that he assisted Ms. Jones in gathering prescriptions from various pharmacies. Detective Luken further testified that he had created spreadsheets summarizing the prescription information that he and Ms. Jones had gathered. Detective Luken further testified that he and Ms. Jones had interviewed Dr. Leon at his residence on March 12, 2003. Detective Luken's testimony at hearing concerning that interview corroborates that of Ms. Jones. (Tr. at 48-60)

19. Detective Luken testified that most of Dr. Leon's prescribing to Patient 3 had preceded Dr. Laws' prescribing, but that there had been an overlap of about three prescriptions. (Tr. at 76-77)
20. Detective Luken testified that he was satisfied upon seeing Dr. Leon's leg that Dr. Leon had obviously suffered a substantial injury. (Tr. at 80)

Dr. Leon's Prescribing of Controlled Substances to Patients 1 through 5

21. Dr. Leon prescribed controlled substance medication to Patient 1 as follows:

Date Prescribed	Medication	Quantity
03/31/2002	Percocet	20
07/18/2002	Vicodin ES	90
07/19/2002	Vicodin ES	30
08/15/2002	Vicodin ES	40
08/15/2002	Vicodin ES	40
08/21/2002	Endocet	20
09/09/2002	Percocet	20
09/09/2002	Vicodin ES	45
09/09/2002	Vicodin ES	45
10/03/2002	Vicodin ES	45
10/03/2002	Vicodin ES	45
10/04/2002	Endocet	20
10/14/2002	Vicodin ES	45
10/23/2002	Vicodin ES	45
11/04/2002	Vicodin ES	50
11/06/2002	Percocet	20
11/16/2002	Vicodin ES	40

11/16/2002	Percocet	20
12/04/2002	Vicodin ES	90
12/04/2002	Vicodin ES	45
12/04/2002	Endocet	20
12/17/2002	Vicodin ES	90
12/18/2002	oxycodone/APAP 10/650	20
12/26/2002	Percocet	20
12/31/2002	Vicodin ES	40
12/31/2002	Percocet	20
12/31/2002	Vicodin ES	90
01/07/2003	Percocet	20
01/28/2003	Vicodin ES	90
01/28/2003	Vicodin ES	40
02/03/2003	Vicodin ES	40
02/07/2003	oxycodone/APAP 10/650	20

(St. Ex. 11 at 17-49)

22. Dr. Leon testified that he knows Patient 1, and that Patient 1 had been a staff nurse in the emergency department at Middletown Hospital. Dr. Leon testified concerning his relationship with Patient 1,

[T]he ER is a somewhat of a unique setting. You get to know people. You spend a lot of time with them, a lot of time under very stressful conditions. So one does get to know them. You get to know their families; and not infrequently, you end up being somewhat of a family doctor for some of them. It's a unique situation. It's hard to describe unless one spends time immersed in that setting, but it does develop some unique relationships because of the nature of the business.

(Tr. at 90-91) Dr. Leon further testified that he is not sure if Patient 1 had been a full-time employee, but that health insurance had been an issue for her. He stated that Patient 1 had been recently divorced, and was a single mother of a small child. He added that Patient 1 had been "struggling a bit" when she came to Middletown Hospital. (Tr. at 91)

23. Dr. Leon testified that Patient 1 had originally approached him asking for a prescription while he was working in the emergency room. Dr. Leon further testified that "there were a couple reasons" why Patient 1 had wanted a prescription. Dr. Leon testified, "She told me she had TM joint pain, which is not a comfortable illness. Again, I think her insurance was an issue. No family physician, single mom, those kind of things, and could you—you know, would you mind. I think that's how it started." (Tr. at 92) Dr. Leon noted that, during the course of his prescribing to Patient 1, he had declined to give her a prescription "many times"; however, "many times [he] did say yes." (Tr. at 92)

Concerning whether he had performed a physical examination on Patient 1, Dr. Leon testified that he believes that he had “looked for a click in her jaw * * * just standing there by somebody’s bed or something[.]” Dr. Leon further testified that he had not detected a click in her jaw, although that does not exclude a diagnosis. Dr. Leon testified that he had advised Patient 1 to see a dentist. However, Dr. Leon testified that, to his knowledge, Patient 1 never had done so. (Tr. at 93-94)

Dr. Leon acknowledged that he had not kept medical records for Patient 1, although he had been aware that he had been required to do so. When asked why he had not, Dr. Leon replied,

Well, initially, we’re seeing these people in not an office setting. For a chart to be generated in the emergency department, it would have to go through registration, which generated some bills and whatnot. Their point of circumventing that was not to have to pay for care. I don’t have means myself. I don’t have a private office. I have no means of generating charts or keeping records or anything like that * * *.

(Tr. at 99) Dr. Leon testified that all of his transactions with Patient 1 had occurred in the emergency department or on hospital grounds. (Tr. at 99-100)

Dr. Leon testified that Patient 1 never paid him for the prescriptions that he wrote for her. (Tr. at 104)

24. Dr. Leon testified that Patient 1 had at first asked for Percocet, but that he had declined to prescribe that for her. Instead, Dr. Leon testified that he had offered to prescribe Vicodin. However, when Mr. Perry, the State’s Assistant Attorney General, pointed out to Dr. Leon that the prescription records indicate that the first prescription had been for Percocet, Dr. Leon testified that he would not dispute the records. He testified that his recollection had been that he had not prescribed that until later. (Tr. at 94-95)
25. Concerning the issue of Patient 1 returning medication to Dr. Leon, Dr. Leon denied that he had ever “worked out any kind of arrangement with her.” Dr. Leon testified that his co-workers in the emergency department had known that he was in pain, and that he had continued to work there “through all [his] surgeries.” Dr. Leon testified that Patient 1 had offered to Dr. Leon to bring him back some medication, and he had accepted it. Moreover, Dr. Leon testified that, initially, he had not asked her to do that, although he “may have [later] as it went on.” Nevertheless, Dr. Leon testified that he had been aware that the medication that he had accepted from Patient 1 had been prescribed for her in her name. Furthermore, Dr. Leon testified that he had been aware that doing so had been a violation of the Board’s rules. (Tr. at 95-97)

Concerning Patient 1's statement to the investigators that she had always diverted back to Dr. Leon the prescriptions for ninety tablets of Vicodin, Dr. Leon testified that that statement may not be accurate. Dr. Leon testified that "many times she just brought me a bottle that had obviously been opened and it was, you know, with pills in it. I didn't count them. So it could be accurate; it could be not accurate. I don't know." (Tr. at 97)

Dr. Leon testified that sometimes it had been prearranged that Patient 1 would return some pills, and sometimes it had not been:

Sometimes I would get the story that the prescription was lost in the washing machine or something like that, and so I would write it—she would say, you know, I'll bring some back. Other times she would just come to work and give me some of them to take home. So we never had a verbal arrangement or any, you know, do this today, bring these tomorrow. It was sort of, you know, catch can.

(Tr. at 98) However, Dr. Leon acknowledged that, on dates when he had written more than one prescription for Patient 1, there had been a prearranged plan for Patient 1 to bring one of the prescriptions back to him. (Tr. at 98-99)

Dr. Leon further testified that, on days when he had written two prescriptions to Patient 1, he had not instructed her to have them filled at separate pharmacies. Dr. Leon testified, "I don't recall ever talking to her about where she went and got these filled. That was a conversation that we never had, to my recollection." (Tr. at 105) Dr. Leon further testified that he had never told Patient 1 to be discreet about how she filled the prescriptions. However, Dr. Leon acknowledged that he had been aware that he could get into trouble if anyone found out what he was doing. (Tr. at 105-106)

26. Dr. Leon testified that he had not been aware that Patient 1 had been selling medication until he was so informed by Ms. Jones and Detective Luken. (Tr. at 102, 106) However, Dr. Leon acknowledged that his last prescription to Patient 1 had been February 3, 2003, and that the investigators had not spoken to him until around March 10 or 12, 2003. Dr. Leon testified,

I knew before because I had gotten a call from the hospital about—somebody had called and said—and I heard the story. So in February I knew that she was selling—or I knew that there was a problem. I didn't know she was selling until they came to my house, but I knew there was a problem, that someone had found out that I had written the scripts for her in February. I think it was the 11th or something like that.

(Tr. at 106-107)

27. Dr. Leon testified that he had taken the medication that Patient 1 had brought back to him for pain relief in the evening or on the weekend when he was off work. Dr. Leon testified that he never took the medication around the clock. Moreover, Dr. Leon testified that he “probably threw more away that [he] ever took.” Whereupon the following exchange occurred,

Q [by Mr. Perry] Why would you throw them away?

A [by Dr. Leon] Dated. They’re sitting around, I probably shouldn’t have these around.

Q But yet you were still in pain?

A Yes.

Q And then you’d write for her again and she would bring more back?

A She would ask and I’d say sure. I have significant pain, so it was nice to have relief once in a while from it.

Q If—this is going to sound strange; but if you were going to prescribe for someone such as yourself with that type of injury, the leg pain, and you were going to prescribe Vicodin ES, as in this case, at this strength—well, I guess that’s the strength right there—how long would you expect 90 pills to last?

A Well, it can be taken as many as—I know folks that are taking five to six a day. So—

Q So that would be less than a month, month’s supply?

A (Indicates affirmatively.)

HEARING EXAMINER: You have to answer verbally.

A I’m sorry. Yes.

Q [by Mr. Perry] But your testimony is you would take them occasionally as needed for pain?

A I did not take them every day. Sometimes after working 14 hours, I would come home pretty uncomfortable. I would take one at home. When I had time off and I spent a lot of time in the yard or working, you know, around stairs, I would take, you know—I mean, occasionally I took two a day, I did.

Q At the same time or spread out?

A No, no, spread out.

Q Okay. This is going to be another strange sounding question, but did you ever feel that your taking this medication was affecting your professional judgment?

A I didn't take the medication at work. I never did that. I suppose that one could say, yes, you know, you're taking a mood-altering medication, but I don't know it's any different than somebody that has a drink with dinner at night and then goes to work the next day. To me, it's sort of equated.

Q So you were able to control when you would take it?

A Yes. I didn't—I'm sorry. I'm not sure I understood the question.

Q You weren't addicted to it, you weren't dependent on it where you just had to have it?

A No. I only took it because—when it got pretty uncomfortable; and usually that was after 12, 14 hours. We—Middletown hospital is a very busy, 55,000 patients a year. It's nonstop. There's no sitting. It's walking, standing 12 hours and usually ends up being that because you usually end up hanging around. So then I'd have about a 30-minute drive home. So by the time I got home after those days, I'd be pretty uncomfortable and I would take one of them just to go to bed, go to sleep.

Q But you're sure that you never took any at work?

A I never took any at work.

Q So at the time that you'd be writing these for Patient 1, you wouldn't be under the influence of the medication itself?

A No.

(Tr. at 108-111)

28. Dr. Leon prescribed Vicodin ES to Patient 2 as follows:

Date Prescribed	Date Filled	Medication	Quantity
Undated	08/23/1998	Vicodin ES	60
09/22/1998	09/23/1998	Vicodin ES	60
Undated	10/04/1998	Vicodin ES	60
10/14/1998	10/17/1998	Vicodin ES	60
11/11/1998	11/12/1998	Vicodin ES	60
12/09/1998	12/10/1998	Vicodin ES	60
12/23/1998	12/24/1998	Vicodin ES	60
01/01/1998 [sic]	01/03/1999	Vicodin ES	60
Undated	01/13/1999	Vicodin ES	60
01/26/1999	01/26/1999	Vicodin ES	60
02/06/1999	02/08/1999	Vicodin ES	60
02/16/1999	02/18/1999	Vicodin ES	60
Undated	02/25/1999	Vicodin ES	60
Undated	03/10/1999	Vicodin ES	60
03/22/1999	03/24/1999	Vicodin ES	60
04/04/1999	04/05/1999	Vicodin ES	60
Undated	06/12/1999	Vicodin ES	60
Undated	07/19/1999	Vicodin ES	60
Undated	08/15/1999	Vicodin ES	60
Undated	08/27/1999	Vicodin ES	60
Undated	11/30/1999	Vicodin ES	60
Undated	01/02/2000	Vicodin ES	60
01/19/2000	01/19/2000	Vicodin ES	60
Undated	02/19/2000	Vicodin ES	60
Undated	05/21/2000	Vicodin ES	60
09/02/2000	09/06/2000	Vicodin ES	60
09/27/2000	09/29/2000	Vicodin ES	60
Undated	10/27/2000	Vicodin ES	60
11/12/2000	11/15/2000	Vicodin ES	60

(St. Ex. 12)

29. Dr. Leon testified that he has known Patient 2 for about eleven years, and that she had worked at Middletown Hospital when Dr. Leon had first started working there. Dr. Leon further testified that she had left for another position after he had been there for about a year. Dr. Leon further testified that he and Patient 2 had begun dating around Christmas 1995, and they were married on October 21, 2000. (Tr. at 86-87, 123-124)

30. Dr. Leon testified that he had prescribed medication to Patient 2 for his own use for pain relief following a motorcycle accident, which is described in greater detail below. Dr. Leon further testified that he had diverted for his own use all of the Vicodin ES that he had prescribed to Patient 2. Dr. Leon stated that, in the period immediately following his accident, he had probably been taking Vicodin ES four times per day. (Tr. at 126-127)

Dr. Leon testified that he had not performed a physical examination on Patient 2, rendered a diagnosis, or kept a medical record for her. (Tr. at 128)

Dr. Leon testified that he had been aware of the Board's rule regarding prescribing medication to family members, and that that had been the reason that he had discontinued such prescribing shortly after he and Patient 2 were married. (Tr. at 130) However, Dr. Leon acknowledged that he had prescribed hydrocodone to Patient 2 on two occasions following their marriage. (Tr. at 131-132)

31. Dr. Leon testified that his first prescription to Patient 2 had been July 23, 1997, shortly after his release from the hospital following his motorcycle accident. Dr. Leon testified that "[t]here were times I didn't have medicine and [my orthopedic surgeon] was out of town or I couldn't reach him." Dr. Leon further testified that he had not wanted to call his physician and ask for pain medication. (Tr. at 186)
32. Dr. Leon prescribed controlled substance medication to Patient 3 as follows:

Date Prescribed	Medication	Quantity
02/25/2002	Vicodin HP	60
03/04/2002	Percocet	60
04/13/2002	Vicodin ES	90
04/30/2002	Percocet	90
05/14/2002	Vicodin ES	90
05/14/2002	Percocet	90
06/30/2002	Percocet	20

(St. Ex. 11 at 52-62)

33. Dr. Leon testified that Patient 3 was an employee in the emergency room who had been "a secretarial or technician kind of" employee. Dr. Leon stated that he had prescribed medication to her because she had asked him to do so. Dr. Leon testified that, as he recalls, Patient 3 had complained of back pain. (Tr. at 111-112)

Dr. Leon acknowledged that he had not performed a physical examination on Patient 3, nor did he render a diagnosis. Dr. Leon further acknowledged that he did not keep any medical

records for Patient 3. Dr. Leon stated that Patient 3 never paid him for the prescriptions. (Tr. at 112-113)

34. Dr. Leon testified that he does not recall ever receiving any medication back from Patient 3. Later, when shown his responses to interrogatories that had been sent to him by the Board, Dr. Leon amended his answer. Dr. Leon testified, “It says that I did obtain medication from [Patient 3]. * * * I honestly—I don’t know. I don’t recall ever obtaining any from Patient 3, but I’ll stand by this if that’s what I said a year ago.” Dr. Leon stated that he believes that his recollection is better now than it had been at the time he answered the interrogatories—“I don’t remember what the date was, but life was pretty ugly in those days”—and that he has not tried to mislead anyone concerning that issue. Finally, Dr. Leon stated that it is possible that he had received medication from Patient 3, but at hearing he could not recall that happening. (Tr. at 114-117)
35. Dr. Leon testified that he is aware that Patient 3 had been receiving prescriptions for hydrocodone from another physician. Dr. Leon further testified that he had stopped writing prescriptions for Patient 3 when he discovered that.¹ When asked how he had learned that Patient 3 was getting medication from another physician, Dr. Leon testified, “I don’t know if it was someone in the department told me or she told me, but it was communicated somehow to me that that was going on and how it was being done.” (Tr. at 117-118)

Dr. Leon testified that he does not recall confronting Patient 3 about that situation. However, Dr. Leon testified, “I probably gave her some reason why I wasn’t going to do it anymore, and it would likely have been that.” (Tr. at 118)

Dr. Leon testified that he had learned that Patient 3 had had a relative who worked in the other physician’s office and who was calling in prescriptions for her. Dr. Leon further testified that he did not know if the other physician had authorized the prescriptions. (Tr. at 119)

36. Dr. Leon prescribed controlled substance medication to Patient 4 as follows:

Date Prescribed	Medication	Quantity
01/04/2000	Vicodin ES	60
03/15/2002	Vicodin ES	90
04/15/2002	Vicodin ES	90
06/10/2002	Vicodin ES	90
07/02/2002	Vicodin ES	90
08/20/2002	Vicodin ES	90

(St. Ex. 11 at 9-16)

¹ Note that this testimony conflicts with that of Ms. Jones on this topic. See Summary of the Evidence 9, above.

37. Dr. Leon testified that he knows Patient 4, and that Patient 4 is his nephew by Dr. Leon's previous marriage. Dr. Leon further testified that he has known Patient 4 since Patient 4 was born. Dr. Leon testified that Patient 4 is now in his twenties. (Tr. at 132-133)

Dr. Leon acknowledged that he had prescribed Vicodin ES to Patient 4. Dr. Leon testified that Patient 4 had come into the emergency department as a registered patient "on a couple of occasions." Dr. Leon testified that, at other times, he would just stop in. Dr. Leon testified that Patient 4 had told Dr. Leon that he needed the medication because he had been working for a landscape company, and had had low back pain. (Tr. at 133-134)

Dr. Leon testified that he had occasionally performed a physical examination on Patient 4, but had not kept any medical record. (Tr. at 134-135)

Dr. Leon testified that he had prescribed medication to Patient 4 as a favor, and that he had not charged him for it. Dr. Leon further testified that Patient 4 had not diverted any of the medication back to him. (Tr. at 136)

38. Dr. Leon prescribed controlled substance medication to Patient 5 as follows:

Date Prescribed	Medication	Quantity
06/21/2001	Vicodin ES	60
08/30/2001	Vicodin ES	60
Undated	Xanax 2 mg	30

(St. Ex. 11 at 3-7)

39. Dr. Leon testified that Patient 5 had been Patient 4's girlfriend. (Tr. at 136)

Dr. Leon testified that Patient 5's complaint had been dysmenorrhea. Dr. Leon testified that Vicodin ES can be prescribed for that condition on an acute basis. Dr. Leon further testified that he had prescribed the medication for Patient 5 because Patient 4 had asked him to. When asked if he had met with Patient 5 face-to-face, Dr. Leon replied that he "did meet her on occasion, because she was his girlfriend." When asked if he had seen her when he issued the prescriptions, Dr. Leon replied, "On occasions I may have. I don't know." Dr. Leon acknowledged that it is possible that he had just written the prescriptions and handed them to Patient 4 without seeing Patient 5. (Tr. at 136-137)

Dr. Leon testified that he had not maintained a medical record for Patient 5, nor had he charged her for the prescriptions. (Tr. at 138)

40. Concerning the prescription for Xanax, Dr. Leon testified that Xanax is a benzodiazepine and sedative hypnotic used to treat anxiety. Regarding the reason for the prescription, Dr. Leon testified, “On that occasion, if I remember correctly, they were going to be traveling, and she had a problem—I don’t recall if it was air—fear of—it was some issue like that. That’s the reason that happened, at least that was the reason given to me.” (Tr. at 138)

Dr. Leon’s Injury from a 1997 Motorcycle Accident

41. Dr. Leon testified that he has been riding motorcycles most of his life. Dr. Leon further testified that, in July 1997, his future wife, Patient 2, had become interested in riding and had purchased a small motorcycle. Dr. Leon had been riding his motorcycle on a Saturday afternoon with Patient 2 following on hers. Dr. Leon testified that, because Patient 2 was a beginning rider, Dr. Leon had been frequently checking his rearview mirror to ensure that Patient 2 was all right. While riding through Lebanon, Ohio, Dr. Leon had been distracted for a moment glancing in his rear view mirror and, “at the last minute,” saw a pickup truck pulling out of the fairgrounds. He swerved to avoid it but was hit on his right side. (Tr. at 145-146)

Dr. Leon testified that his right leg was injured, and he had “an open comminuted fracture of [his] tibia, fibula, right knee, and ankle.” Dr. Leon testified that he had required three surgeries within about a week of the accident to begin to repair the damage, including an intermedullary rod in the tibia “to bring the pieces together,” and the placement of screws and a plate in his ankle. Dr. Leon further testified,

Because it was an open fracture, meaning that the skin was open, they elected to take part of my gastrocnemius, which is the hamstring, I guess, is the layman’s [term], and bring it around over the tibia so it would improve the blood supply and enhance the healing and decrease the likelihood of infection.

(Tr. at 146-147)

42. Dr. Leon testified that he had been prescribed pain medication by his physician, but “not for very long.” (Tr. at 128-129)
43. Dr. Leon testified that in October 1997 he had returned to work, on crutches, doing full shifts. Dr. Leon testified that he “can’t recall whether [he and his orthopedic surgeon] specifically discussed going back to work or not. He probably would not have wanted me to work as much as I was working.” Dr. Leon testified that he had remained on crutches until the late spring or early summer of 1998. (Tr. at 147-149)
44. Dr. Leon testified that he had had continued pain after returning to work. During the period following his return to work, Dr. Leon was using the Vicodin he received from

writing prescriptions to Patient 2. Dr. Leon testified that he had not been receiving any controlled substances from his physicians during that time. (Tr. at 149)

45. Dr. Leon testified that, a year after the accident, the pain had not diminished. Dr. Leon testified that, as a result of the intermedullary rod and bone loss from the accident, he had developed about twelve degrees of “valgus, which is an angulation of the leg,” toward the outside of his leg. Dr. Leon testified that this put a lot of pressure on his inner knee. Moreover, he developed about two centimeters of shortening of the leg. (Tr. at 149-150)

Dr. Leon testified that, in order to correct the shortening and angulation, he underwent an Ilizarov procedure. Dr. Leon testified that one of the foremost surgeons in that procedure, James C. Binski, M.D., practices in Dayton. (Tr. at 150-151)

Dr. Leon described his Ilizarov procedure. Dr. Leon stated that in December 1999 Dr. Binski removed the intermedullary rod from the tibia, and, after an elaborate set of adjustable external fixators were placed, cut through the tibia and the fibula. Dr. Leon testified that the external fixator rings encircling the leg were attached outside of the leg above and below the osteotomy, each ring being attached to the bone by three rods that were fixed to the bone through the skin and other tissue. The rings were then connected to each other outside of the leg by six adjustable rods. Dr. Leon testified, “[E]very day my wife would adjust these about a millimeter a day. I had a printout from a computer that told her how much to adjust. And over four, five, six months, it did lengthen my leg and it began to correct that angulation.” (Tr. at 151-153)

46. Dr. Leon testified that he had returned to work two weeks after undergoing the surgery placing the Ilizarov hardware. Dr. Leon further testified that he had had to wear baggy sweatpants that fit over the apparatus. (Tr. at 153-154)

Dr. Leon stated that patients do not typically return to normal activity two weeks after such surgery. When asked what Dr. Binski had advised him to do, Dr. Leon replied, “Well, he would have preferred that I didn’t go back to work at all for months, I’m sure.” When asked if he had told Dr. Binski that he had returned to work after two weeks, Dr. Leon replied that he had told him that he had returned to work, “but probably didn’t let him know how much [he] was actually having to work.” Dr. Leon further testified that, when he returned to work, he had been working “[m]aybe 40—30, 40 [hours], something like that. It varied a little bit.” (Tr. at 154-155)

Dr. Leon testified that he had worn the Ilizarov hardware for about five months, and that it was removed in April or May 2000. Dr. Leon further testified that “the pain level goes up as the time goes along because of the changing and adjusting these rods and lengthening and stretching tendons. And so it gets worse as one goes along. Towards the end of the time, it’s not very pleasant.” (Tr. at 155-156)

47. Dr. Binski's medical records indicate that Dr. Leon had had surgery to place the Ilizarov hardware on December 13, 1999. (St. Ex. 15 at 74-76) He underwent a second surgical procedure for "[r]evision of spatial frame" on January 7, 2000. (St. Ex. 15 at 72-73) The Ilizarov hardware was removed on April 22, 2000. (St. Ex. 15 at 68-69)
48. Dr. Leon testified that, after the Ilizarov hardware was removed, by the summer of 2000, he had noticed an improvement in his condition. Dr. Leon testified, "I wasn't pain free, but it was better than it had been * * * so I was optimistic about it." Dr. Leon testified that, from that time through about late 2001, he did better. However, Dr. Leon testified that, by late 2001, his pain began to increase. (Tr. at 156-158)

Dr. Leon testified that, after his pain began to increase again in late 2001, he did not go back to Dr. Binski or anyone else to seek assistance. Dr. Leon testified that, instead, he obtained medication through Patient 1. (Tr. at 159)

49. Dr. Leon testified that, had he not returned to work so soon after the accident, he may have had a chance to heal more effectively and would be better off today. When asked why he had gone back to work so soon, Dr. Leon replied,

I had eight angry partners who were working a lot of hours because I was gone and, you know, not real happy about it and families of theirs that weren't happy. And, you know, you have a sense of responsibility to them. I felt bad because I had been gone so much as it was from the initial injury; and it was a combination of things, I suppose.

(Tr. at 172-173)

When asked if his injury has inhibited his ability to practice, Dr. Leon replied,

Well, I've worked in pain constantly since I was hurt. It's very distracting to try to elicit information from a patient when standing at the bedside is difficult for the physician, and pain is distracting. Chronic pain is both depressing and tiresome and distracting.

And I—you know, I had a—I had a real problem wrestling with the fact that our group by our contract had to cover codes in the hospital of non-ER in-hospital patients, which meant, you know, sprints up stairways and down hallways when those moments came. And I—as time went by, I started to have—to struggle with that because I—I knew I couldn't do what I should do to get there in—on a timely basis. And that became more and more of an issue for me.

(Tr. at 173-174) Dr. Leon testified that he did not share his concerns with anybody else. He further testified that his practice partners and other colleagues had known that he had that physical problem. (Tr. at 174-175)

50. Concerning the reasons that Dr. Leon had obtained pain medication inappropriately, rather than simply obtain them through his own physician, the following exchange took place,

Q [by Mr. Perry] Dr. Leon, my last question for you is, and I guess it's the most important one, you've indicated that you were aware that you were doing some things that you shouldn't have been doing as far as prescribing these medications—

A I was.

Q —and specifically the ones that you were doing for your own use. Why didn't you get treatment through legitimate channels?

A You know, I wish I had a logical answer to give you for this debacle. Initially, I was embarrassed to go and ask for pain medication. I didn't want to do that. I—having worked in the emergency room for 20 some years; and right or wrong, chronic pain patients are not the most welcome people in the emergency departments. They're—well, they're shunned. They're treated with some disdain. They're viewed as a nuisance, as people who take up the time of the staff which could be better spent with really sick people.

Q Are you saying drug seekers or just pain patients?

A Both, both. The line is pretty blurred when it comes to both in the emergency room.

Q So you think that all pain patients, even ones that legitimately have a serious condition, are viewed skeptically by the profession?

A Yes, they are. And I was terribly frightened of becoming one of those. That was on my mind. And, you know, trying to keep up a busy schedule, working on crutches, it just was the easy way out, I suppose. I don't know a better term.

I have not been a person that has found it easy to ask for help. I'm trying to work on that these days; but, you know, I've taken care of myself all my life. I've never asked for anything, so it carries on into everything I do. I don't know if any one of those, all of those, none of those brought me to that

terrible lapse in judgment. This is not who I am; but, you know, here I am, and I accept it. I blame no one but myself.

But I've asked myself that question countless times since all of this. And, as I say, I wish I had a logical answer that I could give you that would make sense, but I don't.

(Tr. at 139-141)

51. Dr. Leon testified that he had obtained Vicodin via prescriptions to Patient 2 during the time that he underwent the Ilizarov procedure. (Tr. at 156) Dr. Leon further testified that Dr. Binski had prescribed pain medication for him "immediately postoperatively, but not for very long, as I recall. But I don't know the specific time frame for that." (Tr. at 187) However, Dr. Leon acknowledged that, had he gone to Dr. Binski and told Dr. Binski that he had been experiencing pain, Dr. Binski "[p]robably would have" prescribed pain medication for him. (Tr. at 156)

Note, however, that Dr. Binski's medical records contradict Dr. Leon's testimony. Dr. Binski's records indicate that Dr. Binski had prescribed controlled substance pain medication to Dr. Leon on approximately fifteen occasions between December 1999 and June 2000. Specifically, Dr. Binski prescribed Vicodin ES #30 to Dr. Leon on December 22, 1999, with instructions to take one or two every six hours as needed for pain. Subsequently, Dr. Binski prescribed Vicodin ES #30, with instructions to take one every six hours as needed for pain, on January 6, 12, 19, 26, February 2, 9, 15, 21, March 1, 10, 22, and April 19, 2000. Moreover, a Telephone Triage Form indicates that on June 6, 2000, Dr. Leon had called Dr. Binski's office "requesting pain meds for evening only," and that Dr. Binski authorized a prescription for Darvocet N-100 #30 to be taken every twelve hours as needed for pain. (St. Ex. 15 at 7, 16, 19, 21, 28, 30, 32, 33, 35, 38, 40, 43, 45, 50, 61)

Dr. Leon acknowledged that he had written prescriptions to Patient 2 for his own use for Vicodin ES #60 that were filled on January 2 and 19, February 19, and May 21, 2000. Dr. Leon testified that each would have been a fifteen day supply if he had taken four per day. (St. Ex. 12 at 14-16; Tr. at 193-194)

Dr. Leon testified that Dr. Binski has a solo practice, and is frequently out of the country. Dr. Leon further testified, "I know there were times when he was unavailable" when he had obtained medication through Patient 2. Moreover, Dr. Leon testified that Vicodin ES #30, one every six hours, would only be seven and one-half day's worth of medication. Furthermore, Dr. Leon testified, "I can tell you that I was taking them pretty regularly during that time. The procedure gets worse and the pain level gets worse; and through the end of this, sometime late spring, winter, it can get pretty uncomfortable." (Tr. at 191-193)

When asked if his earlier testimony that he had not received prescriptions from Dr. Binski for an extended period of time had been accurate, Dr. Leon replied, “Obviously, not. I didn’t think I had gotten a prescription from him for any extended period of time. It looks like at least while I had the rings on my leg, I did.” (Tr. at 194)

Further, when asked about his earlier testimony that he did not find it easy to ask for help, and how that testimony related to his June 6, 2000, request for pain medication, Dr. Leon testified that he had gone to work two weeks after his last surgery. Dr. Leon further testified that “toward the end of the adjusting of these rings” was the most painful and uncomfortable part of the procedure. (Tr. at 194-195)

52. Dr. Binski’s medical records indicate that he had written letters to Dr. Leon on July 14, 2000, and January 22, 2001, concerning missed appointments, and emphasizing the importance of receiving follow-up care. (St. Ex. 15 at 80-81) Dr. Leon testified that he had been seeing Dr. Binski on a weekly basis, and sometimes he had missed appointments due to work. Dr. Leon testified that he had had difficulty keeping all of his appointments with Dr. Binski. Dr. Leon further testified that he had had a lot of personal turmoil during that period. Dr. Leon stated that his father had died in July 2000, and in October 2000 his house was destroyed by a tornado. Finally, Dr. Leon added, “I didn’t just stop going.” (Tr. at 196-197)
53. Dr. Leon testified that he had seen Dr. Binski in August 2004, and that Dr. Binski had “broached the subject of additional surgery at some point.” Dr. Leon testified that he may require further corrective surgery, which he described as “painful” and which would require him to be on crutches for nine months. However, Dr. Leon testified that he and Dr. Binski have not made any definite decision as to whether or when such surgery will take place. (Tr. at 236-238)

Dr. Leon’s Intervention in Lieu of Conviction

54. On January 7, 2004, an Information was filed in the Butler County [Ohio] Court of Common Pleas in *State of Ohio v. Alberto Antonio Leon*, Case Number CR03-11-1732. The Information charged Dr. Leon with four counts of Deception to Obtain a Dangerous Drug, in violation of Section 2925.22(A), Ohio Revised Code, a felony of the fifth degree. (St. Ex. 17) Further, on January 7, 2004, Dr. Leon filed with the court a Request for Intervention in Lieu of Conviction. (Respondent’s Exhibit [Resp. Ex.] C)

On February 18, 2004, Dr. Leon appeared in court and entered pleas of guilty to the four counts in the Information. On February 25, 2004, the court filed an Entry Finding Eligibility for Intervention in Lieu of Conviction and Ordering Period of Rehabilitation finding that Dr. Leon was eligible for intervention in lieu of conviction. The court ordered

that Dr. Leon undergo a period of rehabilitation and be:

placed under the control and supervision of the Adult Probation Department for an indefinite period of at **least one year**. During the period of rehabilitation and as a condition of the intervention plan, the defendant shall abstain from the use of illegal drugs and alcohol, submit to regular random testing for drugs and alcohol, faithfully follow and complete the treatment plan established by the State Medical Board of Ohio, and be under the general control and supervision of the Adult Probation Department under the standard conditions of community control and such other conditions as the Court may further order.

(St. Ex. 17) (Emphasis in original)

On March 23, 2004, the Butler County Prosecuting Attorney's office filed with a Board a Prosecutor's Reporting Form. This document notified the Board that Dr. Leon had "been found eligible for treatment or intervention in lieu of conviction." (St. Ex. 16)

55. Dr. Leon testified that, pursuant to the court's order granting him intervention in lieu of conviction, he went through twenty-eight days of inpatient treatment, and entered into aftercare. Dr. Leon further testified, "Actually, I had already gone—I did the program before I went to court. So that portion—most of it's already been fulfilled." (Tr. at 233) Moreover, Dr. Leon acknowledged that he had entered treatment in order to improve his chances of obtaining intervention in lieu of conviction. (Tr. at 243-244)

Dr. Leon testified that he had undertaken treatment at Parkside Behavioral Healthcare in Gahanna, Ohio, commencing on December 1, 2003. Dr. Leon testified that he had spent twenty-eight days at that facility as an inpatient, which was followed by five weeks of intensive outpatient treatment. Dr. Leon further testified that he has entered into a continuing care contract with that facility. Moreover, Dr. Leon testified that he attends four or five meetings per week, including a weekly continuing care meeting at Parkside, and a Caduceus meeting. Finally, Dr. Leon testified that he has a contract with the Ohio Physicians Effectiveness Program [OPEP], which includes weekly urine screens. (Resp. Exs. A and B; Tr. at 166-169, 235-236)

Additional Information

56. Dr. Leon testified that the Board had ordered him to submit to a three-day evaluation at Shepherd Hill in Newark, Ohio. Dr. Leon testified that he had attended this evaluation in May 2003. Dr. Leon testified that he has never received any report concerning that evaluation. (Tr. at 229-231)

By letter dated June 3, 2003, Richard N. Whitney, M.D., Shepherd Hill, Newark, Ohio, reported to the Board concerning Dr. Leon's 72-hour evaluation. Dr. Whitney reported that Dr. Leon had provided prescriptions to nurses and his wife in order to obtain medication to treat chronic pain. Dr. Whitney further reported, "In summary, we have concluded that there is no evidence to support the diagnosis of drug or alcohol dependence in Dr. Leon and we report this as a negative evaluation." (St. Ex. 18)

In a February 27, 2004, letter to Mr. Plinke, Edna Jones, M.D., Medical Director, The Woods at Parkside, echoed Dr. Whitney's conclusion that Dr. Leon did not suffer from opiate dependency. Dr. Jones further stated that Dr. Leon had returned to work too quickly following his injury, which "resulted in increased pain and disability." Dr. Leon responded by self-medicating his pain. Dr. Jones further stated that Dr. Leon was initially impaired by pain and subsequently by opiate abuse. Moreover, Dr. Jones stated that Dr. Leon may be facing further surgery as a result of complications from his last surgery. Finally, Dr. Jones stated that, should Dr. Leon resume "practice again as he did in the past, he will again become disabled due to pain. This would increase his relapse risk to opiate abuse and possible future opiate dependency." (Resp. Ex. G)

57. Dr. Leon testified that he agrees with Dr. Whitney's and Dr. Jones' assessments that he is not drug or alcohol dependent. (Tr. at 241)
58. Dr. Leon testified that he had cooperated with Ms. Jones and Detective Luken, and answered their questions truthfully. Dr. Leon further testified that he has cooperated with the Board, and signed releases of his medical records from his surgeons and his internal medicine physician. (Resp. Ex. D; Tr. at 163-164)
59. Dr. Leon testified that he has no prior disciplinary history with the Board. (Tr. at 170-171)
60. Dr. Leon testified that, on the advice of his criminal attorney, he has surrendered his DEA registration. (Resp. Ex. F; Tr. at 179-180)
61. Dr. Leon testified that he is physically unable to endure the strenuous physical demands and long shifts of emergency medicine. However, Dr. Leon testified, "I would like to think there's something in medicine I could do someday down the road that's less demanding physically." (Tr. at 175-176)

Dr. Leon testified that his actions had been out of character. Dr. Leon testified that, had he not had the motorcycle accident, he would not be before the Board. Dr. Leon testified that he has never been in any trouble before; he doesn't smoke, he never experimented with drugs in college, and nobody in his family has a problem with drugs or alcohol. (Tr. at 176-177)

62. Concerning his plans for practice in the future, Dr. Leon testified,

Well, my board certification's in emergency medicine. Although there are other possibilities as well. I have for a long time played with the idea of a VA. I think I would like to explore that at some point. I'm a veteran. So I've always had a bit of an interest in that or urgent care. I think there are other—perhaps I'd even like to go back to emergency room at some point.

(Tr. at 238-239)

Dr. Leon acknowledged that he would not want to work eighty-hour weeks, but would consider “a normal schedule[.]” (Tr. at 239)

63. Dr. Leon, through his counsel, agreed that the Board did not allege chemical impairment in either notice of opportunity for hearing concerning this matter. Nevertheless, Dr. Leon advised that he would not object should the Board decide to impose sanctions which included requirements for chemical impairment evaluation and treatment.² (Tr. at 281-282).
64. The 2001 and 2003 editions of the Physicians' Desk Reference [PDR] both indicate that Endocet contains oxycodone hydrochloride, and is a Scheduled II controlled substance. These editions of the PDR further indicate that Xanax is a Schedule IV controlled substance. Note that a 2002 edition of the PDR, which covers the year that Dr. Leon prescribed Endocet and Xanax, was not available. (Board Exhibits A and B)

FINDINGS OF FACT

1. Alberto Leon, M.D., repeatedly prescribed controlled substances to Patient 1. Dr. Leon's prescribing to Patient 1, as listed below, included on some occasions writing two separate prescriptions for the same controlled substance, Vicodin, on the same issuance date, both in the name of Patient 1. Dr. Leon issued such prescriptions without personally conducting a physical examination of Patient 1 and without completing and maintaining accurate medical records reflecting his examination, evaluation, and treatment of Patient 1, including the diagnosis and purpose for which the controlled substance was utilized.

² In *In re Eastway* (1994), 95 Ohio App.3d 516, 642 N.E.2d 1135, cert. denied, the Franklin County Court of Appeals held that the Board could not require psychiatric treatment as a condition of probation when it had not charged a physician with being mentally impaired. Therefore, a Board order which includes such sanctions is not supported by reliable, probative, and substantial evidence and is not in accordance with the law. See also *Lawrence S. Krain, M.D. v. State Medical Board of Ohio* (Oct. 29, 1998), Franklin App. No. 97APE08-981, unreported.

Further, Dr. Leon admitted that he had had Patient 1 return a portion of the controlled substances to him.

Date Prescribed	Medication	Quantity
03/31/2002	Percocet	20
07/18/2002	Vicodin ES	90
07/19/2002	Vicodin ES	30
08/15/2002	Vicodin ES	40
08/15/2002	Vicodin ES	40
08/21/2002	Endocet	20
09/09/2002	Percocet	20
09/09/2002	Vicodin ES	45
09/09/2002	Vicodin ES	45
10/03/2002	Vicodin ES	45
10/03/2002	Vicodin ES	45
10/04/2002	Endocet	20
10/14/2002	Vicodin ES	45
10/23/2002	Vicodin ES	45
11/04/2002	Vicodin ES	50
11/06/2002	Percocet	20
11/16/2002	Vicodin ES	40
11/16/2002	Percocet	20
12/04/2002	Vicodin ES	90
12/04/2002	Vicodin ES	45
12/04/2002	Endocet	20
12/17/2002	Vicodin ES	90
12/18/2002	oxycodone/APAP 10/650	20
12/26/2002	Percocet	20
12/31/2002	Vicodin ES	40
12/31/2002	Percocet	20
12/31/2002	Vicodin ES	90
01/07/2003	Percocet	20
01/28/2003	Vicodin ES	90
01/28/2003	Vicodin ES	40
02/03/2003	Vicodin ES	40
02/07/2003	oxycodone/APAP 10/650	20

2. Dr. Leon prescribed Vicodin, as listed below, to Patient 2. Patient 2 became a family member on October 21, 2000. Prior to that time, Dr. Leon had had a dating relationship with Patient 2 since December 1995. Dr. Leon issued such prescriptions in non-emergency situations, without medical justification, without personally conducting a physical

examination of Patient 2, and without completing and maintaining accurate medical records reflecting his examination, evaluation, and treatment of Patient 2, including the diagnosis and purpose for which the controlled substance was utilized. Further, Dr. Leon admitted that he had diverted for self-use all of the medication he had prescribed to Patient 2.

Date Prescribed	Date Filled	Medication	Quantity
Undated	08/25/1998	Vicodin ES	60
09/22/1998	09/23/1998	Vicodin ES	60
Undated	10/04/1998	Vicodin ES	60
10/14/1998	10/17/1998	Vicodin ES	60
11/11/1998	11/12/1998	Vicodin ES	60
12/09/1998	12/10/1998	Vicodin ES	60
12/23/1998	12/24/1998	Vicodin ES	60
01/01/1998 [sic]	01/03/1999	Vicodin ES	60
Undated	01/13/1999	Vicodin ES	60
01/26/1999	01/26/1999	Vicodin ES	60
02/06/1999	02/08/1999	Vicodin ES	60
02/16/1999	02/18/1999	Vicodin ES	60
Undated	02/25/1999	Vicodin ES	60
Undated	03/10/1999	Vicodin ES	60
03/22/1999	03/24/1999	Vicodin ES	60
04/04/1999	04/05/1999	Vicodin ES	60
Undated	06/12/1999	Vicodin ES	60
Undated	07/19/1999	Vicodin ES	60
Undated	08/15/1999	Vicodin ES	60
Undated	08/27/1999	Vicodin ES	60
Undated	11/30/1999	Vicodin ES	60
Undated	01/02/2000	Vicodin ES	60
01/19/2000	01/19/2000	Vicodin ES	60
Undated	02/19/2000	Vicodin ES	60
Undated	05/21/2000	Vicodin ES	60
09/02/2000	09/06/2000	Vicodin ES	60
09/27/2000	09/29/2000	Vicodin ES	60
Undated	10/27/2000	Vicodin ES	60
11/12/2000	11/15/2000	Vicodin ES	60

3. Dr. Leon prescribed controlled substances, as shown below, to Patient 3. Dr. Leon issued such prescriptions without personally conducting a physical examination of her; without completing and maintaining accurate medical records reflecting his examination, evaluation, and treatment of Patient 3, including the diagnosis and purpose for which the

controlled substance was utilized; and despite his knowledge that she was also receiving the same medication from another physician.

Date Prescribed	Medication	Quantity
02/25/2002	Vicodin HP	60
03/04/2002	Percocet	60
04/13/2002	Vicodin ES	90
04/30/2002	Percocet	90
05/14/2002	Vicodin ES	90
05/14/2002	Percocet	90
06/30/2002	Percocet	20

4. Dr. Leon prescribed controlled substances, as listed below, to Patient 4. Dr. Leon issued such prescriptions based upon Patient 4's verbal representation that he was suffering from back pain, without personally conducting a physical examination of him, and without completing and maintaining accurate medical records reflecting Dr. Leon's examination, evaluation, and treatment of Patient 4, including the diagnosis and purpose for which the controlled substance was utilized.

Date Prescribed	Medication	Quantity
01/04/2000	Vicodin ES	60
03/15/2002	Vicodin ES	90
04/15/2002	Vicodin ES	90
06/10/2002	Vicodin ES	90
07/02/2002	Vicodin ES	90
08/20/2002	Vicodin ES	90

5. Dr. Leon prescribed controlled substances, as listed below, to Patient 5. Dr. Leon issued such prescriptions without personally conducting a physical examination of her, and without completing and maintaining accurate medical records reflecting his examination, evaluation, and treatment of Patient 5, including the diagnosis and purpose for which the controlled substance was utilized.

Date Prescribed	Medication	Quantity
06/21/2001	Vicodin ES	60
08/30/2001	Vicodin ES	60
Undated	Xanax 2 mg	30

6. On February 18, 2004, in the Court of Common Pleas, Butler County, Ohio, Dr. Leon entered pleas of guilty to four felony counts of Deception to Obtain a Dangerous Drug, in violation of Section 2925.22(A), Ohio Revised Code. Thereafter, on February 25, 2004, in response to Dr. Leon's previously submitted motion seeking intervention in lieu of conviction for these charges, the court filed an Entry Finding Eligibility for Intervention in Lieu of Conviction and Ordering Period of Rehabilitation that granted his request for intervention in lieu of conviction. The court stayed further criminal proceedings, and ordered Dr. Leon to complete an indefinite period of rehabilitation of at least one year.
7. Among the allegations raised in the Board's July 9, 2003, notice of opportunity for hearing issued to Dr. Leon, the Board alleged that Dr. Leon had diverted for self-use some of the medication he prescribed to Patient 3. However, Ms. Jones testified that Patient 3 had denied returning medication to Dr. Leon. Further, Dr. Leon first denied that he had obtained medication from Patient 3. After being shown a copy of his answers to interrogatories, in which he apparently had admitted receiving medication back from Patient 3, Dr. Leon stated that he would not dispute his earlier answer, and acknowledged that that may have occurred. However, Dr. Leon continued to testify that he could not recall that happening. Accordingly, there is insufficient evidence in the record that Dr. Leon had diverted for self-use some of the medication he had prescribed to Patient 3.

CONCLUSIONS OF LAW

1. The conduct of Alberto Leon, M.D., as set forth in Findings of Fact 1 and 3, constitutes "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Trafficking in Drugs, Section 2925.03, Ohio Revised Code.
2. The conduct of Dr. Leon as set forth in Findings of Fact 1 and 2 constitutes "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Deception to Obtain a Dangerous Drug, Section 2925.22, Ohio Revised Code.
3. The conduct of Dr. Leon as set forth in Findings of Fact 1 through 5 constitutes "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Illegal Processing of Drug Documents, Section 2925.23, Ohio Revised Code, as current and prior versions of that statute have been in effect.
4. The conduct of Dr. Leon as set forth in Findings of Fact 1 through 5 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: Rule

4731-11-02(D), Ohio Administrative Code, General Provisions, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000. 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.

5. The conduct of Dr. Leon as set forth in Findings of Fact 2 that occurred on or after November 11, 1998, 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: Rule 4731-11-08, Ohio Administrative Code, Utilizing Controlled Substances for Self and Family Members, as in effect from November 11, 1998, through March 14, 2001.
6. Dr. Leon’s plea of guilty and/or the judicial finding of Dr. Leon’s eligibility for intervention in lieu of conviction, set forth in Findings of Fact 6, constitute “[a] plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony,” as that clause is used in Section 4731.22(B)(9), Ohio Revised Code.

* * * * *

At the close of the hearing, the parties presented excellent arguments pro and con on the issue of whether Dr. Leon had been impaired during the time of these offenses. The State argued that he had not been impaired; the Respondent argued that he had. Nevertheless, even if one were to accept that Dr. Leon had been impaired by a desire to obtain pain medication, such impairment cannot excuse all of the conduct that formed the basis for this case. For example, Dr. Leon used Patient 1 and Patient 2 to obtain pain medication for himself—he split prescriptions with Patient 1; in Patient 2’s case, he diverted all of the medication to his own use. However, Dr. Leon did not use Patients 3, 4, or 5 to obtain pain medication for himself. Moreover, in Patient 5’s case, he had evidently prescribed controlled substances without even seeing the patient; he prescribed them through Patient 4, who was her boyfriend and Dr. Leon’s nephew. Impairment cannot excuse such conduct.

The Hearing Examiner is further concerned that Dr. Leon’s testimony was not entirely honest. Specifically, Dr. Leon testified that Dr. Binski had not prescribed pain medication to him except during the period immediately following the surgical placement of Ilizarov hardware in December 1999. Dr. Leon’s testimony indicated that he had been embarrassed to ask for help, and that he had not wanted to seem like a chronic pain patient because such patients are looked down upon by medical personnel. However, the State thoroughly impeached this testimony. Dr. Binski’s medical records indicate that Dr. Binski had prescribed controlled substance pain medication on *fifteen occasions* between December 1999 and June 2000. Moreover, in June 2000—over one month after the Ilizarov procedure was finished and the hardware was removed—Dr. Leon called Dr. Binski’s office asking for pain medication.

One certainly must feel sympathy for Dr. Leon for his serious injury and the effect that it has had on his life. Nevertheless, Dr. Leon's conduct crossed too far over the line of excusable or remediable conduct.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Alberto Leon, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

A handwritten signature in black ink, appearing to read 'R. Gregory Porter', written over a horizontal line.

R. Gregory Porter, Esq.
Hearing Examiner



State Medical Board of Ohio

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EXCERPT FROM THE DRAFT MINUTES OF NOVEMBER 10, 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: Fred Andrew Brindle, M.D.; William W. Hunter, Jr., M.D.; Alberto Leon, M.D.; Jack E. Slingluff, D.O.; Peter Steven Stanos, D.O.; and Hsiang Lee Tseng, M.D. A roll call was taken:

ROLL CALL:

Dr. Egner	- aye
Dr. Bhati	- aye
Dr. Buchan	- aye
Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye
Ms. Sloan	- aye

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. Bhati	- aye
Dr. Buchan	- aye
Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- 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.

ALBERTO LEON, M.D.

Ms. Sloan directed the Board's attention to the matter of Alberto Leon, M.D. She advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

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

Dr. Leon was accompanied by his attorney, Eric J. Plinke.

Mr. Plinke stated that the Order before the Board recommends permanent revocation. His objections obviously are directed to the severity of that punishment. At the hearing, Mr. Perry and he had well-argued closing arguments. Mr. Plinke commented that he thought his closing argument was better, but, obviously, the Hearing Examiner disagreed. Mr. Plinke stated that Mr. Perry will sit before the Board in a few minutes and ask that the Board permanently revoke Dr. Leon's license. Mr. Perry will lay out the reasons why he believes the license should be revoked. Mr. Plinke stated that he will try to do the same in just a few moments and then hand over the remainder of his time to Dr. Leon.

Mr. Plinke stated that Dr. Leon's conduct in this case is serious, there's no disputing that, and it warrants serious discipline. Mr. Plinke questioned whether it warrants the most serious discipline. He stated that this is an impairment case that factually might be different from cases the Board has seen before. When you apply those facts to the law, there really is no difference. Dr. Leon is a physician who, up until 1997, when he sustained a horrible and horrific motorcycle accident, was a physician the Board would never have expected to see. Like many physicians who become impaired, Dr. Leon suffered a physical injury, self-medicated his treatment, and ended up coming before the Board because of the conduct in which he engaged to self-medicate. Dr. Leon has been through treatment, is under an aftercare program and an OPEP contract. Dr. Leon is complying with all those things.

Mr. Plinke stated that the unusual circumstance here is that Dr. Leon also was evidently evaluated at Shepherd Hill, and they didn't believe that he was impaired. So there is a conflict here. You have a

conflict between Shepherd Hill's opinion and Parkside's opinion.

Mr. Plinke stated that he believes that this Board has an outstanding record in dealing with impaired physicians. The Board's approach has always been, "when the physician first comes before us, we will suspend the license." In some cases, depending upon the circumstances, the Board suspends for a short period of time. In other cases that are more aggravated, the Board suspends for a longer period of time. The Board provides for reinstatement terms. The Board's approach reflects the medical-model approach to physician impairment.

Mr. Plinke stated that, if you look at the motivation for Dr. Leon's conduct, it was not for pecuniary gain or to harm people. His motivation is the same motivation that any impaired physician has. He was suffering, and in his wrong belief that the medication was necessary to treat his pain, he became an opiate abuser.

Mr. Plinke stated that if the Board adopts the recommended Order, in some manner it undermines the Board's approach to impaired physicians. A permanent revocation order in this case is more of a reflection of a moral-model approach than a medical-model approach.

Dr. Leon stated that he is here speaking for his medical life, commenting that defending his career requires some eloquence. Dr. Leon stated that he is not a public speaker; he is an emergency room (ER) physician, and he has been for a long time. Until not long ago he had a long, uneventful and rewarding career. He's always given his patients his best effort.

Dr. Leon stated that he could speak a long time about regrets and remorse and sleepless nights and self-torment, disappointing many and hurting some he loves very deeply, but he won't take that time. Dr. Leon stated that he was involved in an accident in 1997. He was care-flighted and underwent numerous surgeries since that time to repair his leg. He did get into the habit of medicating himself to get through the days. He went back to work far sooner than he should have, and he worked far more hours than was advisable.

Dr. Leon stated that this past year he has undergone a 28-day program at Parkside. He went through their outpatient program. He is in their continuing care program, and he does drug screens every week for OPEP. He is compliant with all of that.

Dr. Leon stated that he is sorry that he has to be here, and he apologized to the Board members. He stated that, if the Board decides that he should be excluded from medicine forever, it leaves only for him to leave here with whatever little dignity and respect he may have left. Dr. Leon stated that he still has a lot to do in medicine, and he still has many years that he can work. He enjoyed his work. Dr. Leon asked the Board for a second opportunity. He assured the Board that he would never be here looking for a third opportunity.

Ms. Sloan asked whether the Assistant Attorney General wished to respond.

Mr. Perry stated that he couldn't say it any better than Mr. Porter did in his Report and Recommendation, but there are a couple facts he wants to emphasize for the Board. Mr. Plinke mentioned that Dr. Leon had obtained treatment, and that ties in with the intervention in lieu case from Butler County. He reminded the Board that a few months ago it had a discussion about the criminal justice system handling this program, which he believes is a great program for the people for whom it was truly designed, but sometimes it can result in a legal fiction. In this case, Dr. Leon was charged by a bill of information with just four counts of deception. There were 80 plus acts constituting felonies in the Board's complaint. For some reason Butler County charged Dr. Leon with four counts. The Board's most serious charges were, essentially, drug trafficking. Dr. Leon wasn't charged with that in Butler County.

Mr. Perry stated that since 1984 the Supreme Court of Ohio has held that, if you prescribe controlled substances outside the scope of a bona fide physician/patient relationship, that's tantamount to drug trafficking. Dr. Leon wasn't charged with that. Had he been charged with that, he wouldn't have even been eligible for this program. Mr. Perry stated that the treatment that Dr. Leon completed was completed prior to his even stepping into the courtroom, so that when the Court ordered it, he could say that he had already done it. Dr. Leon even admitted that that was done at the insistence of his criminal defense attorney.

Mr. Perry stated that the Report and Recommendation also comments on Dr. Leon's being less than honest in his explanations to the Board. He stated that there are a couple examples he wants to point out. When Mr. Perry was questioning Dr. Leon about his prescribing to Patient 1, and this pattern of prescription sharing, where Dr. Leon would write two prescriptions on the same dates, one of which Patient 1 would bring back, initially Dr. Leon denied that that was a pre-arranged plan. Mr. Perry stated that when he pointed out that there were several dates where Dr. Leon wrote two prescriptions on the same day, if it wasn't a pre-arranged plan, why would Dr. Leon possibly do that. Then Dr. Leon said, "well, maybe a few times it was pre-arranged." Only when it was called to his attention that the State had evidence that didn't match up with his explanation, Dr. Leon would change his explanation.

Mr. Perry continued that Dr. Leon indicated that this all started because he had had this traumatic injury. Mr. Perry stated that he doesn't mean to discount that at all, but Dr. Leon didn't want to be perceived in the medical community as a drug seeker. When Mr. Perry pointed out to Dr. Leon that his accident was in July 1997 and the first prescription written for the person who subsequently became his spouse, was July 23, 1997. That would have been within a week or two of Dr. Leon's release from the hospital. Mr. Perry stated that when he asked Dr. Leon, "when you were doing this right out of the gate upon being released from the hospital, how could you possibly have had a chance of even being perceived as a drug seeker," Dr. Leon's response was basically, "well, I have no explanation for that, Mr. Perry." Mr. Perry stated that Dr. Leon's explanation doesn't add up to the known facts.

Mr. Perry stated that another example would be Dr. Binski's prescriptions in the Spring of 2000. The Report and Recommendation points out that there were at least 15 prescriptions from Dr. Binski during the time period when Dr. Leon claimed that he was writing for himself, self-medicating because he didn't want to bother Dr. Binski, or because Dr. Binski was on vacation.

Mr. Perry stated that, when you boil it all down, what you end up with is 80 plus times where Dr. Leon prescribed controlled substances when, by his own admission, there were no physical exams, no diagnoses, no medical records. A substantial number of these were not for his own drug use. The drugs prescribed for Patients 3, 4 and 5, were not delivered to Dr. Leon. There is no evidence of drug dependence. Parkside said that there is definite opiate abuse because, after all, Dr. Leon was obtaining controlled substances through illicit means. That's abuse. But there was no finding of dependency. Even Dr. Leon admitted that when he engaged in this pattern of behavior he was stone-cold sober, he had complete control of his mental faculties, and he was fully aware of the Board's rules. Unexplainably, he went ahead and did it. This is not only serious, it's almost unbelievably shocking that a physician would engage in this kind of behavior. So, when you look at his pattern of conduct, it is so far over the line, there's only one appropriate outcome, and that is permanent revocation.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF ALBERTO LEON, M.D. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Ms. Sloan	- aye

The motion carried.

Dr. Egner stated that she doesn't agree with either Mr. Plinke or Mr. Perry. She stated that her take on this as she read through the Report and Recommendation, and the testimony Dr. Leon gave at hearing, is that Dr. Leon is a chronic benign pain sufferer. She thinks that he is impaired because of his chronic benign pain. Dr. Egner stated that she doesn't think that Dr. Leon ever received adequate treatment, partly due to his own fault. She doesn't believe that it was the fault of Dr. Leon's physician. Dr. Leon went back to work too early. She doesn't think that he followed the instructions as he should have. She also doesn't think that he looked into alternative methods of pain relief that he certainly knew were available. Dr. Egner stated that she still looks at this as an impairment case – not impaired to the drug, but impaired because of his pain.

Dr. Egner stated that she looks at the behaviors that this Board accepts because of drug impairment, and the Board tries to help those physicians. The Board has accepted some behaviors that are far more egregious

than this. Dr. Egner stated that she's not saying that the Board should let Dr. Leon go out and say that all is well. Dr. Egner stated that the Board has to really monitor Dr. Leon. But she added that she doesn't think that Dr. Leon should permanently lose his license. She thinks that the Board has to put faith in the evaluators who say that he's not impaired by drugs. The Board puts faith in them when they say that physicians are impaired, so why would the Board not believe them now?

Dr. Egner stated that she doesn't think that Dr. Leon can have a standard drug impairment Report and Recommendation, but he should have something similar to it. Dr. Egner stated that Dr. Leon should be taken out of practice. He did prescribe drugs to five people, all kind of in a circle of people he knew. He used incredibly poor judgment, but she believes she understands some of this.

DR. EGNER MOVED TO AMEND THE PROPOSED ORDER BY SUBSTITUTING AN ORDER THAT WOULD SUSPEND DR. LEON'S LICENSE FOR A MINIMUM OF ONE (1) YEAR, AND PLACE THE FOLLOWING REQUIREMENTS FOR REINSTATEMENT OF HIS LICENSE: HE SHOULD COMPLETE A PAIN MANAGEMENT EVALUATION AND PROGRAM; HE SHOULD PRESENT THE BOARD WITH A PRACTICE PLAN FOR BOARD APPROVAL WHEN HE'S MET THE CRITERIA THE BOARD WILL SET; AND HE SHOULD GO THROUGH THE PRESCRIBING AND MEDICAL RECORDKEEPING COURSES AT CASE WESTERN RESERVE. UPON REINSTATEMENT HE WILL BE ON PROBATION FOR FIVE (5) YEARS, AND ONE OF THE CONDITIONS WOULD BE MAINTAINING A LOG OF ALL DRUGS PRESCRIBED, DISPENSED AND ORDERED.

Dr. Egner stated that she does think that the Proposed Order is too harsh. It's really unusual, and maybe Dr. Leon has her fooled, but when she read this, the whole time she read it she just couldn't help but think that if he had ever allowed himself to be treated as a patient should be treated, she doesn't think he would have gotten into all this trouble.

Dr. Steinbergh stated that, after she finished reading this case, she asked herself whether this was a minimal standards case, an impairment case, or a combination of the two? She stated that she agrees with Dr. Egner in principle that there is no question that Dr. Leon suffered from chronic benign pain. She then tried to imagine why he made such poor judgments in prescribing, and, literally, trafficked in drugs. He prescribed all these controlled substances to people who were not even patients. This was very flagrant prescribing. He prescribed to one person he didn't even know or hadn't even met. Some of the other people were more controlled – people who worked in the emergency room. His injury was substantial. He made a very bad choice about how he would manage his pain.

Dr. Steinbergh continued that Dr. Leon's concept of not wanting to be known as a drug seeker was a legitimate one. Emergency room physicians deal with people who come in and request pain medication. The unfortunate part is that they do see people repeatedly, and she would imagine that that taints a doctor's view. Dr. Steinbergh stated that she thinks that doctors come across certain situations in their practices that will begin to affect them. They know about the rules for controlled substance prescribing. Dr. Steinbergh stated that she imagines that that went through Dr. Leon's mind, but she agrees with Dr. Egner that

Dr. Leon never gave himself an appropriate chance to be controlled for pain. That was extremely bad judgment and not very smart for a physician.

Dr. Steinbergh stated that, for her, this was a very strong minimal standards case. She didn't like all this prescribing and drug trafficking. She had a great deal of trouble with this. Dr. Steinbergh added that the Board had no evidence that Dr. Leon is chemically dependent, but it has every evidence that he abused the medicine. Dr. Leon has been assessed. Dr. Steinbergh commented that the fact that Dr. Leon has already been through a 28-day program is really not too impressive to her. She believes that he did that for the legal ramifications.

Dr. Steinbergh stated that she doesn't know whether permanent revocation is appropriate in this case, but she does agree that he needs to be out for a long time. There needs to be a substantial suspension. She added that she agrees with Dr. Egner about the types of stipulations that would be developed if the Board were to agree.

Dr. Egner asked for a second to her motion.

DR. STEINBERGH SECONDED THE MOTION.

Dr. Kumar stated that he had a different take on this case. He stated that he recognizes what Dr. Egner is saying, but one of the things that bothered him quite a bit is that if Dr. Leon was really impaired and really needed the pain medication, when he would take those medications, which were the duplicate prescriptions, he wouldn't use them all. He would throw some of them away. That didn't make sense to him. If it was someone who was really impaired and needed narcotics and pain medication on a constant basis, why, when he had the pills in his hand and he needed those things, would he throw them away and write a duplicate prescription the second time around to get them?

Dr. Steinbergh asked whether Dr. Kumar believes that he really threw the pills away.

Dr. Kumar stated that Dr. Leon said that himself.

Dr. Steinbergh acknowledged that, but asked whether Dr. Kumar really believed him.

Dr. Egner stated that he may have, but she doesn't think that he's impaired by the pain medication or the drugs.

Dr. Kumar stated that if he's not impaired in that way, then this is an issue of minimal standards. He really did not take care of how he was prescribing the medications. A one-year suspension is too little for this. Dr. Kumar stated that he doesn't think that Dr. Leon cared how he was prescribing, and he's not sure it wasn't essentially for his own use. Dr. Kumar added that there is no question that Dr. Leon needs to be evaluated by pain management people, but he would speak against a one-year suspension.

DR. EGNER STATED THAT SHE WOULD AGREE TO A TWO-YEAR SUSPENSION AND ASKED TO AMEND HER MOTION ACCORDINGLY. DR. STEINBERGH, AS SECOND, AGREED.

Dr. Egner stated that she's not minimalizing what Dr. Leon did. He did some terrible things. But she believes that Dr. Leon's judgment was impaired because of the inadequate treatment of his chronic benign pain. The Board has not had this discussion in terms of disciplinary actions, but it has spent the last five years discussing chronic benign pain and pain management, and the difficulties for both the physicians and the patients in regard to this subject. Dr. Egner stated that she agrees with Dr. Steinbergh completely that, especially when you are an ER physician, and you are faced on a fairly regular basis with drug seekers wanting pain medicine in your ER, and you know the attitude that they are met with by that ER staff and by many people you are surrounded by day in and day out. She thinks that Dr. Leon saw himself in an awkward position. Did he make the wrong choices? Of course he did. Should he pay a price for that and be punished for it? Absolutely he should. Dr. Leon does have a significant price to pay, even with the amended Order. Dr. Egner stated that she believes that her proposal shows an openness on the Board's part to recognize this disease process.

Dr. Buchan stated that his take was harsh in this case. Dr. Buchan stated that he felt like this was reckless behavior, reckless prescribing, just horrific. He added that it was conduct that constitutes a felony in this state. Dr. Buchan stated that 99 times out of 100, felony issues mean license revocation. Dr. Buchan added, however, that, on the strength of his colleagues' review of this case, he would be persuaded to go with a longer suspension with terms, but it was not what he came here thinking. Dr. Buchan stated that this kind of reckless behavior is worrisome to him.

Mr. Browning concurred with Dr. Buchan. He added that, if the Board goes in this direction, it's taking a big leap of faith.

Dr. Steinbergh agreed with Dr. Buchan and Mr. Browning that it is a big leap of faith. She added that in no way does she think that Dr. Leon was justified in his thought process, she doesn't believe he was. The only reason she said that she could imagine his thought process as an ER doctor who sees a lot of drug seeking behavior. She stated that she's been on this Board for 11 years and during the process she had a significant injury. She was suffering as Dr. Leon did. She was on crutches for a year but did her job and never missed work. But she had to make the choice that she could not use controlled substances. She made that decision because of her experiences with the Medical Board. She went through every step she could possibly take to exhaust evaluation, exhaust treatment, therapy, and ultimately surgery. The bottom line was that, because of her experience with the Medical Board, she knew that it was unacceptable for her to use controlled substances and expect to practice, which Dr. Leon did. That bothers her. Dr. Steinbergh continued that, on the issue of chronic benign pain, there is no question that he would be in pain. So when she says that she has some degree of understanding, she says that in faith. She doesn't think that any Board member may believe the whole record all the time, and she leans toward being somewhat lenient, although she does believe that there was absolutely reckless prescribing. She can't get that out of her mind. He prescribed this way in order to get some pills to control his own pain. That kind of decision making as a

physician is so inappropriate.

Dr. Kumar stated that many times Dr. Leon prescribed medicines, not just to get some back. He prescribed to Patient 3 after she simply asked for the drug. He didn't perform any examination or anything.

Dr. Steinbergh acknowledged that he had no physician/patient relationship whatsoever with any of these people.

Dr. Kumar stated that those prescriptions were not written for him to get some back for personal use. They were totally written without regard for any prescribing guidelines. Dr. Kumar stated that he has a significant problem because of that. He added that he's sure that Dr. Leon had some discomfort and needed some help.

Dr. Egner stated that that's what she is saying is his impairment. As Dr. Leon was impaired by his own pain, getting drugs as he should not have done, it impaired his judgment in treating others' pain. It was the same sort of thought process. They have back pain and need pain medicine; he had leg pain, he needed pain medicine. Dr. Egner stated that she thinks Dr. Leon's prescribing to those patients, although very wrong, was actually rather consistent with his impaired judgment in treating pain, whether it be his or that of one of these people in that circle. She noted that he didn't prescribe to 50 different people. He prescribed to a small circle of people within that framework. That's how she comes to that conclusion.

Dr. Kumar stated that the Board only knows of five people.

Dr. Bhati asked to focus the issue. The Board knows that he should not have prescribed as he prescribed. Minimal standards of care is an established fact; he hopes that there's no question in anyone's mind about it. The question comes as to whether or not Dr. Leon had problems with the drugs. That is another issue that is being questioned. Normally in a situation like this, the Board would treat this as a permanent loss of his license. He is lucky that even the thought of a two-year suspension is being considered for this physician.

Dr. Robbins agreed that Dr. Leon is lucky that a two-year suspension is being considered. He stated that he came here, wrestling with this case, leaning toward revocation. He added that he's still wrestling, and he finds that if he's wrestling, he'll lean toward a lenient sentence. He doesn't like the death penalty when he's wrestling. Dr. Robbins spoke in favor of Dr. Egner's amendment.

Dr. Steinbergh suggested tabling this matter to draw up an amended order consistent with Dr. Egner's motion. She stated that another thing she would like to address in the motion is that when the Board evaluates the practice plan, the Board would restrict his prescribing practices.

Dr. Egner stated that she doesn't like restricting physicians' prescribing practices for two reasons: First, that's the purpose of requiring the maintenance of a log. Secondly, she's going to assume that he will continue as an ER physician, and the Board would be saying that it doesn't want him to practice adequately

by restricting the prescribing habits. The Board either trusts that, after all the stipulations put into place, Dr. Leon is going to be able to prescribe. Dr. Egner stated that she's not speaking just of Dr. Leon. She doesn't like restricting physicians' prescribing habits under any circumstances, because if you're prescribing appropriately, whether it be scheduled drugs, antibiotics, you're prescribing appropriately. The Board would never say that it's appropriate to never use scheduled drugs in the practice of medicine.

Dr. Steinbergh stated that the practice plan would include a supervising physician and chart review.

Dr. Egner agreed.

DR. KUMAR MOVED TO TABLE THIS MATTER FOR DEVELOPMENT OF AN ALTERNATIVE ORDER. DR. EGNER SECONDED THE MOTION. A vote was taken:

Vote:	Dr. Egner	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

The motion carried.

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Ms. Sloan left the meeting at this time. Dr. Davidson assumed the Chair.

DR. BUCHAN MOVED TO REMOVE THE MATTER OF ALBERTO LEON, M.D., FROM THE TABLE. DR. ROBBINS SECONDED THE MOTION. All members voted aye. The motion carried.

DR. EGNER MOVED TO AMEND THE PROPOSED ORDER IN THE MATTER OF ALBERTO LEON, M.D., BY SUBSTITUTING THE FOLLOWING:

It is hereby ORDERED that:

- A. **SUSPENSION OF CERTIFICATE:** The certificate of Alberto Leon, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than two years.

B. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Leon's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration:** Dr. Leon shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
2. **Controlled Substances Prescribing Course:** At the time he submits his application for reinstatement or restoration, Dr. Leon 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 period(s) in which they are completed.
3. **Medical Records Course:** At the time he submits his application for reinstatement or restoration, Dr. Leon 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 period(s) in which they are completed.
4. **Chronic Benign Pain Assessment:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Leon shall submit to the Board for its prior approval the name and curriculum vitae of a physician of Dr. Leon's choice who specializes in pain management.

Upon approval by the Board, Dr. Leon shall obtain from the approved physician an assessment of Dr. Leon's current status. Prior to the initial assessment, Dr. Leon shall furnish the approved physician copies of the Board's Order, including the Summary of the Evidence, Findings of Fact, and Conclusions, and any other documentation from the hearing record which the Board may deem appropriate or helpful to that approved physician.

Upon completion of the initial assessment, Dr. Leon shall cause a written report to be submitted to the Board from the approved physician. The written report shall include:

- a. A detailed report of the evaluation of Dr. Leon's current status and

condition;

- b. A detailed plan of recommended treatment, if any, based upon the approved physician's informed assessment of Dr. Leon's current needs;
- c. A statement regarding any recommended limitations upon his practice, and
- d. Any reports upon which the treatment recommendation is based, including reports of physical examination and psychological or other testing.

Should the Board approved physician recommend treatment, and upon approval by the Board, Dr. Leon shall undergo and continue treatment weekly or as otherwise directed by the Board. Dr. Leon shall comply with his treatment plan, including taking medications as prescribed for his condition.

Dr. Leon shall continue in treatment until such time as the Board determines that no further treatment is necessary. To make this determination, the Board shall require reports from the approved physician. The reports shall contain information describing Dr. Leon's current treatment plan and any changes that have been made to the treatment plan since the prior report; Dr. Leon's compliance with the treatment plan; Dr. Leon's status; Dr. Leon's progress in treatment; and results of any laboratory or other studies that have been conducted since the prior report. Dr. Leon 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. Leon's quarterly declaration.

In addition, Dr. Leon shall ensure that his approved physician immediately notifies the Board of Dr. Leon's failure to comply with his treatment plan and/or any determination that Dr. Leon is unable to practice due to his condition.

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

5. **Additional Evidence of Fitness To Resume Practice:** In the event that Dr. Leon has not been engaged in the active practice of medicine and surgery for a period

in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to require additional evidence of his fitness to resume practice.

- C. **PROBATION:** Upon reinstatement or restoration, Dr. Leon'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. Leon 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. Leon 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 Dr. Leon's certificate is restored or reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
 3. **Personal Appearances:** Dr. Leon shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Leon's certificate is restored or reinstated, 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. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Leon 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.
 5. **Terms, Conditions, and Limitations Continued from Suspension Period:** Dr. Leon shall continue to be subject to the terms, conditions, and limitations specified in Paragraph B.4. of this Order.
 6. **Practice Plan:** Within thirty days of the date of Dr. Leon's reinstatement or restoration, or as otherwise determined by the Board, Dr. Leon shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. Leon's activities will be directly supervised

and overseen by a monitoring physician approved by the Board. Dr. Leon shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. Leon submits his practice plan, he shall also 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 or Supervising Member will give preference to a physician who practices in the same locale as Dr. Leon and who is engaged in the same or similar practice specialty.

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

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Leon must immediately so notify the Board in writing. In addition, Dr. Leon 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. Leon 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.

7. **Controlled Substances Log**: Dr. Leon shall keep a log of all controlled substances he prescribes, orders, administers, or personally furnishes. Such log shall be submitted in a format approved by the Board thirty days prior to Dr. Leon's personal appearance before the Board or its designated representative, or as otherwise directed by the Board. Further, Dr. Leon shall make his patient records with regard to such controlled substances available for review by an agent of the Board upon request.

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

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

DR. ROBBINS SECONDED THE MOTION. A vote was taken:

Vote:	Dr. Egner	- aye
	Dr. Bhati	- nay
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Davidson	- aye

The motion carried.

DR. EGNER MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF ALBERTO LEON, M.D. DR. ROBBINS SECONDED THE MOTION.

Mr. Browning asked whether other Board members feel that Dr. Leon should take an ethics course.

Dr. Egner commented that this wasn't mentioned earlier. She added that the prescribing course does deal with the ethical issues of prescribing.

A vote was taken on Dr. Egner's motion to approve and confirm the amended Order:

Vote:	Dr. Egner	- aye
	Dr. Bhati	- nay
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Davidson	- aye

The motion carried.



State Medical Board of Ohio

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

NOTICE OF IMMEDIATE SUSPENSION AND OPPORTUNITY FOR HEARING

April 14, 2004

Alberto Leon, M.D.
446 Kinsey Road
Xenia, Ohio 45385

Dear Doctor Leon:

In accordance with Sections 2929.42 and/or 3719.12, Ohio Revised Code, the Office of the Prosecuting Attorney of Butler County, Ohio, reported that on or about February 18, 2004, in the Court of Common Pleas, Butler County, Ohio, you entered pleas of guilty to four felony counts of Deception to Obtain a Dangerous Drug, in violation of Section 2925.22(A), Ohio Revised Code.

Therefore, pursuant to Section 3719.121(C), Ohio Revised Code, you are hereby notified that your license to practice medicine and surgery in the State of Ohio is immediately suspended. Continued practice after this suspension shall be considered practicing medicine without a certificate in violation of Section 4731.41, Ohio Revised Code.

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

- (1) On or about February 18, 2004, in the Court of Common Pleas, Butler County, Ohio, you entered pleas of guilty to four felony counts of Deception to Obtain a Dangerous Drug, in violation of Section 2925.22(A), Ohio Revised Code. Thereafter, on or about February 25, 2004, in response to your previously submitted motion seeking intervention in lieu of conviction for these charges, the court filed an "Entry Finding Eligibility for Intervention in Lieu of Conviction and Ordering Period of Rehabilitation" that granted your request for intervention in lieu of conviction, stayed further criminal proceedings, and ordered you to complete an indefinite period of rehabilitation of at least one year.

Your plea of guilty and/or the judicial finding of eligibility for intervention in lieu of conviction as alleged in paragraph (1) above, individually and/or collectively, constitute "[a] plea of guilty

Mailed 4-15-04

Suspension
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to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony,” as that clause is used in Section 4731.22(B)(9), Ohio Revised Code.

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

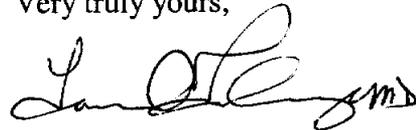
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at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

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

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

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/blt

Enclosures

CERTIFIED MAIL # 7000 0600 0024 5140 1231
RETURN RECEIPT REQUESTED

Suspension
Alberto A. Leon, M.D.
Page 3

cc: Eric Plinke, Esq.
Porter, Wright, Morris & Arthur
41 South High Street
Columbus, Ohio 43215

CERTIFIED MAIL # 7000 0600 0024 5140 1248
RETURN RECEIPT REQUESTED



State Medical Board of Ohio

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

July 9, 2003

Alberto Leon, M.D.
446 Kinsey Road
Xenia, Ohio 45385

Dear Doctor Leon:

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:

- (1) You repeatedly prescribed controlled substances to the person referred to as Patient 1 for the purpose of identification on the attached patient key. (Individuals referred to as Patients 1-5 for the purpose of identification are reflected on the attached confidential patient key that is to be withheld from public disclosure.) Your prescribing to Patient 1, as listed below, included writing two separate prescriptions for the same controlled substance [Vicodin] on the same issuance date, both in the name of Patient 1. You issued such prescriptions without personally conducting a physical examination of Patient 1 and without completing and maintaining accurate medical records reflecting your examination, evaluation, and treatment of Patient 1, including the diagnosis and purpose for which the controlled substance was utilized. Further, you stated that you had Patient 1 return a portion of the controlled substance to you.

<u>Date prescribed</u>	<u>Drug prescribed / amount</u>
03-31-2002	Percocet #20
07-18-2002	Vicodin ES #90
07-19-2002	Vicodin ES #30
07-19-2002	Vicodin ES #30
08-15-2002	Vicodin ES #40
08-15-2002	Vicodin ES #40
08-21-2002	Percocet #20
09-09-2002	Percocet #20
09-09-2002	Vicodin ES #45

*Mailed 7/10/03
7/11/03*

09-09-2002	Vicodin ES	#45
10-03-2002	Percocet	#20
10-03-2002	Vicodin ES	#45
10-03-2002	Vicodin ES	#45
10-14-2002	Vicodin ES	#45
10-23-2002	Vicodin ES	#45
11-04-2002	Vicodin ES	#50
11-06-2002	Percocet	#20
11-06-2002	Vicodin ES	#30
11-16-2002	Vicodin ES	#40
11-16-2002	Percocet	#20
12-04-2002	Vicodin ES	#90
12-04-2002	Vicodin ES	#45
12-04-2002	Percocet	#20
12-17-2002	Percocet	#20
12-17-2002	Vicodin ES	#90
12-26-2002	Percocet	#20
12-31-2002	Percocet	#20
12-31-2002	Vicodin ES	#90
12-31-2002	Vicodin ES	#40
01-07-2003	Percocet	#20
01-28-2003	Vicodin ES	#90
01-28-2003	Vicodin ES	#40
02-03-2003	Vicodin ES	#40
02-06-2003	Percocet	#20

- (2) You prescribed Vicodin, as shown below, to the person identified as Patient 2, a family member. You issued such prescriptions in non-emergency situations, without medical justification, without personally conducting a physical examination of Patient 2, and without completing and maintaining accurate medical records reflecting your examination, evaluation, and treatment of Patient 2, including the diagnosis and purpose for which the controlled substance was utilized. Further, you stated that you diverted for self-use all of the medication you prescribed to Patient 2.

<u>Date prescribed</u>	<u>Date Filled</u>	<u>Drug prescribed / amount</u>
Undated	08-25-1998	Vicodin ES #60
09-22-1998	09-23-1998	Vicodin ES #60
Undated	10-04-1998	Vicodin ES #60
10-14-1998	10-17-1998	Vicodin ES #60
11-11-1998	11-12-1998	Vicodin ES #60
12-09-1998	12-10-1998	Vicodin ES #60
12-23-1998	12-24-1998	Vicodin ES #60

01-01-1999	01-03-1999	Vicodin ES	#60
Undated	01-13-1999	Vicodin ES	#60
01-26-1999	01-26-1999	Vicodin ES	#60
02-06-1999	02-08-1999	Vicodin ES	#60
02-16-1999	02-18-1999	Vicodin ES	#60
Undated	02-25-1999	Vicodin ES	#60
Undated	03-10-1999	Vicodin ES	#60
03-22-1999	03-24-1999	Vicodin ES	#60
04-04-1999	04-05-1999	Vicodin ES	#60
Undated	06-12-1999	Vicodin ES	#60
Undated	07-19-1999	Vicodin ES	#60
Undated	08-15-1999	Vicodin ES	#60
Undated	08-27-1999	Vicodin ES	#60
Undated	11-30-1999	Vicodin ES	#60
Undated	01-02-2000	Vicodin ES	#60
01-19-2000	01-19-2000	Vicodin ES	#60
Undated	02-19-2000	Vicodin ES	#60
Undated	05-21-2000	Vicodin ES	#60
09-02-2000	09-06-2000	Vicodin ES	#60
09-27-2000	09-29-2000	Vicodin ES	#60
Undated	10-27-2000	Vicodin ES	#60
11-12-2000	11-15-2000	Vicodin ES	#60

- (3) You prescribed controlled substances, as shown below, to the person identified as Patient 3. You issued such prescriptions without personally conducting a physical examination of her; without completing and maintaining accurate medical records reflecting your examination, evaluation, and treatment of Patient 3, including the diagnosis and purpose for which the controlled substance was utilized; and despite your knowledge that she was also receiving the same medication from another physician. You stated that you diverted for self-use some of the medication that you prescribed to Patient 3.

<u>Date prescribed</u>	<u>Drug prescribed / amount</u>
02-25-2002	Vicodin HP #60
03-04-2002	Percocet #60
04-13-2002	Vicodin ES #90
04-13-2002	Percocet #90
04-30-2002	Percocet #90
05-14-2002	Percocet #90
05-14-2002	Vicodin ES #90
05-30-2002	Percocet #90
06-30-2002	Percocet #20

- (4) You prescribed controlled substances, as shown below, to the person identified as Patient 4. You issued such prescriptions based upon his verbal representation that he was suffering from back pain, without personally conducting a physical examination of him, and without completing and maintaining accurate medical records reflecting your examination, evaluation, and treatment of Patient 4, including the diagnosis and purpose for which the controlled substance was utilized.

<u>Date prescribed</u>	<u>Drug prescribed / amount</u>
01-04-2000	Vicodin ES #60
03-15-2002	Vicodin ES #90
04-15-2002	Vicodin ES #90
06-10-2002	Vicodin ES #90
07-02-2002	Vicodin ES #90
08-20-2002	Vicodin ES #90

- (5) You prescribed controlled substances, as shown below, to Patient 5. You issued such prescriptions without personally conducting a physical examination of her, and without completing and maintaining accurate medical records reflecting your examination, evaluation, and treatment of Patient 5, including the diagnosis and purpose for which the controlled substance was utilized.

<u>Date prescribed</u>	<u>Drug prescribed / amount</u>
06-21-2001	Vicodin ES #60
08-30-2001	Vicodin ES #60
01-26-2002	Xanax #60

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (3) above, individually and/or collectively, constitute “[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,” as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Trafficking in Drugs, Section 2925.03, Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1), (2), and (3), above, individually and/or collectively, constitute “[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,” as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Deception to Obtain a Dangerous Drug, Section 2925.22, Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1), (2), (3), (4), and (5) above, individually and/or collectively, constitute “[c]ommission of an act that

constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,” as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Illegal Processing of Drug Documents, Section 2925.23, Ohio Revised Code, as current and prior versions of that statute have been in effect.

Further, your acts, conduct, and/or omissions as alleged in paragraph (1), (2), (3), (4), and (5) above, individually and/or collectively, constitute “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code, General Provisions, as in effect from November 17, 1986, through August 31, 2000, and since September 1, 2000. 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.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above that occurred on or after November 11, 1998, individually and/or collectively, constitute “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-08, Ohio Administrative Code, Utilizing Controlled Substances for Self and Family Members, as in effect from November 11, 1998 through March 14, 2001.

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

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

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

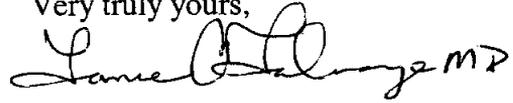
Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that

ALBERTO A. LEON, M.D.

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Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink, appearing to read "Lance A. Talmage M.D.", written in a cursive style.

Lance A. Talmage, M.D.

Secretary

LAT/blt

Enclosures

CERTIFIED MAIL # 7000 0600 0024 5141 7300
RETURN RECEIPT REQUESTED

cc: Eric Plinke, Esq.
Porter, Wright, Morris & Arthur
41 South High Street
Columbus, Ohio 43215

CERTIFIED MAIL # 7000 0600 0024 5141 7317
RETURN RECEIPT REQUESTED