State Medical Board of Ohio

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January 14, 2004

Richard W. Liss, M.D.
5489 Tinsbury Court
Columbus, OH 43235

Dear Doctor Liss:

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 January 14, 2004, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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

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

THE STATE MEDICAL BOARD OF OHIO

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 7000 0600 0024 5150 1023
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.
CERTIFIED MAIL NO. 7000 0600 0024 5150 1047
RETURN RECEIPT REQUESTED

Mailed 1-16-04

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 January 14, 2004, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Richard W. Liss, 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)

January 14, 2004
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*
	*
RICHARD W. LISS, M.D.	*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on January 14, 2004.

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

It is hereby ORDERED that:

> The certificate of Richard W. Liss, 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.

Lance A. Talmage MD

Lance A. Talmage, M.D.
Secretary

(SEAL)

January 14, 2004
Date

STATE MEDICAL BOARD
OF OHIO
2003 DEC 15 A 10: 11

REPORT AND RECOMMENDATION
IN THE MATTER OF RICHARD W. LISS, M.D.

The Matter of Richard W. Liss, M.D., was heard by R. Gregory Porter, Hearing Examiner for the State Medical Board of Ohio, on September 22 through 24 and 26, 2003

INTRODUCTION

I. Basis for Hearing

A. By letter dated January 8, 2003, the State Medical Board of Ohio [Board] notified Richard W. Liss, 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 upon allegations that Dr. Liss had engaged in sexual conduct with a patient, that he had given to that patient her patient record without maintaining a copy of that record, that he had continued to prescribe Valium to that patient despite his awareness of that patient's prior abuse of and detoxification from Valium, and that he had prescribed controlled substances on several occasions to that patient without recording such prescriptions in the patient record.

The Board further alleged that Dr. Liss' conduct constitutes:

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

- "'[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations as are determined, by rule, by the state medical board,' as that clause is used in Section 4731.22(B)(18), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Principles I, II, and IV of the American Medical Association's Principles of Medical Ethics";

- "'[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule,' as that clause is used in Section 4731.22(B)(18), Ohio

Revised Code, to wit: Principles I, II, and IV of the American Medical Association's Principles of Medical Ethics"; and

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

(State's Exhibit 1A)

B. By document received by the Board on February 5, 2003, Douglas C. Boatright and Patrick M. Pickett, Esqs., requested a hearing on behalf of Dr. Liss. (State's Exhibit 1B)

II. Appearances

A. On behalf of the State of Ohio: Jim Petro, Attorney General, by Mark A. Michael, Assistant Attorney General.

B. On behalf of the Respondent: Eric J. Plinke, Esq.

EVIDENCE EXAMINED

I. Testimony Heard

A. Presented by the State

1. Richard W. Liss, M.D., as upon cross-examination
2. Vincas Krompolcas
3. Daughter of Patient 1
4. Patient 1
5. Joseph Segal, M.D.

B. Presented by the Respondent

1. Richard W. Liss, M.D.
2. Richard Clary, M.D.
3. Jessica Liss

II. Exhibits Examined

A. Presented by the State

1. State's Exhibits 1A through 1AA: Procedural exhibits. (Note that State's Exhibit 1W has been sealed to protect patient confidentiality.)

* 2. State's Exhibit 1BB: Patient Key.

* 3. State's Exhibit 2: Copy of a December 16, 2002, expert report from Joseph J. Segal, M.D.

4. State's Exhibit 3: Copy of Dr. Segal's curriculum vitae.

5. State's Exhibits 4, 5, and 6: Copies of the American Medical Association Principals of Medical Ethics for 1998-1999, 2000-2001, and 1996-1997, respectively. (Note: Portions of State's Exhibits 5 and 6 were redacted by the Hearing Examiner post hearing by the agreement of the parties. See Hearing Transcript at page 407)

* 6. State's Exhibits 7 through 9: Copies of medical records for Patient 1.

* 7. State's Exhibit 10: Copies of prescriptions written for Patient 1 by Dr. Liss.

* 8. State's Exhibit 11: Copies of correspondence between Dr. Liss and Patient 1.

* 9. State's Exhibit 12: Copies of credit card transaction records for Dr. Liss.

* 10. State's Exhibit 13: Copy of a utilities transfer record.

11. State's Exhibit 17: Copy of a transcript of an April 24, 2002, deposition of Dr. Liss.

* 12. State's Exhibit 18: Certified copy of an April 4, 2002, Affidavit of Patient 1.

B. Presented by the Respondent

1. Respondent's Exhibit A: Copy of the curriculum vitae of Richard H. Clary, M.D.

* 2. Respondent's Exhibit B: Copy of Dr. Clary's June 10, 2003, expert report.

* 3. Respondent's Exhibit C: Copy Dr. Liss' expert report.

C. Presented by the Hearing Examiner Post Hearing

* Board Exhibit A: Page 24 of the Hearing Transcript. See Procedural Matters 1, below.

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

PROFFERED MATERIALS

The following document was neither admitted to the hearing record nor considered by the Hearing Examiner, but is being sealed and held as proffered material:

Board Exhibit B: Unredacted pages 198 through 213, and 215, of the Hearing Transcript and condensed transcript. See Procedural Matters 2, below.

PROCEDURAL MATTERS

1. Page 24 of the Hearing Transcript contains patient names. The Hearing Examiner separated this page from the Hearing Transcript post hearing, marked it as Board Exhibit A, and sealed the exhibit to protect patient confidentiality. A redacted version of page 24 was substituted and included in the Hearing Transcript.

2. The following pages of the Hearing Transcript and condensed transcript contain material that is irrelevant to this hearing, and were redacted by the Hearing Examiner post hearing by agreement of the parties: Pages 198 through 209, 210 (except for lines 10 through 15), 211, 212, 213 (through line 21) and 215 (lines 15 and 16). The original pages were marked as Board Exhibit B, sealed, and held as proffered material. (See Hearing Transcript at page 411)

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. Richard W. Liss, M.D., testified that he had obtained his medical degree in 1978 from Case Western Reserve University in Cleveland, Ohio. Dr. Liss further testified that he subsequently completed a residency in internal medicine at Mount Carmel Medical Center in Columbus, Ohio. Moreover, Dr. Liss testified that he practices internal medicine in

Columbus. Finally, Dr. Liss testified that he holds an active license to practice medicine in Ohio, and holds an inactive license in New York. (Hearing Transcript [Tr.] at 16-17)

2. Dr. Liss testified that he has been engaged in the private practice of internal medicine at a number of office locations in the central Ohio area. Dr. Liss further testified that he no longer has an office-based practice, and works exclusively in nursing homes and hospitals. Dr. Liss testified that he currently employs one person, his wife, as an office manager who handles paperwork and billing. Dr. Liss testified that he has an answering service if patients need to contact him, although nursing home staff usually do that for them. Dr. Liss further testified that hospital patients generally have their own primary care physicians. (Tr. at 17-20)

3. Dr. Liss testified that most of his patients are covered by Medicare or Medicaid. (Tr. at 20)

4. Dr. Liss testified that he has never had any training in psychiatry, aside from his internal medicine residency. Dr. Liss further testified that he has had no specific training in substance abuse treatment, other than "some courses [he] took[.]" (Tr. at 45)

General Information Concerning Dr. Liss' Treatment of Patient 1

5. Dr. Liss' medical records indicate that Patient 1's first visit to his office had been July 8, 1994. (St. Ex. 7 at 4, 17a; Tr. at 131) Dr. Liss' medical records also indicate that, prior to that visit, a letter dated January 7, 1994, had been sent to him by MedPlan that stated, in part, "It is MedPlan's policy to notify the member's PCP of an admission to the hospital. Please note that [Patient 1] * * * was admitted to Riverside Methodist Hospital for cocaine, alcohol dependence on January 3, 1994." (State's Exhibit [St. Ex.] 7 at 70)

   Dr. Liss's medical records indicate that Patient 1's final visit to his office had been December 4, 2000, although they also reflect prescriptions issued to her as late as March 28, 2001. (St. Ex. 8 at 6a, 23a)

   Dr. Liss testified that Patient 1 first became a patient of his in 1994, and ceased being his patient in July or August 2001, when she moved away from the area. Dr. Liss further testified that Patient 1 had been on Medicaid at that time, and that he had been assigned to be her physician. Dr. Liss testified that, in 1994, when Patient 1 first became his patient, he had had two offices: one on West Broad Street in Columbus, and another in Westerville. (Tr. at 28, 36, 53-55)

Dr. Liss' Sexual Relationship with Patient 1

General Information

6. Dr. Liss testified that, sometime around late 1995 and mid 1996, Dr. Liss and his wife had been "having problems." Dr. Liss further testified that, at the same time, he and Patient 1 had been "interested in doing something more about our mutual feelings for each other * * * [and Patient 1 had] indicated a willingness to pursue more of a relationship[.]" (Tr. at 39-40)

   Dr. Liss testified that he had informed Patient 1 of his marital difficulties during telephone conversations with her. When asked how such a topic had come up, Dr. Liss testified that Patient 1 had contacted him through his answering service "a couple of times with some questions and we just had some conversations on the phone." Dr. Liss further testified that such conversations sometimes lasted "a half hour or so[,]" concerned her medications "and so on, but then [they] would kind of wander off in other directions." (Tr. at 40-42)

7. Dr. Liss acknowledged that he had had a personal relationship, which included sexual intercourse, with Patient 1, but that "at the time that we did have the relationship, the doctor/patient relationship had been mutually terminated." Moreover, Dr. Liss testified that he had had sexual intercourse with Patient 1 on a number of occasions during these periods. Finally, Dr. Liss testified that the last time that he and Patient 1 had had sexual intercourse had been in either 2000 or 2001. (Tr. at 29-38, 49-50)

8. Dr. Liss testified that the period of time during which they were sexually intimate "did not last very long," although they remained close friends. Dr. Liss further testified that the "vast majority" of the time there had been no sexual or romantic relationship. Moreover, Dr. Liss testified that the close friendship that he had had with Patient 1 had not compromised his objectivity as her physician. Furthermore, Dr. Liss testified that, if there had been any influence, "it would have been in the sense that I even had a deeper understanding of exactly what it was to which she was referring when she had particular complaints." Finally, Dr. Liss testified that his medical records attest to the fact that he had documented her past history, and had an objective, analytical approach to her care. (Tr. at 444-446)

9. Dr. Liss testified that some of his medical records for Patient 1 are missing, and are not included among the hearing exhibits. Dr. Liss stated that the missing records included a statement written on a plain piece of paper to the effect that Dr. Liss and Patient 1 had terminated their physician/patient relationship because they were entering into a personal relationship. Dr. Liss further testified that the paper was "signed and dated," and was kept in the back of Patient 1's chart. Dr. Liss testified that he believes that the document was created in April or May 1996. Moreover, Dr. Liss testified that, when Patient 1 "wished to recontinue a physician/patient relationship," the same piece of paper was used to document that Dr. Liss and Patient 1 were ending their personal relationship and reentering a

physician/patient relationship. Finally, Dr. Liss testified that that portion of the document was also "signed and dated." (Tr. at 430-433)

Dr. Liss testified that he believes that Patient 1 had signed the document to reenter the physician/patient relationship sometime in 1998. (Tr. at 536-537) Dr. Liss further testified that they had subsequently reentered into a brief personal relationship, so there would have been a third signature on that document memorializing that. Moreover, Dr. Liss testified that, every time he and Patient 1 switched roles between the physician/patient relationship and a personal relationship, it had been documented by a signed sheet in the medical record. (Tr. at 537-542) Furthermore, Dr. Liss testified:

> I understood that I was pushing the edge of the envelope. I'm not saying that this would be a common way to conduct things. I mean, I'm certainly not trying to portray it as such.
>
> But within the context of what was going on, like I said, even though I knew it was pushing the envelope, it was still within—my opinion was it was still within the boundaries of how the envelope should be handled. Because of what we were trying to do was be able to carry on something where her medical condition could be addressed and I could still be her friend, versus, well, if we're going to take it any further than that, it's not just drives, spending time together, phone calls, which to my knowledge is perfectly acceptable, as far as you can have a friend of yours as a patient, is my understanding. If it's going to be in some other direction, we have to be able to document the fact that we are not going to be going as doctor and patient.

(Tr. at 538-539)

10. Dr. Liss testified that he is not aware who had handled Patient 1's prescribing during periods when he had not acted as Patient 1's physician. Dr. Liss further testified that he had not asked for those medical records when he resumed her care. Moreover, Dr. Liss testified, "I do recall that she told me who she had been seeing. But, again, these were not extremely long periods, so I didn't specifically ask for those records." Finally, Dr. Liss testified that he had not believed that there would have been anything "extra in terms of information from those records." (Tr. at 51-52)

11. Patient 1 testified that she and Dr. Liss had begun a personal relationship in early 1996, around the time that Dr. Liss ran a pregnancy test and Patient 1 discovered that she was pregnant with her son. (Tr. at 275-276)

    When asked to describe how the personal relationship between Dr. Liss and Patient 1 had developed, Patient 1 testified that Dr. Liss "was just being kind." Patient 1 further testified that she had just learned that she was pregnant, "was working at a not so great place," and "was kind of out there on [her] own." Patient 1 testified that Dr. Liss had offered to give

her a ride home from her appointments, although she never accepted those offers. Patient 1 further testified that Dr. Liss gave her his pager number. Moreover, Patient 1 testified, "[O]ne time I paged him because I was out in the cold on the streets, and he picked me up and took me somewhere." Furthermore, Patient 1 testified that her appointments with Dr. Liss were always the last appointment of the day. Patient 1 testified that she had not asked for those times, and that Dr. Liss' office did the scheduling. Finally, Patient 1 testified that the personal relationship had begun because "I'd like to think he was attracted to me." (Tr. at 278-279)

12. Patient 1 testified that the sexual component of her relationship with Dr. Liss had begun one or two months before they took a trip to Disney World, which she testified had taken place in May 1996. Patient 1 further testified that it had continued through 2000. Patient 1 further testified that, during that time, she had had sexual relations with Dr. Liss "[q]uite frequently." Moreover, Patient 1 denied that her personal relationship with Dr. Liss had been intermittent; rather, they were together throughout that period. (Tr. at 279-280, 320-321)

    Patient 1 testified, "After he and I went to Florida together, I never went back to his office as a patient[.]" Nevertheless, Patient 1 testified that Dr. Liss continued to treat her medically. Finally, Patient 1 testified that she continued to ask Dr. Liss to give her prescriptions; Dr. Liss would "[n]ot always" give them to her, but sometimes did. (Tr. at 275-276)

    Patient 1 further testified that, during the period of her sexual relationship with Dr. Liss, she had considered him to be her doctor. Patient 1 testified that she no longer went to Dr. Liss' office, however, she did not go to any other doctor's office, either. Patient 1 further testified that she had received treatment from no other physicians during that period. Finally, Patient 1 testified that she no longer required medical insurance after the birth of her son: "I didn't need to go see a doctor. I was—I had my own personal doctor." (Tr. at 281)

    Shortly thereafter, the following exchange occurred concerning the issue of Patient 1's status as Dr. Liss' patient:

    Q. (by Mr. Michael): I just want to be clear. During the time from when your personal relationship started to when it ended with Dr. Liss, were there periods of time where you were his patient and were not his patient because of the personal relationship?

    A. (by Patient 1): I never considered myself his patient once we lived together. He never—he still wrote me prescriptions, but I never went to his office for anything. I never went for exams or anything involving his office.

(Tr. at 306)

Patient 1 testified that, after 1996, Dr. Liss did not charge her for any of the prescriptions or other services that he rendered for her. (Tr. at 282)

13. Dr. Liss denied that there had been a time when he had treated Patient 1 without her coming to his office. Dr. Liss further testified that he was "very well aware of the fact that we were dealing with a patient that had a complex history and so forth." Dr. Liss testified that he is far too "maniacal" about record keeping, particularly concerning controlled substances. Dr. Liss further testified that, when Patient 1 had wanted to become his patient again, he had made it very clear to her that it had to be "done by the book." (Tr. at 452-453)

    Dr. Liss testified that his medical records for Patient 1 support his testimony that he had continued to see her in his office. (Tr. at 453-456)

    Dr. Liss testified that he had charged Patient 1 for his services. (Tr. at 475)

14. Dr. Liss' earlier medical records for Patient 1 indicate that Patient 1's last visit to his office had been February 6, 1996. They further indicate that Dr. Liss had issued prescriptions for Soma #15 on February 19, 23, and 28, 1996; and for Ativan 0.5 mg. #30 on April 15, 1996. (St. Ex. 7 at 11a, 29a, 30a, and 33) Further, Dr. Liss' later records for Patient 1 indicate visits to Dr. Liss' office in December 1998; February, August, and December 1999; and January, April, May, November, and December 2000. (St. Ex. 8 at 1a-6a) There are no medical records covering Dr. Liss' care of Patient 1 for the period from April 16, 1996, through December 1998, although there is evidence that Dr. Liss issued a prescription for Valium 5 mg #60 on March 3, 1998; and again on April 16, 1998. (St. Ex. 10)

Trips Taken by Dr. Liss with Patient 1

15. Dr. Liss testified that he could recall taking three trips with Patient 1: one to Disney World in Florida, one to Kings Island in 1998 or 1999, and one to Dallas, Texas, in 2000. (Tr. at 226-227)

    With regard to the Disney World trip, Dr. Liss acknowledged that his credit card records reflect that he had taken a trip to Disney World in December 1996. Dr. Liss further testified, however, that he has taken a number of trips to Disney World, and could not recall if that had been the trip that he had taken with Patient 1. (St. Ex. 12 at 8; Tr. at 218-221)

    Dr. Liss testified that he believes that he and Patient 1 had been in a sexual relationship during the time of the Disney World trip. (Tr. at 228)

With regard to the Kings Island trip, Dr. Liss testified that he had been acting as Patient 1's physician at that time, and had not been in a sexual relationship with her. Dr. Liss stated, "We were just friends at the time. I had tickets. I said, you know, do you want to go along and take the kids?" Whereupon the following exchange took place:

Q. (by Mr. Michael): Do you ever take patients with your kids and their kids on these kinds of trips?

A. (by Dr. Liss): I've taken friends of mine who are patients on things, yeah.

Q. Females with children—

A. No.

Q. —along with your children?

A. No.

(Tr. at 226-228)

With regard to the trip to Dallas, Dr. Liss testified that he is "almost certain" that he had not been in a personal relationship with Patient 1 during that time. Dr. Liss denied that he and Patient 1 had engaged in a sexual relationship during their trip to Dallas. Dr. Liss testified that he had asked her to accompany him because he had been separated from his wife at the time, and he had been aware that Patient 1 had been feeling depressed. However, Dr. Liss further testified that he and Patient 1 did not have separate hotel rooms. (Tr. at 228, 501-503)

16. Patient 1 testified that she had gone with Dr. Liss to Disney World in May 1996. Patient 1 further testified that that had been during their sexual relationship. (Tr. at 282)

Cohabitation of Dr. Liss and Patient 1

17. Patient 1 testified that Dr. Liss "got [her] an apartment in June [1996]" in the Tuttle Crossing area of Columbus. Patient 1 further testified that Dr. Liss did not live with her in that apartment, although "[h]e came and moved in and stayed about four days, and then went back to his wife." However, Patient 1 testified that Dr. Liss kept some of his belongings at that apartment, and had had his own room or office there. Moreover, Patient 1 testified that Dr. Liss came to the apartment frequently, and that she and Dr. Liss had sexual relations in that apartment, although Dr. Liss would not spend the entire night. Patient 1 testified that she had lived in that apartment for less than one year. (Tr. at 282-284)

Patient 1 further testified that, upon leaving that apartment, she had moved into an apartment in another apartment complex that Dr. Liss helped provide for her. Patient 1 testified that she had lived there with her three daughters and one son. Patient 1 testified that Dr. Liss did not pay all of the rent, but that he helped. Patient 1 further testified that Dr. Liss "helped with food and diapers or—he didn't let us go without anything." Patient 1 testified that, in return, she had given Dr. Liss the checks that she had received from the Social Security Administration following her husband's death. Moreover, Patient 1 testified that Dr. Liss' name was on the lease for that apartment. Furthermore, Patient 1 testified that Dr. Liss had had his own room in that apartment as well, where Dr. Liss "stored things" such as records and movies. Finally, Patient 1 testified that she had lived in the second apartment for less than one year. (Tr. at 284-286)

Moreover, Patient 1 testified that, after she left the second apartment, she had moved in with a friend, Vincas Krompolcas. Patient 1 testified that, subsequently, Dr. Liss had gotten her an apartment very close to Dr. Liss' home, less than two blocks away. Patient 1 testified that this was in 1998, which she can remember because her son had been almost two years old at that time. Patient 1 testified that Dr. Liss had kept some of his belongings in the basement of that apartment, but did not live with her there. Finally, Patient 1 testified that she had lived there for several months. (Tr. at 286-287)

Finally, Patient 1 testified that Dr. Liss had obtained an apartment for himself in 1998 or 1999, and that she "ended up moving in with him." Patient 1 testified that Dr. Liss had gotten himself that apartment because "[h]e said he was leaving his wife." Patient 1 testified that she had moved in with Dr. Liss in 1998 or 1999 after having been hospitalized for pneumonia. Patient 1 further testified that she had lived with Dr. Liss in that apartment for between four and six months. Moreover, Patient 1 testified that her oldest daughter and her son had lived with them, as well as Dr. Liss' daughter, Jessica. (Tr. at 287-288)

Patient 1 testified that she lived in that apartment with Dr. Liss until Dr. Liss moved out to return to his wife. Patient 1 testified that she has not lived with Dr. Liss since that time. (Tr. at 290-291)

18. Patient 1 testified that her sexual relationship with Dr. Liss had continued "[s]ome, but not much" after he left their apartment to return to his wife. Patient 1 testified that they had continued to see each other, and that Dr. Liss would "still come over to [Mr. Krompolcas'] and see [her]," but not as often. (Tr. at 291)

19. The Daughter of Patient 1 testified on behalf of the State. Daughter of Patient 1 testified that she is now 18 years old. (Tr. at 256-257)

    Daughter of Patient 1 testified that, in 1996 or 1997, she had been living with her father in Lancaster, Ohio. Patient 1 and Dr. Liss had been living together in an apartment in the Sawmill and Bethel Road area of Columbus. Daughter of Patient 1 further testified that she had moved in with her mother and Dr. Liss, and lived with them for between three and six

months. Thereafter, Daughter of Patient 1 moved back to her father's home. Moreover, Daughter of Patient 1 testified that this had occurred "the summer after sixth grade, so '97, '98 maybe." (Tr. at 257-259)

20. Jessica Liss testified that she is the daughter of Dr. Liss. Ms. Liss further testified that she is now 22 years old. Ms. Liss testified that Patient 1 had lived with Dr. Liss for a couple of weeks at an apartment near Interstate 270 in Columbus, and that Ms. Liss is certain that Patient 1 did not live with Dr. Liss at any other apartment. (Tr. at 610-611)

21. Dr. Liss testified that there had been occasions when Dr. Liss had separated from his wife and rented an apartment. Dr. Liss further testified that Patient 1 had stayed with him occasionally during those times. Later, when Dr. Liss returned to his wife, Patient 1 would move into the apartment and take over the lease "because she really didn't have anyplace to live[.]" Dr. Liss testified that this had occurred on two occasions at apartments that he had rented. (Tr. at 224-225)

22. Dr. Liss testified that, during those times when Patient 1 had stayed with Dr. Liss in Dr. Liss' apartment, he had been in a sexual relationship with Patient 1 and was not acting as her physician. (Tr. at 225-226)

    However, Patient 1 testified that, during the time she had lived with Dr. Liss, she had continued to use Valium prescribed to her by Dr. Liss. (Tr. at 291) Nevertheless, Dr. Liss denied that he had prescribed medication to Patient 1 during the times when they had been engaged in a sexual relationship. (Tr. at 479)

Personal Correspondence Between Dr. Liss and Patient 1

23. Dr. Liss wrote a number of letters to Patient 1 that were of a highly personal nature. (St. Ex. 11) First, by letter dated March 26, 1996, Dr. Liss informed Patient 1 that he had fallen in love with her in February 1996. (St. Ex. 11 at 55) Dr. Liss testified that that letter had not been the first time that he and Patient 1 had discussed their personal feelings for each other. (Tr. at 512-516) Second, in a letter dated March 29, 1996, Dr. Liss again informed Patient 1 that he loved her. (St. Ex. 11 at 55-62)

    Dr. Liss' medical records for Patient 1 indicate that he had prescribed Ativan 0.5 mg #30 to Patient 1 on April 15, 1996. (St. Ex. 7 at 30a, 33)

    An undated letter references Dr. Liss' request that Patient 1 let him know when it would be a good time for Dr. Liss to come and "get stuff." Dr. Liss testified that he and Patient 1 had been living together, had broken up, and that Dr. Liss had wanted to retrieve his belongings. (St. Ex. 11 at 18; Tr. at 204-207)

24. Patient 1 wrote an undated letter to Dr. Liss thanking Dr. Liss for "the beautiful necklace" that he had given to her. Patient 1 further stated, "My wish is to have at least 60 more years with the man I love—you." (St. Ex. 11 at 28)

Testimony of Vincas Krompolcas

25. Vincas Krompolcas testified on behalf of the State. Mr. Krompolcas testified that he knows Patient 1, and that Patient 1 used to be his girlfriend. Mr. Krompolcas further testified that Patient 1 had been his girlfriend starting in 1990. Mr. Krompolcas testified that she had remained his girlfriend until 2000. Moreover, Mr. Krompolcas testified that he and Patient 1 have remained friends. Finally, Mr. Krompolcas testified that Patient 1 and her children had lived with him at his residence intermittently since 1990. (Tr. at 239-240, 244, 252-254)

    Mr. Krompolcas testified concerning the meaning he attributes to the term, "girlfriend": "Just, you know, I don't want to get married or things like that. Just have, you know, what do you call—good relationship, that's all. * * * She do everything for me and I do everything for her." Mr. Krompolcas further testified that he and Patient 1 had engaged in a sexual relationship from 1990 to 2003. Moreover, Mr. Krompolcas testified that Patient 1 is still a friend, but no longer his girlfriend, because Mr. Krompolcas is "too old." Finally, Mr. Krompolcas noted that he is currently 78 years old. (Tr. at 245-248)

    Mr. Krompolcas testified that, in about 2000, he had been in the bedroom of his home on the north side of Columbus, making love to Patient 1. Mr. Krompolcas further testified that he got up from the bed and was surprised to see Dr. Liss in the room with them. Moreover, Mr. Krompolcas testified that he left the room to get something, and when he returned, he witnessed Dr. Liss and Patient 1 engaged in a sexual act. (Tr. at 240-242)

    Mr. Krompolcas testified that, although Patient 1 had been his girlfriend at the time he witnessed Dr. Liss and Patient 1 engaged in a sexual act, Mr. Krompolcas had not been upset to see Patient 1 having sex with another man. (Tr. at 246)

Testimony of Joseph J. Segal, M.D., Regarding Dr. Liss' Sexual Relationship with Patient 1

26. Joseph J. Segal, M.D., testified as an expert on behalf of the State. Dr. Segal testified that he had obtained his medical degree from Indiana University in 1976. He then completed a residency in internal medicine from 1976 through 1979 at Jewish Hospital of Cincinnati. Subsequently, from 1979 through 1981, Dr. Segal participated in an infectious diseases fellowship at Barnes Hospital, Washington University of St. Louis, School of Medicine. Dr. Segal was certified by the American Board of Internal Medicine [ABIM] in 1979 and, in 1982, obtained subspecialty certification in infectious diseases from the ABIM. (St. Ex. 3; Tr. at 341-344)

Dr. Segal testified that he currently is employed by the Drake Center in Cincinnati, and has been so employed since November 2000. Dr. Segal testified that the Drake Center is a long-term acute care rehabilitation hospital. Dr. Segal further testified that, prior to his employment at the Drake Center, he had practiced medicine for 14 years in a group practice called Medical Associates of Cincinnati. Finally, Dr. Segal testified that his former practice had consisted of 75 percent internal medicine, and 25 percent infectious disease medicine. (Tr. at 342, 376-378)

27. Dr. Segal testified that he is familiar with the Principals of Medical Ethics of the American Medical Association. (Tr. at 345-346)

- Principal I of the American Medical Association [AMA] Principals of Medical Ethics states as follows: "A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity." (St. Ex. 4, 5, and 6)

- Principal II states: "A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception." (St. Ex. 4, 5, and 6)

- Principal IV states: "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law." (St. Ex. 4, 5, and 6)

Dr. Segal further testified that the AMA reviewed the ethical implications of physician/patient sexual contact in AMA Opinion 8.14. AMA Opinion 8.14 states:

> Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detracts from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.
>
> If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, the physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.
>
> Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.

(St. Ex. 4, 5, and 6)

Dr. Segal acknowledged that AMA Opinion 8.14 does not explicitly prohibit a physician from engaging in a romantic relationship with a former patient; rather, it sets minimum guidelines for the physician to do so in an ethical manner. (Tr. at 381-383)

28. Dr. Segal testified that, in his opinion, a physician/patient relationship had existed between Dr. Liss and Patient 1 and, by Dr. Liss engaging in a sexual relationship with Patient 1, he had violated the AMA Principals of Medical Ethics I, II and IV, as well as Opinion 8.14. (Tr. at 356-358)

    Dr. Segal further testified that a physician who engages in a sexual relationship with an active patient falls below the minimal standards of care. (Tr. at 358-359)

29. Dr. Segal testified concerning a situation where the physician and the patient alternate multiple times between having a physician-patient relationship and discontinuing that relationship in order to have a personal relationship. Dr. Segal testified:

    > I think once there's been a doctor/patient relationship, or even a personal relationship, if there's been a personal relationship, it's very difficult to have a doctor/patient relationship with that patient because of the things that have been established. And the opposite is true, if you have a doctor/patient relationship and then you have a personal relationship. Clearly, they may not be coming to the relationship on equal standing.

    (Tr. at 373-374)

30. Dr. Segal testified that, before a physician could engage in a personal relationship with a patient, "the patient would have to be discharged from that practice, referred to another physician, and any kind of practice of medicine, prescribing habits, any kind of ongoing medical care, would have to be discontinued." Dr. Segal further testified that he found no evidence in Dr. Liss' medical records for Patient 1 that suggests that the physician/patient relationship had been terminated, or that they had sought to engage in a personal relationship. (Tr. at 374-375)

    Dr. Segal testified that Dr. Liss' medical record for Patient 1 that were available for review covered two time periods: July 1994 through April 1996, and December 3, 1998, through December 4, 2000. Dr. Segal testified that, if there had been some clear indication in medical records between April 1996 and December 1998 that the physician/patient relationship between Dr. Liss and Patient 1 had been terminated, it is possible that that relationship would have complied with AMA Opinion 8.14. (Tr. at 383-385)

Dr. Liss' Response to Dr. Segal's Testimony Concerning Dr. Liss' Personal Relationship with Patient 1

31. Dr. Liss testified that he had been aware of ethics rules that prohibit a physician from having sex with patients. Dr. Liss further testified that he believes that he had complied with those ethics rules in his relationship with Patient 1. Dr. Liss testified that the personal affection between him and Patient 1 had developed over a period of time. Dr. Liss further testified:

> And I think it became very—as the facts became more and more obvious to me that this was where things were heading, it was at that particular time that I felt that it was time to specifically document the fact that, yes, we're going to have a relationship, and if we are, I have to document the fact that this relationship is not part of the doctor/patient relationship; this is something separate and personal. And I emphasized that to Patient 1 when I had that document—when I had her sign that document, because I wanted it as clean as possible in the record.
>
> * * *
>
> As sort of an addendum to that, I have—how shall I put it?—a mania, almost, because of the previous events, that I recognized the vital importance of keeping those kinds of documents and having that kind of documentation and being able to show timelines and so on so that there wouldn't be questions about such things.

(Tr. at 441-444) Dr. Liss acknowledged that he does not have that document, but that it had been maintained as part of Patient 1's medical record. (Tr. at 444)

32. Dr. Liss testified that he had engaged in a romantic relationship with Patient 1 because he and Patient 1 "were in love." Moreover, Dr. Liss testified that he had never lost his medical objectivity, and that that is borne out by his medical records. Dr. Liss testified that, from a medical standpoint, he had done everything appropriately. However, Dr. Liss stated that, from a personal standpoint, "it was a mess." (St. Ex. 7 at 67A, 68A; St. Ex. 11 at 55; Tr. at 504-511)

Dr. Liss' April 24, 2002, Deposition Testimony Concerning his Sexual Relationship with Patient 1

33. In an April 24, 2002, deposition before a member of the Board's staff, Dr. Liss testified that he and Patient 1 had first had sexual intercourse in 1992. Dr. Liss testified that that had occurred four times prior to their ending their personal relationship later in 1992. Dr. Liss further testified that he and Patient 1 had taken a trip to Disney World that year as well. Moreover, Dr. Liss testified that 1996 was "way too late[,]" and that that trip had taken place before 1996. (St. Ex. 17 at 133-137)

At hearing, Dr. Liss testified that discrepancies between his deposition testimony and his testimony at hearing resulted from his having been confused during the deposition concerning dates. Dr. Liss further testified that, at the hearing, he had had "a better time frame to work with because [he had] had a chance to look over the medical record." (Tr. at 228-232)

Dr. Liss testified that, during his deposition, he had had a copy of his more recent medical record for Patient 1—those contained in State's Exhibit 8—but that his earlier records—those contained in State's Exhibit 7—had not been made available to him by the Board. (Tr. at 424-425)

Later in the hearing, on re-cross examination, Dr. Liss was questioned at length concerning the truthfulness of his deposition testimony that his romantic relationship with Patient 1 had been confined to four sexual encounters in 1992. Dr. Liss' lengthy replies that his deposition testimony had, in fact, been truthful are unconvincing. (Tr. at 520-535)

Dr. Liss' Missing Patient Records for Patient 1

34. Dr. Liss testified that the medical record for Patient 1 that is part of the hearing record is not complete. Dr. Liss further testified that the progress notes for some of the prescriptions are missing, among other things. Moreover, Dr. Liss acknowledged that it is his responsibility to maintain the patient record. (Tr. at 426-428)

35. Dr. Liss testified that, when his medical record for Patient 1 had been subpoenaed by the Board, the only records that he had had in his possession had been those for December 3, 1998, and later. Dr. Liss testified that his records from the period 1994 though December 1998 had been stolen. Moreover, Dr. Liss testified that there had been no sign of a break-in, and that Dr. Liss had not suspected that a thief had gained access to his storage facility and stolen one particular chart. Finally, Dr. Liss testified that he suspected that someone had obtained that record long before it had been transported to the storage facility. (Tr. at 61-62, 66-67)

    Dr. Liss further testified that, five days prior to the hearing, he had met with Patient 1 and she had admitted to him "that she had actually stolen the record." (Tr. at 62-67)

    Dr. Liss adamantly denied that he had ever given to Patient 1 a large portion of her medical record. (Tr. at 67, 465)

36. Patient 1 testified that she had come into possession of some of her medical record from Dr. Liss. Patient 1 testified that Dr. Liss' wife "had taken them and somehow they ended up back in the apartment that we lived at." Patient 1 testified that they had been stored in a box marked with her name. When informed that Dr. Liss had testified that she had stolen the medical records, Patient 1 replied, "How could I steal something that's got my name on

it that's in a box with my name on it? That's in the apartment where I live." Patient 1 further testified that Dr. Liss had asked her to return those records; however, by that time, Patient 1's friend Bridgette had taken possession of them. (Tr. at 293-294)

Patient 1 testified that the box had also contained personal items, as well as letters between Dr. Liss and Patient 1. (Tr. at 194-195)

37. Patient 1 testified that Dr. Liss had never given her medical records to her. (Tr. at 315-316)

38. Dr. Liss testified at length concerning how Patient 1's medical records could have ended up at the apartment he had shared with Patient 1. Dr. Liss testified that if a patient's chart was stored at one office, and he was scheduled to see that patient at his other office, he would carry the record between those offices. Sometimes, in the interim, he would take them home. Dr. Liss denied that he stored medical records in the apartment. (Tr. at 437-441)

39. Dr. Liss testified that, when the romantic relationship between him and Patient 1 ended, there had been some unhappiness on the part of Patient 1, her family, and her friends. (Tr. at 487-489)

    Dr. Liss testified that, in addition to medical records and personal letters between Dr. Liss and Patient 1, other items had also been taken from his belongings. Dr. Liss testified that these items had included "adult and personal photographs of a sexual nature" that Dr. Liss had taken of his wife. Dr. Liss further testified that somebody had photocopied one of those photographs, then posted the photocopies up and down what Dr. Liss calculated to be a 12-block area around Dr. Liss' home. Dr. Liss testified that they had been placed on mailboxes, bus signs, stop signs, trees, and a shopping mall. Words written on those photocopies said, "Lost Family pet. If found, please return to pound. Miss Liss." Dr. Liss said that that had been extremely upsetting, particularly because they had been placed in locations where children would see them. Dr. Liss further testified that he and his wife had personally visited every home where he and his wife had found the photocopies and apologized. (Tr. at 493-496)

    Dr. Liss testified that he does not believe that Patient 1 was the individual who had copied and posted the picture of Dr. Liss' wife. Rather, Dr. Liss believes that someone else who is close to Patient 1 was responsible for that incident. (Tr. at 551-552)

40. Dr. Segal testified with regard to the storage of patient medical records. Dr. Segal stated that they cannot be left where other people could look at them or take them. The physician must take some measures to protect the records. Dr. Segal testified that, if a physician stores them at his or her home, they must be kept in an area where they will not be lost or destroyed. Dr. Segal further testified that patient records should not be commingled with personal items. (Tr. at 397-398)

Dr. Liss' prescribing of Valium to Patient 1

General Information

41. Dr. Liss prescribed Valium to Patient 1 on the following dates:

Date	mg	Quantity	Refills	Recorded in Chart
10/25/94	5	50	0	Yes
11/22/94	5	50	0	Yes
12/06/94	5	50	0	Yes
12/20/94	5	60	0	Yes
01/05/95	5	60	0	Yes
01/24/95	5	56	0	Yes
02/09/95	5	56	0	Yes
02/23/95	5	56	0	Yes
03/10/95	5	56	0	Yes
03/24/95	5	84	0	Yes
04/07/95	5	84	0	Yes
04/20/95 (diazepam)	5	168	0	Yes
05/19/95	5	84	0	Yes
06/02/95	5	90	0	Yes
07/07/95	5	56	0	Yes
07/21/95	5	84	0	Yes
08/04/95	5	84	0	Yes
09/01/95	5	75	0	Yes
10/06/95	5	75	0	Yes
11/10/95	5	84	0	Yes
12/08/95	5	50	0	Yes
12/22/95	5	50	0	Yes
12/26/95	5	40	0	Yes
01/11/96	5	50	0	Yes
01/25/96	5	40	0	Yes
02/06/96	5	40	0	Yes
03/03/98	5	60	0	No
04/16/98	5	60	0	No
08/16/99	10	90	0	Yes
09/21/99 (diazepam)	10	60	0	No

Date	mg	Quantity	Refills	Recorded in Chart
10/16/99 (diazepam)	10	90	0	No
10/21/99 (diazepam)	10	90	0	No
12/02/99	10	50	1	Yes
01/14/00	10	50	2	Yes
03/04/00 (diazepam)	10	50	0	No
03/11/00 (diazepam)	10	50	0	No
04/26/00	10	50	0	Yes
05/04/00	10	25	0	Yes
11/26/00	10	15	0	Yes
12/04/00	10	15	0	Yes
12/07/00	10	10	0	Yes
03/28/01	10	35	0	Yes

(St. Ex. 7 at 10, 14a, 33-34; St. Ex. 8 at 3a-6a, 25; St. Ex. 10)

Dr. Liss medical records for Patient 1 further indicate that he had tried Patient 1 on lorazepam and nortriptyline on July 8, 1994; Pamelor and Ativan on July 22, 1994; Desyrel on November 7, 1994; Desyrel and Buspar on November 18, 1994; Paxil on November 12, 1994; and Effexor on December 20, 1994. (St. Ex. 7 at 34)

Dr. Liss' Knowledge of Patient 1's Psychiatric and Substance Abuse History

42. Dr. Liss testified that he had obtained releases from Patient 1 for her past medical care, and that he had received copies of such records. Dr. Liss further testified that it had been his practice to review copies of past medical records for his patients prior to the inclusion of those past records into his medical records. (Tr. at 67-68)

43. Dr. Liss' medical records for Patient 1 included the following records of hospital treatment:

- The records include a discharge summary from Riverside Methodist Hospitals [RMH] concerning a January 28 through February 3, 1992, hospitalization of Patient 1 for "[p]olysubstance abuse and suicidal ideation." The history of the present illness states, in part, that Patient 1 had presented to RMH

  > with significant alcohol and drug history * * * for detoxification. * * * Patient states that she drinks at least a six pack of beer a day, one half a fifth of hard liquor every day as well. She uses Percodan at least four to five a day and also takes four to five Valiums a day. Patient states that she used to do cocaine and use IV drugs but has not done that for several years.

  (St. Ex. 7 at 92; Tr. at 165-166)

- Dr. Liss' records for Patient 1 include reports of hospitalizations for sexual assault and trauma. Some of these indicate a significant history of abuse, which included cigarette burns to her genitals, rectal area, and breasts, and sexual assault with a hot curling iron. One of the reports, dated November 29, 1993, indicated that these injuries had been sustained from "her 'pimp.'" (St. Ex. 7[1])

- A discharge summary indicates that Patient 1 had been hospitalized at RMH for alcohol dependency and Valium dependency from January 3 through 9, 1994. The discharge summary noted the following under the heading, "Events Leading to Hospitalization":

  > This is the first RMH admission for this 29 year old white female with polysubstance abuse. Valium is her primary problem. Last use was seven days ago. Uses up to 90 mg daily times one year. Detox'd herself in November. Clean times twenty days, then resumed. 4 out of 4 on the CAGE questions. Personality changes. Cocaine snorting times years. Last use three days prior to admission. IV use of cocaine in the past. Dilaudid and Heroin. HIV negative in October. Used some LSD three weeks ago. Previous treatment at Maryhaven times three days and at Concord Counseling and AA and has a sponsor. Questionable positive seizure in November.

  (St. Ex. 7 at 85) The history and physical examination report for that hospitalization indicates that Patient 1 had been a "go-go dancer[,]" but had quit her job two weeks prior to her hospitalization. The report further states that Patient 1 "did not go to school after the sixth grade and is basically illiterate." The section entitled "History of Present Illness" states:

  > The patient gives a long history of being addicted to Valium, beer, cocaine. She states that she does not know when she began to drink but 'I was very young.' When asked if she drank in high school she states that she didn't go to high school. She states she drinks about twelve beers a day, begins to drink in the a.m. She states she also used Valium orally, last use one week ago. She uses four to five a day and at times has taken as many as five 10 mg Valium to sleep. She states she last took a drink in the parking lot before coming in today. She said she snorts cocaine, perhaps one gram a day, last use about 48 hours ago. She occasionally smokes it. She has admitted to IV use of medications, last use about three months ago. She states she has used cocaine intravenously and also 'speed balls' which is a mixture of Dilaudid and cocaine she says. She has shared needles, but she does not believe she

[1] See St. Ex. 7 at 81-82 concerning the quotation.

> had shared them since twelve years ago. She is HIV negative, which was tested in October of 1993 when she went to St. Ann's emergency room for a rape.
>
> She does admit to an OMVI in 1987. She denies other legal problems. She does admit to seizure history. She states she had a seizure in November of 1993 when she was trying to come off Valium by herself. She denies other seizures. She denies liver history.

(St. Ex. 7 at 87) Note that the report indicates that Patient 1 is a "poor historian." (St. Ex. 7 at 87)

Dr. Liss testified that the records of that hospitalization were sent to Dr. Liss on November 29, 1994, and that he had reviewed them prior to placing them in his chart. (Tr. at 156-157)

- Dr. Liss' medical records for Patient 1 include a copy of an operative report by Michael G. Stiff, M.D., dated November 4, 1994, concerning an esophagogastroduodenoscopy. The operative report states, among other things, that Patient 1 had presented with "protracted nausea and vomiting." The operative report further states that Dr. Stiff had seen Patient 1 in February 1994 for alcohol-induced gastritis. Moreover, the report states, "She denies drinking any alcohol in the last 63 days. However, she has been on Valium she states for 20 years which would put her starting at age 10 and she ran out of Valium three days ago so certainly this could potentially be a drug withdraw [sic] reaction." Finally, the operative reports that the procedure did not reveal any abnormalities and that Dr. Stiff believed "this is probably secondary to drug withdraw [sic] or psychogenic." (St. Ex. 7 at 73-74)

- Dr. Liss' progress note dated November 8, 1994, states that Patient 1 had been hospitalized from November 2 through 4 to be tested for ulcers. She subsequently was seen in an emergency room on November 6 for vomiting and muscle spasms. Dr. Liss concluded his progress note for that visit by stating, "Is she going through withdrawal?? [check] records." (St. Ex. 7 at 17b; 136)

  Dr. Liss' medical record for Patient 1 included a discharge summary for that hospitalization. The discharge summary lists diagnoses that include "Intractable vomiting, suspect benzodiazepine withdrawal syndrome[, and] Pre-existing drug and ethanol abuse." The history of the present illness states, in part, that Patient 1 "had discontinued her routine use of Valium around three days prior to admission and subsequently developed diffuse progressive nausea with profound unrelenting vomiting, but without abdominal pain." The discharge summary further states that the patient "was subsequently discharged home with a weaning dose of Serax 50 mg to cover the benzodiazepine withdraw [sic]." Finally, it states, "Follow-up is with Dr. Liss in approximately two weeks' time." (St. Ex. 7 at 71-72; Tr. at 147-149)

- On March 1, 1996, Patient 1 was admitted to St. Ann's Hospital by Dr. Liss for abdominal pain with persistent nausea and vomiting, pregnancy of 16 weeks gestation, and dehydration. In his history and physical examination report, Dr. Liss noted in his assessment, "It should be noted that the murmur heard on the exam today is new, and with the patient having a past history of drug abuse including intravenous drug abuse, the possibility of a valvular lesion must be considered." (St. Ex. 7 at 68a; Tr. at 141-144)

  Further in his assessment, Dr. Liss noted, "At the present time, the patient appears to be generally not involved in any significant drug abuse and has not been for some time since she discovered that she was pregnant." (St. Ex. 7 at 69a)

44. Dr. Liss testified that Patient 1's medical history had included a long history of psychiatric problems resulting from physical and emotional violence done to her. Dr. Liss testified that some of the physical abuse upon Patient 1 had been "fairly extreme." Dr. Liss further testified that Patient 1 had been hospitalized psychiatrically on at least one occasion. Moreover, Dr. Liss testified that he had believed that Patient 1 suffered from post-traumatic stress disorder [PTSD]. (Tr. at 68-69)

    Dr. Liss testified that he had also been aware that Patient 1 had suffered from a long history of polysubstance abuse, which had included Valium abuse. Dr. Liss further testified that he had been aware that she had undergone treatment for such abuse. Finally, Dr. Liss testified that he had received copies of records of such treatment. (Tr. at 70-73)

    However, during the April 24, 2002, deposition, Dr. Liss had testified as follows:

    Q. (by David Katko): Earlier today, before the extended interruption, you indicated that Patient No. 1 had a controlled substance abuse problem years and years ago. Do you remember saying that?

    A. (by Dr. Liss): Yes.

    Q. When was the last time you were aware that Patient No. 1 had a problem in terms of abusing controlled substances?

    A. It's my understanding, that based on my recollection from the patient record, that probably around 20 years ago is when the patient had those type of problems in her teen-age years.

    Q. 1982?

    A. That sounds about right, yes, 20 years.

Q. So your understanding is the Patient No. 1 had not had an abuse of controlled substances issue since, let's say, since the mid-1980s?

A. Not to my knowledge.

Q. Not to your knowledge. Please identify, to your knowledge, each and every controlled substance that has been abused by Patient No. 1 in the past.

(Mr. Boatright): Objection. If you know.

A. I would really have no way of knowing.

Q. You have no way of knowing. You're sure about that?

* * *

A. To the best of my recollection, again, I don't recall any specific substances. However, I do recall that there was an issue about alcohol abuse and I do recall that there was an issue about suicide because she had attempted to commit suicide.

(St. Ex. 17 at 63-65)

Moreover, Dr. Liss gave the following testimony during the April 24, 2002, deposition:

Q. (by David Katko): * * * Has Patient No. 1 ever been admitted to any health care facility to deal with chemical or controlled substance abuse withdrawal, to your knowledge?

A. (by Dr. Liss): I will go back to the statement I made previously. The only thing I have, which I am aware, goes back to her teen-age years which is many years ago, 20.

Q. Did you understand from Patient No. 1 that she had been hospitalized for withdrawal from controlled substances 20 years ago?

A. No, I won't say that.

Q. So do you have any awareness of Patient No. 1 ever having been in a health care facility for dealing with withdrawal issues related to controlled substances?

A. No.

Q. Never?

A. No.

Q. Never received a patient record indicating that?

(Mr. Boatright): Objection. Asked and answered. Go ahead.

A. No.

Q. Have you ever received copies of drug treatment records from Riverside Methodist Hospital relating to Patient No. 1?

(Mr. Boatright): Objection. Asked and answered. You can answer again.

A. Not to my recollection.

* * *

Q. * * * Have you ever received copies of drug treatment records from any other health care facility relating to Patient No. 1?

A. No.

Q. Never?

A. No.

Q. Has Patient 1, to your knowledge, ever been in Maryhaven for chemical dependency treatment?

A. Not to my knowledge.

(St. Ex. 17 at 70-72)

At hearing, Dr. Liss testified that he had answered the deposition questions in the manner that he had because he had not had his earlier patient records for Patient 1 available to him during the deposition. Dr. Liss testified that he had not denied having been aware of Patient 1's history of substance abuse, but had been unable to recall without having his medical records in front of him. (Tr. at 74-76, 172-177) Dr. Liss further testified that he would have received Patient 1's treatment records back in 1994 or 1995, "[a]nd now I'm supposed to remember without access to records eight years, nine years later. Well do you remember this? No." (Tr. at 76)

Dr. Liss' Testimony Regarding His Prescribing of Valium to Patient 1

45. Dr. Liss testified that, during the course of his treatment of Patient 1, he had prescribed medication to her, which had included Valium. Dr. Liss testified that he had prescribed Valium for Patient 1 because "it seemed based on the interview the drug that worked best for controlling her [anxiety] symptoms." He testified that her symptoms had included irritability, jumpiness, the "appearance of depression, tremulousness, palpitations. Pretty much the usual set of symptoms you get with somebody who has anxiety." Dr. Liss further testified that he believes that he had started Patient 1 on Valium after he had learned of her history of substance abuse, and had prescribed Valium "[b]ecause it was the best drug to use." Moreover, Dr. Liss testified that it was "[a]bsolutely" within the standard of care to prescribe Valium to Patient 1 despite her history of substance abuse. (Tr. at 51, 95-96)

    Dr. Liss testified that Patient 1 had had a significant history of physical abuse. Dr. Liss further testified that simply stating that Patient 1 abused drugs is an "oversimplification of a fairly complex problem that she really did have." Dr. Liss testified that Patient 1 had told him that Valium had worked best for controlling her symptoms and enabling her to function on a daily basis, including raising her three children. Moreover, Dr. Liss testified that Valium had been more effective for her than any other medication that he had tried for her. Furthermore, Dr. Liss testified that he had prescribed Valium to her "on a fairly scheduled basis." Finally, Dr. Liss testified:

    > [T]he question is how are you going to help this person deal with their particular medical condition. And the answer is you use the drugs that are available that work the best, and then you make sure you keep an eye on things that, indeed, they're being used the way that you intend to have them used, the way that you're prescribing them.
    >
    > * * *
    >
    > So if you just want to sit back and pretend that you're a wonderful doctor and you're not going to give somebody a medicine because, oh, it just isn't by the book, versus what you're looking at when you're dealing with a person, I think that you would make a decision that you will find the treatment that works best for this person so they can function.

    (Tr. at 96-99)

    Dr. Liss testified that, although medical literature indicates that a selective serotonin reuptake inhibitor [SSRI] such as Prozac is the best therapy for disorders such as Patient 1's, Dr. Liss testified that he has not been "impressed with how the drugs work." Moreover, Dr. Liss testified that a trial of SSRI medication for Patient 1 had not been successful: "I didn't really feel that it was really doing very good. She didn't feel it was

doing very good. She felt, again, that the Valium worked best." Dr. Liss testified that he had also tried Patient 1 on Xanax, which proved to be too short-acting for Patient 1's sustained, low-grade anxiety. Dr. Liss testified that Valium is a longer acting drug. (Tr. at 101-102)

46. Dr. Liss testified that he had believed Patient 1 when she told him that the only drug that worked for her was Valium. In addition, Dr. Liss testified that he had noted in his medical records that he had considered the potential for Patient 1 to abuse Valium. (Tr. at 169-170) Dr. Liss referred to a progress note dated December 20, 1994, which states, in part, "Takes all meds only from me. → no other source per [patient]. Discussed need for close [follow-up]. Refused to give additional drugs. To not use 'street' drugs. To not use [alcohol]." (St. Ex. 7 at 16a) Moreover, when asked where it states in his progress note that he had considered Patient 1's past drug abuse problems, Dr. Liss testified that the December 20, 1994, progress note stated, "see old records." Dr. Liss testified that "the old records are replete with that information." (St. Ex. 7 at 16a; Tr. at 171)

Dr. Liss was asked on cross-examination if he would be concerned if a patient with a 20-year history of abuse of a particular drug repeatedly claimed that therapies other than her drug of choice were ineffective. Dr. Liss replied that, to his knowledge, as long as the patient was using the medication as directed, and had been tried on other medications and indicated that the drug in question worked best, "there is absolutely nothing that prohibits or would contradict that you would" prescribe that medication for the patient. Further, Dr. Liss testified that, if the State is implying that the patient was exhibiting drug-seeking behavior, then Dr. Liss would counter that by saying that the patient "has a lot of issues." Moreover, Dr. Liss testified that anyone who had a loved one who had undergone the same experiences suffered by this patient would want to find a physician for that loved one who would treat that person with a medication that would allow him or her to function normally. Finally, Dr. Liss testified that, to his knowledge, during the period that he treated Patient 1 with Valium, she had not had any hospitalizations for suicide attempts or drug overdoses. (Tr. at 103-108)

When asked how he could differentiate a patient's insistence that Valium worked best for her as an honest statement rather than drug-seeking behavior, Dr. Liss testified that, first, he asks detailed questions of the patient concerning why the other drugs were not working as well. Dr. Liss further testified that drug-seeking patients generally try to obtain larger and larger amounts of the medication. Moreover, if the physician becomes convinced over a period of time that the patient was being honest and not misusing the medication or obtaining it from other sources, then that indicates that the patient is not drug-seeking. Dr. Liss testified that Patient 1 always appeared to comply with the regimen that Dr. Liss prescribed. (Tr. at 468-469)

Dr. Liss testified that he had been aware of the possibility that Patient 1 had engaged in drug-seeking behavior while he was treating her. Dr. Liss testified that he had handled that the way he would any other patient who receives a controlled substance, and asked her

frequently if she was receiving medication from any other physician or source, and if she was complying with the treatment regimen that they had agreed upon. (Tr. at 465-466)

47. Dr. Liss testified that he had felt that it was within his capabilities as an internal medicine physician to treat Patient 1's problems, even though she had had a 20-year documented history of polysubstance abuse. Dr. Liss testified that as long as the Valium was used properly, it was the most effective medication for treating Patient 1's problems. Dr. Liss noted that he had kept very close control over the amount of Valium made available to Patient 1, and that his medical records support this assertion. (Tr. at 99-100)

    Dr. Liss further testified that he had not believed that it had been necessary to consult with other physicians concerning Patient 1's treatment, given her condition and history of substance abuse. Dr. Liss testified that Patient 1 had seen specialists in the past, including psychiatrists, and that Patient 1 had felt that they had not helped her. Moreover, Dr. Liss testified that when he had suggested to Patient 1 that she see a psychiatrist, "she just laughed and thought that was ridiculous because she had seen so many psychiatrists[.]" Dr. Liss further testified:

    > [O]ne of the reasons that allowed us to become close was that in order for me to understand what was going on with her, we had to get into some fairly personal and deep issues having to do with things. And, unlike a lot of doctors, I think I actually understood from her point of view what it must have been like to have to live through this [in reference to Dr. Liss' own experience of sexual abuse during childhood[2]].

    (Tr. at 113-115)

    In addition, Dr. Liss testified that he has "great respect for some psychiatrists" and "very little respect for a lot of psychiatrists." Moreover, Dr. Liss testified that there are very few patients that he believes he cannot handle psychiatrically. Dr. Liss noted that he has many patients in nursing homes that he manages with "the heaviest duty of the heavy duty antipsychotics and so on." Finally, Dr. Liss testified that if the patients are "not actively suicidal or if they're not actively hallucinating schizophrenics, [Dr. Liss] can take care of them." (Tr. at 118-120)

48. Dr. Liss testified that, in his opinion, the care and treatment he had rendered to Patient 1 in prescribing Valium to her had been within the minimal standards of care. Dr. Liss further testified that he believes that his treatment had been appropriate and beneficial to the patient. Further, in his expert report, Dr. Liss stated:

    > I have reviewed the Board's allegations and [Patient 1's] medical charts in preparation of this report. [Patient 1] clearly benefited from the use of

[2] See Tr. at 43-44.

> diazepam for the treatment of her anxiety brought on primarily by a post traumatic stress disorder. The etiology of her PTSD can be found in the medical record. She had been tried on short acting benzodiazepines along with SSRIs with limited success as can be seen in the medical record. Other therapies for anxiety such as the tricyclic tertiary amines, tricyclic secondary amines, serotonin agonist and re-uptake inhibitors, and norepinephrine dopamine in re-uptake inhibitors had little or no success. The medical record shows documentation in regards to the therapies attempted and rationale used for choosing medications. The success of using diazepam over any of the other treatment modalities is also clearly indicated.
>
> Although long acting benzodiazepines are not the first choice in treating anxiety related disorders, the medical records [sic] clearly shows its success in comparison to other treatment approaches that were applied. Since the primary goal of therapy is improvement in the patient's condition, the use of long acting benzodiazepines is clearly justified.
>
> In my medical opinion, I did not violate R.C. 4731.22(B)(6) in my care and treatment of [Patient 1].

(Respondent's Exhibit [Resp. Ex.] C; Tr. at 503-504)

Patient 1's Testimony Regarding Dr. Liss' Prescribing of Valium to Her

49. Patient 1 testified that she has a long history of drug abuse. Patient 1 testified that her drug abuse history began when she was ten years old and ran away from home. Patient 1 testified that she had lived on the street, and had abused any drugs that she could obtain, including Valium. Patient 1 further testified that Valium had been one of her drugs of choice. Moreover, Patient 1 testified that, prior to beginning treatment with Dr. Liss, she had abused Valium, and had been detoxified and hospitalized for her abuse of drugs, including Valium. (Tr. at 271-273)

    Patient 1 testified that she does not believe that she had told Dr. Liss of her history of drug abuse the first time she met him. Patient 1 further testified "I was probably drug seeking. I wasn't about to sit and tell him I had a problem with narcotics, because obviously I wanted him to write me a prescription for narcotics." (Tr. at 273-274)

50. Patient 1 testified that she had continued to abuse Valium during her pregnancy with her son, and that her son had been born with Valium in his system. Moreover, Patient 1 testified that Dr. Liss had been one of her sources of Valium during this time. Furthermore, Patient 1 testified:

    > [Dr. Liss] actually changed me off the Valium to Somas once we found out I was pregnant. Because supposedly that wouldn't have been so harmful to the

> fetus—not the fetus but the baby. No. You know what I mean? Because supposedly the Somas—because obviously I had been taking the Valium long enough I couldn't just quit taking them.
>
> He made the choice to switch to the safer drug to use while I was carrying my son. But yes, during my pregnancy, towards the end of my pregnancy, I did ask for some—I'm ashamed to say it, but, yes, I used some Valium, like, three days before my son was born.

(Tr. at 276)

51. Patient 1 testified that Dr. Liss had been aware that she was an addict during the time that he prescribed medication for her. Patient 1 testified that she was aware that he knew that "[b]ecause he lived with me. Because he saw my abuse of alcohol and pills. And I do believe in one apartment we had to call a squad because I OD'd on some Somas that he had left laying in the apartment." (Tr. at 302)

    Patient 1 described how she had obtained the prescriptions from Dr. Liss: "We would meet and go for a ride, and he would give me the prescription." When asked if Dr. Liss had required Patient 1 to have sex in return for the prescriptions, Patient 1 testified, "It wasn't like he forced me to, but, yeah, we would go for rides and have sexual acts. But it wasn't—he never forced me to." (Tr. at 302-303)

    Patient 1 testified that she and Dr. Liss had gone for car rides numerous times. Patient 1 further testified that Dr. Liss would give her prescriptions during these rides, but that the prescriptions were not the sole reason that they would be out together. Patient 1 testified, "That was really the only way that we could be together without his wife knowing about it." (Tr. at 324-325)

52. Dr. Liss testified that he "totally disagreed" with the implication of Patient 1's testimony that he had exchanged drugs for sex. (Tr. at 448-449)

Dr. Segal's Testimony Regarding Dr. Liss' prescribing of Valium to Patient 1

53. Dr. Segal testified, "I think that prescribing a medication, particularly a controlled substance, to a patient that is known to have had problems with it and required detox for it, whether the patient wants it or not, falls below the minimum standards." Dr. Segal further testified that the minimal standards of care would require the assistance of an outside consultation before continuing such prescribing. Moreover, Dr. Segal testified that Dr. Liss' medical records contain recommendations that Patient 1 seek consultation, but the patient refused to comply. (Tr. at 367-368)

    Dr. Segal testified that, were he confronted with a patient such as Patient 1, who had an addiction problem with Valium, and who sought treatment with Valium, he would refer

that patient either to a psychiatrist or to an expert in substance abuse. Dr. Segal further testified that, without specialized training, an internal medicine physician would not have the necessary expertise to treat such a patient. (Tr. at 369-370)

54. Dr. Segal acknowledged that, given past incidents of physical abuse, it is "[m]ost likely" that Patient 1 had suffered from post-traumatic stress disorder [PTSD] and anxiety. However, Dr. Segal further testified that he does not believe that Valium is the best medication to treat anxiety or PTSD. Further, Dr. Segal testified that he does not believe that he, Dr. Segal, would have the expertise necessary to treat anxiety, PTSD, or depression that does not respond to other medications. Moreover, if the patient refused consults, it is likely that the patient's problem would simply be beyond his expertise to treat. Dr. Segal analogized the situation to treating a hypertensive patient whose condition does not respond to medication the internal medicine physician tries. If the patient refuses consults with a cardiologist or nephrologist, then "[a]t some point in time, I think I'm doing more harm than good trying things that don't work. I have to say, I can't do this anymore." (Tr. at 388-390)

    When asked if that would be a "fine line to walk" when dealing with a patient with past suicidal ideations, Dr. Segal testified that it is then "even more important to have an expert consult opinion." When asked what would happen if the patient still refused the expert consult, Dr. Segal testified, "At some point in time, the patient has to be certainly somewhat responsible for their own care." (Tr. at 390-391)

55. Dr. Segal testified that patients who are addicted to a particular medication will often say that "[n]o other medicine seems to work except the one that they want and are addicted to. And so they try to force the issue of getting the medication that they want." (Tr. at 370)

56. Dr. Segal testified that physician objectivity is important to determine the effectiveness of medication in treating a patient. Dr. Segal further testified that a personal relationship between the patient and physician would have a negative impact on the physician's objectivity. (Tr. at 370-371)

    Dr. Segal testified that knowledge of a patient's prior history of drug abuse gained by a physician in a prior physician/patient relationship could be used to exploit a personal relationship with that patient. Dr. Segal further testified that it could be considered exploitation if a physician continued to prescribe drugs to such a former patient during a personal relationship, and that such conduct would be unethical, according to AMA Opinion 8.14. (Tr. at 396-397)

57. Dr. Segal acknowledged that Dr. Liss' medical records indicate that Dr. Liss had tried Patient 1 on appropriate anti-anxiety medications such as Buspar and Desyrel, and had referred Patient 1 to counseling for anxiety. Moreover, Dr. Segal acknowledged that Dr. Liss' medical records indicate that Dr. Liss did not prescribe large amounts of Valium

with multiple refills to Patient 1. Dr. Segal further acknowledged that Dr. Liss appeared to have controlled Patient 1's intake of Valium. (Tr. at 392-395)

Dr. Liss' Response to Dr. Segal's Testimony Regarding Prescribing of Valium to Patient 1

58. Concerning Dr. Segal's testimony that Dr. Liss had failed to consult with other professionals in his treatment of Patient 1, Dr. Liss testified that "consultations are necessary and should be used when appropriate." However, "there were two things that worked against going in that direction." Dr. Liss testified that, first, most physicians would label Patient 1 as a "drug addict" and either refuse to treat her or refuse to give her any medication. Second, Dr. Liss testified that, in reviewing her medical records, he had concluded that "they had blown the diagnosis. * * * [T]hey kept pounding on the fact that she was a drug addict." Dr. Liss testified that, although she may have had a problem with addiction, "her real problem was that she had from the earliest childhood a horrible, horrible life." Dr. Liss further testified that he had believed that "her main problems were post-traumatic stress, anxiety, [and] depression," and that there is good documentation of that. In addition, Dr. Liss testified that Patient 1 honestly believed that Valium was effective in treating her problems, and had not been drug-seeking or obtaining the drug to get high. Moreover, Dr. Liss testified that Patient 1 "was very up front from the very beginning" concerning her abuse of drugs. Furthermore, Dr. Liss testified that Patient 1 had been to many different counselors and psychiatrists who would "pigeonhole her" and try therapies that Patient 1 knew didn't work. Finally, Dr. Liss testified that "[s]he had dealt with these people before. It was simply not a good experience for her." (Tr. at 469-475)

59. Dr. Liss testified that he does not agree with Dr. Segal's approach that, at some point, he should terminate the physician/patient relationship rather than continue to prescribe Valium. Dr. Liss testified that he believed that he had understood Patient 1 and that he was helping her. Dr. Liss further testified that he had understood what he was trying to do, and that Patient 1 had been a compliant patient. Moreover, Dr. Liss testified that he had not provided to Patient 1 prescriptions for Valium with refills because it had put less temptation in front of her to abuse the drug, and allowed Dr. Liss to better monitor Patient 1's use of the drug. (Tr. at 475-477)

Testimony of Richard H. Clary, M.D., Regarding Dr. Liss' Prescribing of Valium to Patient 1

60. Richard H. Clary, M.D., testified as an expert on behalf of Dr. Liss. Dr. Clary obtained his medical degree in 1970 from the Ohio State University College of Medicine. From 1970 to 1971, Dr. Clary participated in an internship at the Indiana University Hospital Department of Surgery. From 1971 until 1983, Dr. Clary practiced emergency medicine. Subsequently, from 1983 through 1986, Dr. Clary participated in a psychiatry residency at Harding Hospital. From 1986 through the present, Dr. Clary has been engaged in the private practice of psychiatry in Columbus, Ohio. Dr. Clary testified that he is board certified in psychiatry. (Resp. Ex. A; Tr. at 558-562)

Dr. Clary testified that, today and since 1998, his practice consists of office and outpatient practice. Dr. Clary testified that, prior to that, he had done office practice, outpatient work, and hospital work. Dr. Clary testified that, currently, he sees patients "that run the gamut of the psychiatric disorders. Dr. Clary further testified that the condition he treats most often is depression, and that he also sees patients with anxiety problems, panic attacks, schizophrenia, and bipolar disorder. Moreover, Dr. Clary testified that his clinical practice takes about two-thirds of his time, and that the remaining one-third consists of disability evaluations for Worker's Compensation and the various state retirement plans. (Tr. at 560-561)

61. Dr. Clary testified that he is familiar with Dr. Liss from Dr. Clary's earlier hospital work, and may have seen some of Dr. Liss' patients during that time. Dr. Clary further testified, however, that he has not seen any of Dr. Liss' patients since 1998. (Tr. at 563-564)

62. Dr. Clary testified that, in his opinion, Dr. Liss' utilization of Valium in his treatment of Patient 1 had been "appropriate under the conditions that he saw the patient." Dr. Clary testified that Dr. Liss had been aware of Patient 1's past psychiatric history and history of substance abuse. Dr. Clary further testified that a history of substance abuse is not an absolute contraindication to treat a patient for medical problems using the substance that the patient used to abuse, and cited as an example a former addict who requires pain medication for cancer. (Tr. at 567-568)

    With regard to anxiety and depression, Dr. Clary testified that such conditions must be treated, even if the patient has a history of abusing the same medications that may be needed for treatment. Dr. Clary stated that it makes treatment more complicated and difficult; however, "you just can't say you can never, ever use these medications on these individuals." (Tr. at 568-569)

    Dr. Clary testified that, from his review of the records, it appeared that Patient 1 had a history of depression, anxiety, and PTSD. Dr. Clary further testified that Valium is an appropriate medication to treat the symptoms of all of those conditions. Moreover, Dr. Clary testified that Dr. Liss had attempted treatment with other medications, such as Buspar and Desyrel, but that the patient was either unable to tolerate side effects or the medications were ineffective. Dr. Clary also noted that Dr. Liss had referred Patient 1 to counseling several times. (Tr. at 569-570)

63. Dr. Clary acknowledged that it is "certainly possible" that a patient seeking Valium might tell her physician that other drugs are not working. Dr. Clary further acknowledged that a physician would want to be careful in such a situation. However, Dr. Clary further testified that such statements by the patient would be only "one red flag," and if the patient were otherwise using the medication responsibly, then that by itself would not preclude Dr. Clary from maintaining such a patient on Valium. (Tr. at 592-594)

When asked how a physician can determine that a patient with a history of drug abuse is being honest in telling the physician that medications other than the drug of choice don't work, Dr. Clary replied:

> I think part of it is a judgment call. I think if you see situations where a person is always—they're calling in for early refills on their medications, they're losing their prescriptions, stories like that where they're needing extra refills, more medication. They're taking more than what's recommended or prescribed. That is the red flag or danger signal. But if they're taking the medicine on a consistent basis and they're not asking for early refills or taking more than you recommended, I think that's appropriate and safe to use it in those circumstances.

(Tr. at 571-572) Dr. Clary further noted that Dr. Liss had asked Patient 1 on several occasions if she had been receiving medication from other sources, and if she had been abusing any substances. (Tr. at 570)

64. Dr. Clary testified that, with regard to the Board's January 8, 2003, notice of opportunity for hearing, he believes that Dr. Liss' use of Valium in his treatment of Patient 1 had been within the standard of care. (Tr. at 582-583)

65. On cross-examination, Dr. Clary testified that, if a physician were having a sexually intimate relationship with a patient, it could potentially interfere with the physician's ability to treat the patient objectively. Dr. Clary further testified that the observations recorded by the physician in the patient's medical record could be affected by such a relationship. (Tr. at 590-592, 599-600)

Further, on cross-examination, Dr. Clary was presented with the following hypothetical:

> Between '93 and 2001, in this hypothetical, a physician makes a choice to continue prescribing Valium to someone with a 20-year history of Valium abuse. During the course of '93 to 2001, prior to taking this patient on, the physician has an affair with her. She becomes his patient. He develops feelings for her, personal feelings, interest in her, maybe reciprocated on the patient's part.
>
> Prior to her ceasing to become a patient, those feelings are expressed. They embark on a personal sexual, intimate relationship for a period of time, followed by a period of time where they return and physician/patient, followed by another period of time of personal relationship, sexual, intimate relationship, maybe followed by a subsequent time of physician/patient relationship.
>
> Is it appropriate for that physician to continue those treatment periods with somebody in that situation?

(Tr. at 597-598) Dr. Clary responded that "that would make the relationship very, very complicated and make it very—I think it would make it more difficult to do that, to prescribe medication. * * * There might be some times when it is. It would be very difficult, I think." (Tr. at 599)

Prescriptions Issued to Patient 1 by Dr. Liss but not Recorded in the Medical Record

66. Dr. Liss' patient records for Patient 1 fail to reflect the following prescriptions issued or called in by Dr. Liss for controlled substances:

Date	Drug	Quantity
03/03/98	Valium 5 mg	60
04/16/98	Valium 5 mg	60
02/11/99	Propoxyphene with APAP	5
02/13/99	Propoxyphene with APAP	5
02/14/99	Phenobarbital 30 mg	10
02/15/99	Propacet 10/650 mg	20
02/16/99	Phenobarbital 30 mg	10
02/18/99	Phenobarbital 30 mg	60
09/21/99	Diazepam 10 mg	60
10/16/99	Diazepam 10 mg	90
10/21/99	Diazepam 10 mg	90
03/04/00	Diazepam 10 mg	50
03/11/00	Diazepam 10 mg	50

(St. Ex. 10)

67. Dr. Segal testified that it is below the minimal standards of care for a physician to fail to record prescriptions for controlled substances in the patient medical records. (Tr. at 365-366)

68. Dr. Liss testified that his records of some prescriptions issued to Patient 1 are missing because a large portion of his medical record for that patient is missing. (Tr. at 480)

Hospital Patient Records for Patient 1 for Treatment Obtained at Grant Hospital

69. At hearing, the State presented certified copies of records of Patient 1's treatment at Grant Hospital [Grant] in Columbus, Ohio. Note that there is no evidence that Dr. Liss had obtained these records as part of his treatment records for Patient 1, or that he had reviewed them. These records include the following:

- Patient 1 was hospitalized from December 8, 1987, through January 28, 1988, for suicidal ideation and diagnoses that included "Adjustment disorder with mixed disturbance of emotions and conduct" and "Personality disorder not otherwise specified [self-defeating personality disorder])." (St. Ex. 9 at 136-344)

- Patient 1 was hospitalized from January 18 through 23, 1990, for a diagnosis of "adjustment disorder, with mixed emotional features." (St. Ex. 9 at 10-58)

- Patient 1 was hospitalized in August 1996 for delivery of an infant. The infant was delivered on August 24, 1996. (St. Ex. 9 at 59-125) A labor and delivery history and physical examination progress note dated August 23, 1996, states, among other things, "32 [year old] G_4P_3 [with] ? EDC (states 8/19/96) presents with SROM @ 14:00. Virtually no PNC—saw Jeffrey Hunter (FP) [times 1]." (St. Ex. 9 at 73) Further, a progress note dated August 24, 1996, at 18:35 states, among other things, "[Patient] admits that she took some Valium a few days ago. She got them from 'a friend.'" (St. Ex. 9 at 77)

- On January 9, 1999, Patient 1 was seen in the Emergency Department for a chief complaint of being unable to see with her right eye. A physician who saw her indicated that she was emotional, difficult to understand at times, and made " a lot of strange comments." The physician suspected that there were "a lot of psychological overtones to the answers" that Patient 1 provided. The physician noted that Patient 1 had stated initially that she could not see out of the eye, and later that the problem was pain in the eye. Moreover, a nursing note states that Patient 1 had said, "'I drank a fifth of some moonshine before trying to get rid of the pain. It didn't knock me out.'" (St. Ex. 9 at 2-9)

Additional Information

70. Patient 1 testified that she had met with Dr. Liss at a restaurant approximately two weeks prior to the hearing. Patient 1 further testified that they discussed the Board hearing at that time. Whereupon the following exchange took place:

    Q. (by Mr. Michael): And did Dr. Liss tell you how he wanted you to testify here today?

    A. (by Patient 1): Yeah. Something about a piece of paper, to say I signed a piece of paper that we've lost or something.

    Q. Okay. Do you know what that paper was supposed to represent?

    A. Not exactly. I wasn't clear on it. Something about I signed it saying I wasn't his patient anymore, or I was, or something like that. I think—I believe it was something saying I wasn't.

    Q. To your knowledge, did you ever sign such a document?

    A. No I never signed any document. To my knowledge. I mean, if I did, I don't have it, and apparently he doesn't have it. And if anybody would have something like that, it would be his wife, because she was always taking anything that had anything to do with me.

    Q. So if you had signed something at any point in time, your memory is that it did not have to do with your status as to whether or not you were his patient?

    A. I don't have any memory of that, no.

    (Tr. at 303-304)

    Patient 1 further testified that she had had several telephone conversations with Dr. Liss for "the last week and a half" prior to the hearing. Patient 1 testified that some of those conversations were initiated by Dr. Liss. Moreover, Patient 1 testified that Dr. Liss had told her that he had had a private investigator follow Patient 1. (Tr. at 305-306)

    Finally, Patient 1 testified that she had paged Dr. Liss a number of times during the two or three weeks prior to the hearing, perhaps twenty times. Patient 1 further testified that she had paged Dr. Liss from the hospital following a recent horse-riding accident. (Tr. at 308-310)

71. Dr. Liss agreed that Patient 1 had paged him as many as twenty times during the three weeks prior to the hearing. Dr. Liss testified that she had done so because he and Patient 1

"were very close," she moved around a lot, and if she had an issue, such as her recent fall from a horse, she liked to discuss it with Dr. Liss. (Tr. at 456-458)

Dr. Liss testified that he had met with Patient 1 at Max and Erma's shortly before the hearing. Dr. Liss testified that Patient 1 had been very upset by the fact that she was to testify against Dr. Liss. Dr. Liss testified that normally they would have taken a drive to discuss things, but that Patient 1 was physically uncomfortable as a result of her accident, so they went to a restaurant. (Tr. at 458-459)

Dr. Liss testified at length concerning the discussion he had had with Patient 1 at Max and Erma's prior to the hearing. Dr. Liss testified that Patient 1 had told him that she did not want to testify, and that Dr. Liss told her he was not an attorney and could not advise her. Dr. Liss testified that he told her that "they're trying to characterize [Dr. Liss' and Patient 1's] relationship" as being drugs for sex. Dr. Liss testified that Patient 1 agreed that it had not been like that, and Dr. Liss told Patient 1 to simply tell the truth about the relationship. Moreover, Dr. Liss testified that he knew that the missing document concerning the termination of the physician/patient relationship was important, and he had attempted to coax Patient 1 to remember it without telling her what it was, "trying to get that lightbulb, if you will, to turn on for her." Dr. Liss testified that she could not seem to recall it, but that she told him that her recent concussion had affected her memory. Finally, Dr. Liss testified that they discussed her recent injury. Dr. Liss denied that he had told Patient 1 how to testify. (Tr. at 460-464)

FINDINGS OF FACT

1. In the routine course of his practice, Richard W. Liss, M.D., undertook the treatment of Patient 1 in July 1994. Dr. Liss continued to treat Patient 1 through April 1996. Dr. Liss again undertook the treatment of Patient 1 in March 1998, and continued to treat Patient 1 through March 2001.

   The hearing record does not include medical records indicating that Dr. Liss provided medical care to Patient 1 for the period April 15, 1996 through March 3, 1998. Nevertheless, Dr. Liss testified that the periods of time during which he and Patient 1 had discontinued the physician/patient relationship to engage in a sexual relationship had not lasted long. Moreover, Patient 1's testimony suggests that there had not been *any* break in Dr. Liss' medical care for her. However, without some substantial evidence to the contrary, such as testimony concerning office visits or treatment that took place between April 1996 and March 1998, the evidence does not support a finding that Dr. Liss provided medical care to Patient 1 between April 15, 1996, and March 3, 1998.

2. The evidence supports a finding that Dr. Liss and Patient 1 had engaged in sexual conduct during the period from approximately March or April 1996 through at least 2000 or as late as 2001.

Dr. Liss asserted that he had not had a sexual relationship with Patient 1 at any time when he had been acting as her physician. Dr. Liss testified that, around April or May 1996, Patient 1 had signed and dated a piece of paper that said that she was terminating her physician/patient relationship with Dr. Liss, and that she and Dr. Liss were entering into a personal relationship. Dr. Liss further testified that this document had been kept in his patient record for Patient 1. Moreover, Dr. Liss testified that, later, when Patient 1 had wished to re-enter a physician/patient relationship with Dr. Liss, this same piece of paper had been used to document that Patient 1 and Dr. Liss were ending their personal relationship, and that Patient 1 was re-entering a physician/patient relationship with Dr. Liss. Finally, Dr. Liss testified that this scenario had been repeated at least twice, using the same piece of paper. Nevertheless, Dr. Liss could not produce that paper at hearing. Dr. Liss testified that that piece of paper had apparently been stolen, along with other medical records of his treatment of Patient 1 through April 1996.

However, Dr. Liss resumed his medical care of Patient 1 in March 1998 when he prescribed Valium to her, and had medical records in his possession covering his treatment of Patient 1 from December 1998 through April 2001. The medical record for that period contains no document signed by Patient 1 indicating that the physician/patient relationship had terminated. Nevertheless, Vincas Krompolcas testified that he had witnessed Dr. Liss and Patient 1 engaged in sexual activity in or around 2000. Moreover, Dr. Liss took Patient 1 with him to Dallas in 2000, and they shared a hotel room.

In addition, Patient 1 testified that she could not recall signing any paper that stated that she had ended her physician/patient relationship with Dr. Liss. Further, Patient 1 testified that she had met with Dr. Liss shortly before the hearing, and that he had told her or asked her to testify that she had signed such a document. Dr. Liss' response at hearing that he had not tried to influence Patient 1's testimony, and had merely tried to prod her memory, is not persuasive.

Moreover, Dr. Liss is not a credible witness. Dr. Liss testified during an April 2002 deposition that he had met Patient 1 in 1992, had had sexual intercourse with Patient 1 on four occasions in 1992, and that their sexual relationship had ended in late 1992—two years before Patient 1 became his patient. When confronted at hearing concerning the glaring inaccuracy of this testimony as compared to Dr. Liss's testimony at hearing, Dr. Liss stated that, during the deposition, he had become confused on the issue of dates because he did not have his complete medical record to review. In effect, Dr. Liss asked this Board at hearing to accept as truth that, in 2002, Dr. Liss could not recall having had a sexual relationship with Patient 1 that had lasted from 1996 through at least 2000, that had included trips that he and Patient 1 took together, and that had included cohabitation at some point between 1998 and 2000.

Furthermore, with regard to Dr. Liss' credibility as a witness, Dr. Liss testified at the April 2002 deposition that Patient 1's abuse of drugs had been a problem twenty years previously

when Patient 1 was a teenager. Dr. Liss further testified at the deposition that he had not been aware of any subsequent substance abuse problem for Patient 1, and that he would have had no way of knowing if any had existed. Dr. Liss also testified at the deposition that he had not known of any specific substances that Patient 1 had abused. Further, Dr. Liss testified at the deposition that he had not been aware that Patient 1 had ever been hospitalized for controlled substance withdrawal or treatment, and could not recall having received any treatment records from any facility concerning same. In fact, Dr. Liss's earlier medical record for Patient 1 contains voluminous records from other providers concerning Patient 1's abuse of drugs as recently as 1994, and include records of controlled substance withdrawal and treatment. Further, some records *written by Dr. Liss* in March 1996 address Patient 1's history of drug abuse, and note that she had ceased abusing drugs upon discovering she was pregnant—she was at 16 weeks gestation at that time. When questioned at hearing concerning the inaccuracy of his deposition testimony, Dr. Liss again testified that he had not had access to his earlier medical records for Patient 1, and that he had simply been unable to recall the facts. Such testimony is simply preposterous.

Accordingly, the evidence is sufficient to find that, during the course of Dr. Liss' treatment of Patient 1 for the period of approximately March or April 1996, and March 1998 through July 2000, Dr. Liss engaged in sexual conduct with Patient 1.

3.a. The evidence is insufficient to support a finding that Dr. Liss gave Patient 1 her patient record related to the period 1994 to 1996.

3.b. The evidence clearly indicates that Dr. Liss had failed to properly safeguard Patient 1's medical record. Accordingly, the evidence is sufficient to support a finding that Dr. Liss had failed to maintain a copy of his medical record for Patient 1 for the period 1994 to 1996.

4. Dr. Liss continued to prescribe Valium to Patient 1 despite his awareness of, and documented instances of, prior drug abuse and detoxification from Valium for Patient 1.

5. Dr. Liss' patient record for Patient 1 fails to reflect the following prescriptions issued by Dr. Liss for controlled substances:

Date	Drug	Quantity
03/03/98	Valium 5 mg	60
04/16/98	Valium 5 mg	60
02/11/99	Propoxyphene with APAP	5
02/13/99	Propoxyphene with APAP	5

Date	Drug	Quantity
02/15/99	Propacet 10/650 mg	20
02/16/99	Phenobarbital 30 mg	10
02/18/99	Phenobarbital 30 mg	60
09/21/99	Diazepam 10 mg	60
10/16/99	Diazepam 10 mg	90
10/21/99	Diazepam 10 mg	90
03/04/00	Diazepam 10 mg	50
03/11/00	Diazepam 10 mg	50

CONCLUSIONS OF LAW

1. As set forth in Findings of Fact 1, 2, 3b, 4, and 5, Richard W. Liss, M.D., undertook the care and treatment of Patient 1. While Patient 1 was under his treatment, Dr. Liss engaged in sexual conduct with Patient 1. Further, Dr. Liss continued to prescribe Valium to Patient 1 despite his awareness of, and documented instances of, prior drug abuse and detoxification from Valium for Patient 1. Finally, Dr. Liss issued prescriptions for controlled substances to Patient 1 without documenting such prescriptions in his medical record for that patient.

   Overwhelming evidence was presented by the State that sexual conduct with a patient, and failure to record prescriptions for controlled substances in a patient's medical record, fall below the minimal standards of care.

   With regard to Dr. Liss' prescribing of Valium to Patient 1, the evidence is undisputed that Patient 1 had a history that extends back to her childhood of abusing alcohol and drugs, including Valium. Further, she had been hospitalized for detoxification from Valium and other substances. Dr. Liss had been aware of this history early in his treatment of Patient 1. The State's expert testified that, without specialized training, an internal medicine physician lacks the expertise necessary to treat a patient such as Patient 1 with her drug of choice. Dr. Liss, an internal medicine physician, had had no such specialized training. Moreover, complicating the matter further, Dr. Liss entered into a sexual relationship with Patient 1 in 1996. Dr. Liss' own expert testified that, if a physician were having a sexual relationship with a patient, it could potentially interfere with the physician's ability to treat the patient objectively, and would make it more difficult to prescribe such medication.

   Dr. Liss argued that he had been able to appropriately treat Patient 1's anxiety and post traumatic stress disorder with Valium. Dr. Liss testified concerning his disdain for most psychiatrists, and his belief that he had been able to treat all but the sickest psychiatric patients. Dr. Liss further testified that his intimate relationship with Patient 1 had actually *enhanced* his ability to treat her psychiatric problems. Such testimony is ludicrous.

Dr. Liss further testified that he had carefully monitored Patient 1's use of Valium. Nevertheless, the evidence indicates that, in October 1999, he had issued two prescriptions to Patient 1 for Valium 10 mg #90 within five days of each other. In addition, Dr. Liss testified that he had often asked Patient 1 if she were abusing any substances, and presumably had trusted her responses that she was not. Nevertheless, Dr. Liss had clearly been unable to monitor Patient 1's intake of other substances—for example, on January 14, 2000, Dr. Liss issued a prescription to Patient 1 for Valium 10 mg #50 with two refills. Five days earlier, Patient 1 had been seen at Grant Hospital where she told a nurse that she had drunk a fifth of moonshine. Furthermore, although Dr. Liss asserted that Patient 1 had never exhibited drug-seeking behavior, other evidence indicates that her insistence that Valium had been the only medication that relieved her anxiety symptoms may *itself* have been drug-seeking behavior. Finally, Patient 1 testified that she had sought Valium from Dr. Liss, had continued to abuse drugs during Dr. Liss's treatment of her, and that Dr. Liss had been aware of her continued abuse of drugs.

Accordingly, the conduct of Dr. Liss, as set forth in Findings of Fact 1, 2, 4, and 5, constitutes "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

2. The conduct of Dr. Liss, as set forth in Findings of Fact 2, constitutes "[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations as are determined, by rule, by the state medical board," as that clause is used in Section 4731.22(B)(18), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Principles I, II, and IV of the American Medical Association Principles of Medical Ethics.

3. The conduct of Dr. Liss, as set forth in Findings of Fact 2, constitutes "[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule," as that clause is used in Section 4731.22(B)(18), Ohio Revised Code, to wit: Principles I, II, and IV of the American Medical Association Principles of Medical Ethics.

4. Rule 4731-11-02(D), Ohio Administrative Code, requires that patient medical records accurately reflect the utilization of any controlled substance used to treat a patient, as well as the diagnosis and purpose for which the controlled substance is used. Accordingly, the conduct of Dr. Liss, as set forth in Findings of Fact 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.

5. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, Dr. Liss' violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

* * * * *

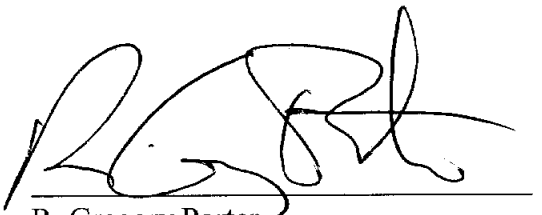
Dr. Liss' sexual conduct with a patient, inappropriate prescribing of Valium to that patient, and failure to record prescriptions for controlled substances in that patient's medical record merits the severest sanction.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Richard W. Liss, 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.



R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

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

EXCERPT FROM THE DRAFT MINUTES OF JANUARY 14, 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 record, the proposed findings, conclusions, and order, and any objections filed in the matters of: Mark L. Allen, M.D.; Glenda M. Dahlquist, M.D.; Joseph W. Fischkelta, P.A.; Timothy A. Gooden, M.D.; Richard W. Liss, M.D.; Larry John Little, M.D.; and Geoffrey D. Snyder, M.D. A roll call was taken:

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

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.

.....

RICHARD W. LISS, M.D.

.....

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF RICHARD W. LISS, M.D. DR. ROBBINS SECONDED THE MOTION.

.....

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

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	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.

State Medical Board of Ohio

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

January 8, 2003

Richard W. Liss, M.D.
5489 Tinsbury Ct.
Columbus, OH 43235

Dear Doctor Liss:

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) In the routine course of your practice, you undertook the treatment of Patient 1 (as identified on the attached Patient Key- Key confidential to be withheld from public disclosure) in or about 1994 and you continued to treat Patient 1 up to and including 2001.

(a) During the course of your treatment of Patient 1, you engaged in sexual conduct with Patient 1 during the period of approximately April 1996 through July 2000.

(b) You gave Patient 1 her patient record related to the period 1994 to 1996 and failed to maintain a copy of that record.

(c) You continued to prescribe Valium to Patient 1 despite your awareness of and documented instances of prior drug abuse and detoxification from Valium for Patient 1.

(2) Your patient record for Patient 1 fails to reflect the following prescriptions issued by you for controlled substances:

Date	Drug	Quantity
03/03/98	Valium 5 mg.	60
04/16/98	Valium 5mg.	60
02/11/99	Propoxyphene with APAP	5
02/13/99	Propoxyphene with APAP	5
02/14/99	Phenobarbital 30 mg.	10
02/15/99	Propacet 10/650 mg.	20
02/16/99	Phenobarbital 30 mg.	10

Mailed 1-9-03

02/18/99	Phenobarbital 30 mg.	60
09/21/99	Diazepam 10 mg.	60
10/16/99	Diazepam 10 mg.	90
10/21/99	Diazepam 10 mg.	90
03/04/00	Diazepam 10 mg.	50
03/11/00	Diazepam 10 mg.	50

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further your acts, conduct, and/or omissions as alleged in paragraph (1)(a) above that occurred prior to March 9, 1999, individually and/or collectively, constitute "[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations as are determined, by rule, by the state medical board," as that clause is used in Section 4731.22(B)(18), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Principles I, II, and IV of the American Medical Association's Principles of Medical Ethics.

Further, your acts, conduct, and/or omissions as alleged in paragraph (1)(a) above that occurred on or after March 9, 1999, individually and/or collectively, constitute "[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule," as that clause is used in Section 4731.22(B)(18), Ohio Revised Code, to wit: Principles I, II, and IV of the American Medical Association's Principles of Medical Ethics.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: 4731-11-02 (D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code.

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

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is

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

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

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, effective March 9, 1999, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Anand G. Garg, M.D.
Secretary

AGG/blt
Enclosures

CERTIFIED MAIL # 7000 0600 0024 5150 7827
RETURN RECEIPT REQUESTED

cc: Douglas C. Boatwright, Esq.
The Midland Building
250 East Broad Street
Columbus, OH 43215-3742

CERTIFIED MAIL # 7000 0600 0024 5150 7834
RETURN RECEIPT REQUESTED

STATE OF OHIO
THE STATE MEDICAL BOARD OF OHIO
77 SOUTH HIGH STREET
17th FLOOR
COLUMBUS, OHIO 43215

September 14, 1990

Richard W. Liss, M.D.
2391 W. Broad Street
Columbus, Ohio 43204

Dear Doctor Liss:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Joan Irwin Fishel, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of the Minutes of the State Medical Board, meeting in regular session on September 12, 1990, including Motions approving and confirming the Reoort and Recommendation as the Findings and Order of the State Medical Board.

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

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

THE STATE MEDICAL BOARD OF OHIO

Henry G. Cramblett, M.D.
Secretary

HGC:em
Enclosures

CERTIFIED MAIL RECEIPT NO. P 290 319 163
RETURN RECEIPT REQUESTED

cc: Philip R. Bradley, Esq.
Richard D. Topper, Esq.

CERTIFIED MAIL NO. P 290 319 164
RETURN RECEIPT REQUESTED

Mailed 9/18/90

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *

*

RICHARD W. LISS, M.D. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio the 12th day of September, 1990.

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

It is hereby ORDERED:

That Richard W. Liss, M.D., be placed on probation for a period of three (3) years under the following terms and conditions:

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

2. Dr. Liss shall submit quarterly declarations under penalty of perjury stating whether there has been compliance with all the conditions of probation;

3. Dr. Liss shall appear in person for interviews before the full Board or its designated representative at six (6) month intervals, or as otherwise directed by the Board:

4. In the event that Dr. Liss should leave Ohio for three (3) continuous months, or reside or practice outside the state, Dr. Liss must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of this probationary period;

Richard W. Liss, M.D.

5. Dr. Liss shall complete at least one program per year for each year of the probationary period of approved Category I Continuing Medical Education related to the violations noted in this decision. The exact number of hours per year shall be detemined by the Board or its designee and shall not total less than 25. These programs shall be in addition to the Continuing Medical Education requirements for relicensure. The programs shall be submitted to the Board or its designee for prior approval. Dr. Liss shall provide documentary proof satisfactory to the Board of successful completion of these courses.

6. Upon successful completion of probation, Dr. Liss' certificate will be fully restored.

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

(SEAL)

Henry G. Cramblett, M.D.
Secretary

September 18, 1990
Date

REPORT AND RECOMMENDATION
IN THE MATTER OF RICHARD W. LISS, M.D.

The Matter of Richard W. Liss, M.D., came on for hearing before me, Joan Irwin Fishel, Esq., Attorney Hearing Examiner for the State Medical Board of Ohio, on June 19 and 20, 1990.

INTRODUCTION AND SUMMARY OF EVIDENCE

I. Basis for Hearing

A. By letter dated January 10, 1990 (State's Exhibit #3), the State Medical Board notified Richard W. Liss, M.D., that it proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio due to his prescribing of controlled substances for Patient #1, (identified in a Patient Key which has been sealed to protect patient confidentiality), for complaints of sinusitis, low back pain, sciatica, and a fall on the ice. The Board alleged that Dr. Liss' acts, conduct, and/or omissions constituted;

1. "Failure to use reasonable care discrimination in the administration of drugs", and "failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease", as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code; and

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

B. By letter received by the State Medical Board on January 23, 1990 (State's Exhibit #4), Philip R. Bradley, Esq., requested a hearing on Dr. Liss' behalf.

II. Appearances

A. On behalf of the State of Ohio, Attorney J. Celebrezze, Jr., Attorney General, by John C. Dowling, Assistant Attorney General

B. On behalf of the Respondent: Philip R. Bradley, Esq., and Richard D. Topper, Esq.

III. Testimony Heard

A. Presented by the State

1. Karen Ann Glasgow, M.D., by deposition in lieu of live testimony taken on March 7, 1990

2. Richard W. Liss, M.D., as on cross-examination

B. Presented by the Respondent

1. Richard W. Liss, M.D.

2. Patient #1 by video deposition in lieu of live testimony taken on April 23, 1990

3. William H. Sweet, M.D., by video deposition in lieu of live testimony taken on June 8, 1990

4. Laurens Park White, M.D.

5. James A. Hardy, M.D.

6. Donald Stanslovski, Ph.D.

IV. Exhibits Examined

In addition to those listed above, the following exhibits were identified and admitted into evidence in this Matter:

A. Presented by the State

* 1. State's Exhibit #1: Dr. Liss' patient record for Patient #1 as subpoenaed by the State and covering the time period of February 5, 1985 through July 7, 1988.

2. State's Exhibit #2: Curriculum vitae of Karen Ann Glasgow, M.D.

3. State's Exhibit #5: January 24, 1990 letter to Attorney Bradley from the State Medical Board advising that a hearing initially set for February 5, 1990, was postponed pursuant to Section 119.09, Ohio Revised Code.

4. State's Exhibit #6: January 26, 1990 letter to Mr. Bradley from the State Medical Board scheduling the hearing for March 13, 1990.

5. State's Exhibit #7: Entry dated February 15, 1990 granting the State's request to take the deposition in lieu of live testimony of Karen Ann Glasgow, M.D.

6. State's Exhibit #8: Entry dated February 27, 1990 granting the Respondent's continuance request and rescheduling this Matter for April 10, 1990.

7. State's Exhibit #9: Entry dated March 22, 1990 ordering the deposition in lieu of live testimony via telephone of Patient #1, continuing the Matter until June 19, 1990, and further ordering that any future depositions in lieu of live testimony be conducted in person in Franklin County, Ohio.

8. State's Exhibit #10: Entry dated April 12, 1990 granting the Respondent's request to take the deposition in lieu of live testimony of William Sweet, M.D.

9. State's Exhibit #11: Transcript of the deposition in lieu of live testimony of Karen Ann Glasgow, M.D.

B. Presented by the Respondent

1. Respondent's Exhibit A: Curriculum vitae of Laurens Park White, M.D.

* 2. Respondent's Exhibit B: Type-written copy of Dr. Liss' patient record for Patient #1 from the period February 5, 1985 through February 18, 1989. In additiion to the office notes from July 7, 1988 through February 18, 1989 that are within State's Exhibit #1, this exhibit also includes a copy of the January 10, 1990 citation letter sent to Dr. Liss by the Board, a letter from Dr. Mechenbier dated February 2, 1987, an x-ray report from December 31, 1988, and a referral report from Dr. James A. Mechenbier, dated January 25, 1989. The notes from Dr. Mechenbier contain an additiional entry for January 25, 1989.

3. Respondent's Exhibit C: A chart prepared by Dr. Stanslovski, wherein he converted the narcotic properties of the controlled substances prescribed to Patient #1 by Dr. Liss into their equivalent of Tylenol #3 tablets. The chart shows the equiavlent amount of Tylenol #3 tablets made available to Patient #1 per day.

4. Respondent's Exhibit D: Compilation of articles to which Dr. Liss testified that he had referred either during or after his treatment of Patient #1, including: a.) "Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases", R. Portenoy, M.D., and K. M. Foley, M.D., Pain, Vol. 25, 1986; b.) "Long-Term Use of Narcotic Analgesics in Chronic Pain", R. D. France, B. J. Urban, and F. J. Keefe, Soc. Sic. Med., Vol. 19, No. 12, 1984; c.) "Narcotic Maintenance for Chronic Pain, Medical and Legal Guidelines", F. S. Tennant, Jr., M.D., D.P.H., and G. S. Uelmen, J.D., Postgraduate Medicine, Vol. 73, No. 1, 1983; d.) "Concepts in Pain Control", T. G. Kantor, Seminars in Arthritis and Rheumatism, Vol. 18, No. 4, 1989; e.) "The Tragedy of Needless Pain", R. Melzack, Scientific American, Vol. 262, No. 2, 1990.

5. Respondent's Exhibit E: Compilation of articles referred to by Dr. William Sweet during his testimony, including: a.) "Opioids in the Treatment of Chronic Nonmalignant Pain", Surgical Practice News-Current Issues in Pain Management, Vol. 9, No. 7, 1988; b.) "Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases", R. Portenoy, M.D., and K. M. Foley, M.D., Pain, Vol. 25, 1986; c.) Collection of tables regarding

the research of A. Bouckums; d.) "The Tragedy of Needless Pain", R. Melzack, Scientific American, Vol. 262, No. 2, 1990; e.) "Opioid Analgesics in the Treatment of Chronic Intractable Pain of Non-Neoplastic Origin", A. Taub, M.D., Ph.D., Chapter 10, Narcotic Analgesics in Anesthesiology, L. Kitahata and R. Collins, Williams and Wilkins, 1982; f.) Draft copy of "Opioid Therapy in the Management of Chronic Back Pain", R. K. Portenoy, M.D., 1988.

6. Respondent's Exhibit F: Hand-written summary of the testimony of Karen Glasgow, M.D., prepared by Richard Topper, Esq.

7. Respondent's Exhibit G: Curriculum vitae of Richard W. Liss, M.D.

8. Respondent's Exhibit H: Transcript of the deposition in lieu of live testimony of Patient #1, taken on April 23, 1990.

9. Respondent's Exhibit I: Transcript of the deposition in lieu of live testimony of William H. Sweet, M.D., taken on June 8, 1990.

10. Respondent's Exhibit J: Video tape of the deposition in lieu of live testimony of Patient #1 taken on April 23, 1990.

11. Respondent's Exhibit K: Video tape (two volumes) of the deposition in lieu of live testimony of William H. Sweet, M.D., taken on June 8, 1990.

NOTE: THE ABOVE EXHIBITS MARKED WITH AN ASTERISK (*) HAVE BEEN SEALED TO PROTECT PATIENT CONFIDENTIALITY

C. Hearing Exhibits

1. Hearing Exhibit #1: Respondent's Motion to Dismiss, filed with the Board on June 15, 1990.

2. Hearing Exhibit #2: Excerpt from the 1986 Physician's Desk Reference (PDR) for Percocet, admitted on the Hearing Examiner's own motion.

3. Hearing Exhibit #3: Excerpt from the 1987 PDR for Demerol, admitted on the Hearing Examiner's own motion.

4. Hearing Exhibit #4: Excerpt from the 1987 PDR for Valium, admitted on the Hearing Examiner's own motion.

FINDINGS OF FACT

1. Richard W. Liss, M.D., treated Patient #1 (so identified to protect patient confidentiality) between February 5, 1985 and February 18, 1989. The patient's main complaint during this period was chronic sinusitis. An important secondary complaint was occasional flare-ups of lower back pain. From May 16, 1985 through January 28, 1987, Dr. Liss' treatment for these two complaints included the prescribing of various controlled substances for pain. A comparison of Dr. Liss' patient record (State's Exhibit #1 and Respondent's Exhibit B) and the State's citation letter (State's Exhibit #3), indicates that with the following corrections, the State's citation letter lists the totality of Dr. Liss' prescribing of controlled substances for Patient #1:

   a. Delete the prescription of Percocet on 3/20/85. Though Percocet is noted in the patient record for that date, it is not clear whether it had been prescribed by Dr. Liss and Dr. Liss was not questioned regarding it at hearing;

   b. Delete the prescription of Percocet on 4/10/85;

   c. Add a prescription of 30 Percocet for 6/15/85;

   d. Add a prescription of 50 Percocet on 2/12/86;

   e. Change the amount of 50 Percocet on 7/13/86 to 30;

   f. Change the amount of 50 Percocet for 10/1/86 to 30;

   g. Add a prescription of 50 Percocet on 10/18/86;

   h. Delete one of the prescriptions for 50 Percocet on 11/18/86;

   i. Indicate that the prescription of 50 Demerol for 12/8/86 included one refill;

   j. Change the amount of 30 Demerol on 12/31/86 to 20;

   k. Delete the two prescriptions noted for 1/6/87;

   l. Change the amount of 30 Valium on 1/11/87 to 50.

   With those corrections and additions, the total amount of controlled substances prescribed by Dr. Liss to Patient #1 during an approximate 19-month period are as follows:

Sched. II Analg.	Sched. III Analg.	Sched. IV Analg.	Sched. IV Anxiolytic
Percocet 1,745 d.u.	Tylenol #3 & #4 90 d. u.	Darvocet N-100 50 d.u.	Valium 690 d.u.
Demerol 880 d.u.	Vicodin 50 d.u.	Darvon 30 d.u.	

These facts are established by an examination of State's Exhibit #1 and Respondent's Exhibit B.

2. Percocet is a Schedule II narcotic analgesic with a principal ingredient of oxycodone. According to the Physician's Desk Reference (PDR), Percocet is indicated for the relief of moderate to severe pain with a recommended adult dosage of one tablet every six hours as needed for pain. Demerol is a Schedule II narcotic analgesic generally known as meperidine hydrocloride. According to the PDR, Demerol is indicated for the relief of moderate to severe pain, with a recommended adult dosage of 50 mg. to 150 mg. every three or four hours. With both Percocet and Demerol, dosage should be adjusted according to the severity of the pain and the response of the patient. The PDR also notes that dosages for Percocet may occasionally exceed the recommended dosage in those patients who have become tolerant to the analgesic effect of nacotics. With both substances the PDR warns of drug dependence and the potential for abuse with the possible development of psychic dependence, physical dependence and tolerance upon repeated administration. The PDR further warns that Demerol should be used with great caution and in reduced dosage in patients receiving other narcotic analgesics because of the risk of respiratory depression, hypotension and profound sedation or coma.

   According to the PDR, Valium is a Schedule IV anxiolytic indicated for the short term relief of anxiety. It can also be used as an adjunct for relief of muscle spasm. The usual adult daily dosage is 2 mg. to 10 mg., 2 to 4 times daily. The PDR cautions against using more than one central nervous system depressant, such as Percocet, Demerol, or Valium at the same time because of an addictive effect.

   These facts are established by Hearing Exhibits #2, #3, and #4.

3. From January 1985 through June 1987, Patient #1, a 1982 graduate of the medical school at the University of Dominica in the British West Indies, was in a psychiatric residency at a hospital in Columbus, Ohio. Patient #1 had also done his internship in Columbus. In 1987, Patient #1 had been appointed the chief resident out of twelve in his residency. In April 1989, Patient #1 left Columbus to begin working at a hospital in Vancouver, Washington. Patient #1 currently serves as assistant medical director at that hospital and is one of the main consultants on the substance abuse unit at another hospital.

   Patient #1 and Dr. Liss had met in 1981 and by the time that Dr. Liss had begun treating Patient #1 they had become good friends. They saw each other socially about once every two weeks and also saw each other occasionally during the course of their various professional responsibilities.

   These facts are established by the testimony of Patient #1 (Respondent's Exhibit H, pgs. 9, 11-15, 19).

4. Since at least 1970, Patient #1 has suffered from chronic sinusitis. The condition had originally been diagnosed following Patient #1's examination for the draft. As a result of this diagnosis, Patient #1 received a 4F deferment making him completely ineligible for military service. Patient #1 testified that while he had lived in Ohio he had suffered frequent acute attacks of the sinusitis. He testified that various physicians had told him that the seasonal temperature and pressure changes in Ohio contributed to these attacks and that they also could be related to his strong history of allergies. He further testified that at the time Dr. Liss initiated narcotic treatment, the attacks had been more severe than in the past.

   Patient #1 had received treatment on numerous occasions for his chronic sinusitis prior to seeking treatment from Dr. Liss, including treatment with Dr. James Mechenbier. Treatment over the years had consisted of anti-biotics, decongestants, antihistamines, non-steroidal anti-inflammatory drugs, and occasional narcotic analgesics. Numerous x-rays had been taken. Reports for x-rays done in 1981 and 1982 are part of the patient record. Patient #1 testified that various doctors had recommended surgery, specifically the Caldwell-Luc procedure, and a move to a different climate, both of which he found to be unacceptable suggestions. Patient #1 had resisted the Caldwell-Luc procedure because he had felt it was a fairly invasive and excessive procedure with a low success rate. Others had recommended that he not undergo the procedure.

   During Patient #1's acute sinusitis attacks, he would suffer eye pain on both sides of his face, ear pain and ear pressure, facial pain above and below the eyes and in the cheeks. This pain would often affect his ability to sleep making it difficult to concentrate while listening to his psychiatric patients. Patient #1 described the effect of an acute attack on his job performance as dramatic. On a scale of 1 to 10, with 1 representing a pain-free state and 10 representing absolutely incredible pain, Patient #1 rated the pain he suffered during these acute attacks as an 8.

   Objective signs of this pain, as noted by Dr. Liss in the patient record, were pain to palpation, an inability to transilluminate the sinuses, peridontal swelling, retraction of both tympanic membranes, rigidity of neck muscles and multiple lymph nodes.

   These facts are established by the tesimony of Patient #1 (Respondent's Exhibit H pgs. 20-33) and by the testimony of Dr. Liss (Tr. II 50-52, 76).

5. Patient #1 also sought treatment from Dr. Liss for lower back pain. His first complaint of lower back pain was September 13, 1985. Patient #1 testified that he had originally injured his lower back during his internship. He had been on an examination table giving a patient CPR. When he had finished, he attempted to step down onto a stool only to discover that the stool had been removed.

Dr. Liss testified that Patient #1's low back pain had been objectively documented by tenderness to palpation, spasms, straight leg raises, range of motion tests, an EMG and x-rays.

These facts are established by the testimony of Patient #1 (Respondent's Exhibit H pgs. 36-37), the testimony of Dr. Liss (Tr. Vol II 77-78), State's Exhibit #1 and Respondent's Exhibit B.

6. For the first four months of treatment of Patient #1's chronic sinusitis, Dr. Liss tried various antibiotics, non-steroidal anti-inflammatory drugs, and decongestants, including: Amoxil, Ceclor, Entex LA, Motrin, and PCN VK 250. Patient #1 had continued to suffer acute attacks of the sinusitis and had had minimal pain relief with these treatments.

   These facts are established by State's Exhibit #1, Respondent's Exhibit B, and by the testimony of Dr. Liss (Tr. II 24).

7. The first prescription by Dr. Liss of a narcotic analgesic for pain control was on May 16, 1985. Dr. Liss recorded physicial findings of sinus pain and congestion and a continuation of right-sided tooth pain. In addition to instructing Patient #1 to continue with the antibiotics, Dr. Liss gave him ten samples of Tylenol #3. The record also reflects that Patient #1 rejected Dr. Liss' suggestion of allergy testing.

   These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

8. Two office visits later, on June 2, 1985, Patient #1 complained of pain for the last 24 hours which had resulted in no sleep. Dr. Liss found a possible tooth abscess. Following his examination, Dr. Liss prescribed penicillin, and 50 Percocet to be taken every six hours.

   These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

9. At office visits of June 15, 1985, July 15, 1985, August 26, 1985 and August 30, 1985, after engaging in a physical examination of the patient, Dr. Liss prescribed Percocet for Patient #1's pain. He also continued to prescribe antibiotics for the sinusitis. The patient record for August 30, 1985 indicates that Patient #1 had used up half of the prescription for 50 Percocet he had received just four days earlier. This reflects a usage of approximately six Percocet per day. Dr. Liss advised a consultation with an ear, nose and throat specialist.

   These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

10. On September 13, 1985 the patient record reflects a complaint of lower back pain. A physical examination was done and Dr. Liss noted lumbar spasms and a decreased range of motion. He advised heat and rest and prescribed 30 Valium 5 mg. to be taken every six hours. He also wrote a prescription for 50 Percocet though it is not clear if this was for back pain, sinus pain, or both. No complaints of sinus pain are noted.

    On December 12, 1985 Patient #1 complained of having wrenched his back. The back pain continued to be noted for the next two office visits of December 19, 1985 and December 30, 1985. The prescription total for these three examinations was 10 Flexeril, 90 Percocet, and 50 Valium 5 mg.

    Dr. Liss testified that all the Valium prescribed throughout his treatment of Patient #1 was for muscle spasms and not to potentiate the effect of the narcotics.

    These facts are established by State's Exhibit #1, Respondent's Exhibit B, and by the testimony of Dr. Liss (Tr. II 88).

11. From the outset of his treatment of Patient #1, Dr. Liss had advised him to see a dentist regarding a tooth that had been causing him pain. At sometime in early January 1986, Patient #1 did finally have the tooth extracted. Unfortunately, during the extraction a large part of the tooth root migrated up into the maxillary sinus where it became impacted, necessitating surgery. On January 14, 1986, Patient #1 underwent a Caldwell-Luc procedure by Dr. John Cheek for removal of the tooth root.

    Dr. Cheek's office records, (which are included as part of the patient record in this Matter), indicate that Patient #1 had told him that he had been taking Percocet.

    On the day of surgery, Dr. Cheek prescribed 30 Percocet for Patient #1. The following day he prescribed 30 Dilaudid 2 mg. On that same day, Dr. Liss prescribed 30 Percocet and 30 Demerol 50 mg. for Patient #1. On January 16 Dr. Cheek prescribed 50 Demerol 100 mg. and 50 Percocet. On January 18, Patient #1 reported no pain relief and Dr. Liss prescribed 50 Percocet and 100 Demerol. On January 21, Dr. Cheek prescribed 30 Percocet. On January 25, Dr. Liss prescribed 50 Darvocet N-100 and 30 Darvon.

    Dr. Liss testified that Patient #1 had told him he had received prescriptions for pain medications from Dr. Cheek but that they had not been effective. Patient #1 testified that he had not tolerated the Dilaudid or the Demerol well. The patient record for January 16 notes only "no relief with any meds at home." There is no indication, however, that either doctor knew of the full extent of the other's prescribing. Between the two physicians Patient #1 was provided with a total of 400 dosage units of Schedule II narcotic analgesics in an eleven day period.

    These facts are established by State's Exhibit #1, Respondent's Exhibit B, the testimony of Patient #1 (Respondent's Exhibit H, pg. 47) and by the testimony of Dr. Liss (Tr. Vol. II 38).

12. Dr. Liss testified that Patient #1 did not take the narcotic pain medication everyday. His pattern of usage depended upon the sinus flare-ups and generally was as follows in a 30-day period: Day one through day 10, days of an acute flare-up, Patient #1 would take 5 to 7 Percocet a day; as the pain lessened, anywhere from the next 3 to 4 days, Patient #1 would take 2 to 3 Percocet per day; Patient #1 would then go off the Percocet completely and use only aspirin for one to two weeks. With the possibility of another flare-up toward the end of the month, it was not uncommon for Patient #1 to use a total of 80 Percocet during a 30-day period.

    These facts are established by the testimony of Dr. Liss (Tr. II 26).

13. On March 8, 1986 Dr. Liss decided to try aggressive analgesia with rapid weaning. Previous Percocet prescriptions from Dr. Liss had instructed Patient #1 to take a tablet every 4 to 6 hours or every 6 hours. With the prescription given on March 8, 1986 Dr. Liss instructed Patient #1 to take 2 Percocet every 6 hours for 48 hours, followed by one Percocet every 4 hours for 48 hours, followed by one Percocet every 6 hours for 48 hours, and finishing with one Percocet every 6 hours as needed for pain.

    These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

14. Also on March 8, 1986, Patient #1 telephoned Dr. Liss expressing a desire not to take so much Percocet. Dr. Liss telephoned a prescription to the pharmacy for 50 Tylenol #4 but did not rescind the earlier Percocet prescription. Both Dr. Liss and Patient #1 testified that Patient #1 had not tolerated Tylenol very well; the codeine had made him nauseous.

    These facts are established by State's Exhibit #1, Respondent's Exhibit B, the testimony of Dr. Liss (Tr. Vol. II 15) and by the testimony of Patient #1 (Respondent's Exhibit H, pg. 45).

15. Following the March 8, 1986 visit, Dr. Liss began to note in the patient record both his and the patient's discomfort with the amount of Percocet needed for pain relief. On March 22, 1986 Dr. Liss notes that he wants to try to get the patient off of Percocet because it is not really helping. On that day he prescribed 50 Vicodin. By the next visit, on March 29, 1988, Patient #1 reported that he was trying to decrease the Percocet but that it helped the best. Fifteen Percocet were prescribed. On April 5, 1986, after an increase in pain with no relief from non-steroidals and Tylenol, Dr. Liss prescribed 30 Demerol 100 mg. and urged the patient to follow-up with an ear, nose and throat specialist.

    Patient #1 did not get another narcotic prescription until June 6, 1986 when Dr. Liss prescribed 50 Demerol 100 mg. On June 15, 1988, Dr. Liss noted "try to get off narcotics" and did not prescribe any Percocet or Demerol. Two days later, Dr. Liss told Patient #1 he did not want to use Demerol and the patient agreed. Thirty Tylenol #4 were prescribed.

Again, the patient was told to see the ENT and he seemed more receptive to the possibility of surgery. Percocet prescriptions were resumed on June 22, 1986 when Dr. Liss noted in the patient record "Plan: ENT!!!"

These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

16. Patient #1 saw Dr. Clifton Hood, an ear nose and throat specialist, on or about June 24, 1986. The only record of this examination is a letter from Dr. Hood to Dr. Liss which is included in the patient record. That letter reports that Patient #1 was suffering a slight hearing loss because of his sinus congestion. Dr. Hood's letter notes no knowledge of Patient #1's use of narcotic analgesics. Dr. Hood contemplated the need for a myringotomy, a surgical procedure to relieve ear pressure and hoped to examine Patient #1's hearing loss again in three to six months.

    These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

17. During July 1986, Patient #1 received a total of five Percocet prescriptions from Dr. Liss for a total of 190 dosage units. On July 13 Dr. Liss noted Patient #1 was using a lot of Percocet. On July 19 he noted "I'm running out of ideas to control the pain!" On July 29 he noted that Patient #1 was to follow-up with Dr. Hood.

    These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

18. There were four Percocet prescriptions and one Demerol prescription during August 1986 for a total of 150 dosage units of narcotic analgesics. On August 11 Dr. Liss noted "I'm really running out of suggestions." He even suggested Patient #1 move to Arizona. On August 21 Dr. Liss noted "little relief with pain meds (habituated by now). To get off Percocet." On August 25 Dr. Liss noted "using up to 6 Percocet with minimal relief!?"

    These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

19. Patient #1 was back down to 3 to 4 Percocet per day by September 5, 1986. However, he was still reporting marginal pain relief. Dr. Liss prescribed 30 Percocet that day. On September 20, 1986 the pain was such that Patient #1 would hardly let Dr. Liss examine him. Fifty Percocet were prescribed with a notation that the patient was to follow-up with Dr. Hood.

    These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

20. Patient #1 again promised to see Dr. Hood on October 1, 1986. The physical examination this day was unchanged and Patient #1 received a prescription from Dr. Liss for 30 Percocet. Sometime before October 23, Patient #1 did see Dr. Hood. There is no record of this visit within Patient #1's patient record, but Patient #1 did testify that Dr. Hood found a mryingotomy to be unnecessary because of decreased hearing loss. No narcotics were prescribed on this visit.

    These facts are established by State's Exhibit #1, Respondent's Exhibit B, and by the testimony of Patient #1, (Respondent's Exhibit H, pg. 49).

21. On October 28, 1986 Patient #1 reported that he had been lifting heavy objects and developed a sudden pain down his leg to his knee. Dr. Liss noted certain physical findings and prescribed 50 Valium 5 mg. along with 50 Percocet. An x-ray was done around this time. The back pain continued and another Percocet prescription was given on November 5. The next visit on November 9 notes that with the sinus and back pain, Patient #1 was using 4 to 12 medications per day. Dr. Liss recommended that Patient #1 see a pain specialist, Dr. David Leak. The total controlled substances prescribed in November 1986 were 410 dosage units.

    These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

22. In November 1986, Dr. Liss began discussing with Patient #1 his tolerance to the Percocet. Dr. Liss was dissatisfied with the amount of the drug that was needed to achieve pain control. On November 18, 1986, the patient reported that in two days he had taken about half of the prescription for 50 Percocet that he had received on November 11. On November 28 the patient reported that he was using 10 Percocet a day. On this day, Dr. Liss instructed Patient #1 to try Demerol 100 mg. in place of the Percocet. Until Dr. Liss' prescribing of narcotic analgesics for Patient #1 ended in late 1987, Demerol was prescribed instead of Percocet.

    These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

23. Dr. Liss testifed that he had switched to Demerol because he had wanted to control Patient #1's pain with the lowest possible narcotic dose. He further testified that Demerol has less narcotic than Percocet but the same analgesic effect. After switching to a lesser narcotic, Dr. Liss hoped to get Patient #1 off of narcotics completely.

    These facts are established by the testimony of Dr. Liss (Tr. II 14, 17-19).

24. During the month of December 1986, Dr. Liss prescribed 280 dosage units of Demerol for Patient #1. On December 8, Dr. Liss reported that Patient #1 was totally off the Percocet. The Demerol was working and he urged Patient #1 to see Dr. Leak; 50 Demerol were prescribed. An EMG was done on December 9, 1986. The next visit was December 14 when sinus symptoms

were noted along with continuing back/leg pain; 30 Demerol were prescribed. A painful "knot" in the leg was reported by Patient #1 on December 17 and Dr. Liss prescribed 50 Valium 10 mg. and 50 Demerol 100 mg. A follow-up with Dr. Leak was recommended. On December 22, despite the fact that the knot was gone, the back pain was better, and no sinus symptoms were noted, Patient #1 received a prescription for 50 Demerol 100 mg. The patient had not seen Dr. Leak. A return of the back pain, precipitated by lifting done by Patient #1 over Christmas, was reported on December 27. A spine CT was done that day. Fifty Valium and 50 Demerol were prescribed by Dr. Liss along with a long talk regarding pain medications. The plan was to decrease the Demerol to 50 mg., than to stop using it. On December 31, no back or sinus pain was reported, however, 20 Demerol were prescribed. Two days later Patient #1 returned because he had fallen on the ice. He had a bruised right hip, spasms, and pain. Dr. Liss considered a repeat EMG and a hip x-ray. He prescribed 50 Demerol 100 mg.

The pain was not as severe but continuing on January 11. Patient #1 had decreased his Demerol use by about half and had agreed to contiune decreasing to the point where he was exclusively using non-steroidal, anti-inflammatory drugs. He was prescribed 50 Valium and 50 Demerol. On January 26, Patient #1 reported to Dr. Liss that he was feeling worse. Thirty Demerol, accompanied by a strong recommendation to see Dr. Leak, were prescribed. On January 28, 1987, Patient #1's sinuses were better but his back pain was worse. He was prescribed 30 Valium 5 mg., and 50 Demerol. This was the last Schedule II narcotic pain substance prescribed by Dr. Liss for Patient #1.

These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

25. On February 10, 1987 Patient #1 saw Dr. David Leak, a pain specialist. Dr. Leak's consultation and evaluation report, (included with the patient record in this Matter), indicates that Patient #1 reported his past use of Percocet and Demerol. Dr. Leak addressed only Patient #1's back pain. He instructed the patient on the use of a TENS unit and prescribed Norgesic and Ketoprofen.

These facts are established by State's Exhibit #1 and by Respondent's Exhibit B.

26. Patient #1 testified that he had not been resistant to the consultations recommended by Dr. Liss; he was resistant to the Caldwell-Luc procedure. He was not resistant to the myringotomy. His sinus symptoms were unchanged by the left Caldwell-Luc done in January, 1986. He had also resisted seeing an ENT becuase he had known what their recommendations would be. Orthopedists in the past had recommended long periods of rest, something Patient #1 was simply not able to do.

These facts are established by the testimony of Patient #1 (Respondent's Exhibit H, pg. 35, 42-43, 48).

27. Dr. Liss continued to treat to Patient #1 until February 18, 1989. His modes of treatment after February 1987 were mostly antibiotics, steroids and anti-inflammatories. There were only two further prescriptions for controlled substances: one for 20 Darvocet N-100 on December 31, 1988, and one for 10 Tylenol #3 on January 15, 1989. Patient #1 testified that he currently does not use narcotics to control his sinus pain, except for an occasional Tylenol #3. He believes that the climate in Washington has resulted in fewer acute sinusitis attacks.

    Though Patient #1's sinusitis and back problems continued after the narcotics were no longer prescribed, it does appear that he improved. During the narcotic treatment period Patient #1 had seen Dr. Liss approximately once every nine days. After that treatment ceased the visits averaged approximately one every twenty one days.

    These facts are established by State's Exhibit #1, Respondent's Exhibit B, and the testimony of Patient #1 (Respondent's Exhibit H, pgs. 52-53, 69).

28. Dr. Liss did not feel that his use of narcotic analgesics in the treatment of Patient #1's pain had been below the minimal standard of care. Dr. Liss felt that the choice of therapy depends upon the quality of life you want to offer the patient. Dr. Liss had wanted to help Patient #1 "work at his best capacity". (Tr. Vol II 74) Patient #1 had to have control of the pain in order to function in his residency. He also had felt that he simply had no other options. He had tried antibiotics for approximately four months prior to prescribing controlled substances. Patient #1 was resistant to surgery and was not about to adopt the suggestion that Dr. Liss and previous doctors had made regarding moving to a different climate. Dr. Liss did not feel that the amounts prescribed had been inordinately large; times of higher dosages corresponded to times of higher pain, usually pain with multiple causation factors.

    Even while prescribing the narcotics and the Valium, Dr. Liss had continued his attempts to treat the cause of Patient #1's pain by continuing to prescribe antibiotics, antihistamines or decongestants for the sinusitis, and rest, and heat and antidepressants for the back.

    Dr. Liss had felt comfortable in prescribing narcotics to Patient #1 because of the knowledge of Patient #1 that he had acquired during their friendship. He felt he had known Patient #1's behavior patterns and thought patterns, and would have more of an opportunity to discern any changes in those patterns. From his observation, he did not believe Patient #1 to have a history of drug or alcohol abuse and did not feel it was necessary to make a specific inquiry to that effect before prescribing narcotics. Dr. Liss testified that he had only seen Patient #1 consume an occasional beer or glass of wine. He had never seen Patient #1 use illegal drugs.

During and after his treatment of Patient #1, Dr. Liss did research on the issue of the management of long-term chronic pain with narcotics. He specifically recalled reading the article by Portenoy and Foley (see Finding of Fact #35). He offered the articles marked as Respondent's Exhibit D as the fruits of his research and as support of his actions. Before switching to Demerol he had done research on the issue of the efficacy of different narcotics.

These facts are established by the testimony of Dr. Liss (Tr. Vol. II 17-20, 49-52, 74).

29. At no time did Dr. Liss feel that Patient #1 had become addicted to the narcotics. Patient #1 did not use the drugs every day. When he was not having sinus pain and not taking narcotics, he did not show any withdrawal symptoms. No withdrawal symptoms were noted by Dr. Liss when Patient #1 completely stopped using the narcotics in early February 1987. Dr. Liss did not feel that Patient #1 had exhibited any drug-seeking behavior. Furthermore, during both their professional and personal relationship, Dr. Liss had noticed no diminution of Patient #1's reasoning and cognitive abilities.

These facts are established by State's Exhibit #1, Respondent's Exhibit B, and the testimony of Dr. Liss (Tr. Vol II 35, 97-101).

30. Karen A. Glasgow, M.D., testified as an expert witness on behalf of the State. Dr. Glasgow is board certified in internal medicine and is preparing to take the certifying examination in a new board specialty of addictionology in December, 1990. Dr. Glasgow's testimony was based on her review of State's Exhibit #1.

In Dr. Glasgow's opinion, it is appropriate to prescribe Schedule II narcotic substances for acute severe pain such as that from trauma, surgery, or terminal cancer; it is not appropriate to prescribe them in a long-term chronic pain situation because of the likelihood of habituation, tolerance, and addiction. In most cases, in Dr. Glasgow's opinion, narcotics should not be prescribed in an acute pain situation for more than two weeks.

Dr. Glasgow believed that Patient #1 had evidenced drug-seeking behavior. He had been resistant to consultations, which to Dr. Glasgow indicated that he preferred his disease-his drug source. As further evidence, she pointed to March 8, 1986 when the patient phoned in to say that he had not wanted to take the Percocet that Dr. Liss had pescribed for him that day. Dr. Liss had phoned in a prescription for Tylenol #3 but there is no indication in the record that the patient did not also fill the Percocet prescription. A lack of withdrawal symptoms noted around the time of the cessation of narcotic treatment, is not conclusive proof of nonaddiction in Dr. Glasgow's opinion. Some patients feel more discomfort than others, some reporting only flu-like symptoms for three days.

Dr. Glasgow had felt that Patient #1 was an impaired physician. She pointed to the entry in the patient record that indicated that Patient #1 was taking 10 Percocet per day. In her opinion, an individual using that much Percocet could not function effectively as a physician. The higher cortical senses do not get transmission with that much narcotic. If Patient #1 had taken all of the narcotic substances prescribed by Dr. Liss, in Dr. Glasgow's opinion, Patient #1 would have been addicted.

Dr. Glasgow did not feel that Dr. Liss' switch from Percocet to Demerol had been of any use as a means of weaning Patient #1 off of the Percocet. In her opinion, Demerol is the same potency as Percocet and Dr. Liss was simply substituting one narcotic for another. The proper method to wean someone from a narcotic, in Dr. Glasgow's opinion, is to use a non-narcotic, such as Clonidine, which occupies the same receptor site as the narcotic.

Dr. Glasgow did feel that Patient #1's long-standing battle with sinusitis would make his sinus tissue more susceptible to injury. Furthermore, she testified that Patient #1's pain would have been amplified by virtue of the fact that at times it involved two different body systems: the sinuses and the lower back. Dr. Glasgow felt, however, that the ultimate management of the problem is up to the physician and not the patient. In Dr. Glasgow's opinion, regardless of the patient's refusal to submit to surgery or to follow through with suggested consultations, the physician does not have an obligation to prescribe narcotics to a patient.

In Dr. Glasgow's opinion, Dr. Liss had not exercised reasonable care discrimination in the administration of drugs and had not used acceptable scientific methods in the selection of drugs or other modalities. Dr. Liss' prescription of narcotics over a 19-month period was excessive and did not address Patient #1's underlying medical problems. The patient had become tolerant to the drugs which no longer had any effect as analgesics. He simply substituted one narcotic for another, still not treating the underlying problem. In Dr. Glasgow's opinion, Dr. Liss had failed to meet the minimal standards of care for the community.

These facts are established by the entirety of Dr. Glasgow's testimony (State's Exhibit #11).

31. William H. Sweet, M.D., a board certified neurosurgeon from Massachusetts, testified as an expert witness on behalf of Dr. Liss. Dr. Sweet testified based upon his review of the patient record, his review of Patient #1's testimony and his review of a summary of Dr. Glasgow's testimony. (Respondent's Exhibit F). Dr. Sweet's career has focused on the issue of pain control. He co-authored the text, Neurosurgical Management of Pain. Dr. Sweet has not done surgeries for the past five years and has focused exclusively on the non-surgical management of chronic pain.

It was Dr. Sweet's opinion that Dr. Liss' treatment of Patient #1 with narcotic substances for chronic nonmalignant pain constituted reasonable care discrimination in the administration of drugs and met the minimal standard of care of other similarly situated physicians. In rendering this opinion, Dr. Sweet placed considerable emphasis on the fact that Patient #1 had been appointed chief resident while receiving narcotics from Dr. Liss, finding this to be evidence of achievment of Dr. Liss' goal. In Dr. Sweet's opinion, a physician's goal is to "make the patient a whole to the extent that he can do a fruitful job..." In Dr. Sweet's further opinion, "no matter what had been necessary to give the patient to do this, within reason, I would have said that if the patient could behave as this patient did, do his job in a sufficiently capable function to merit the accolade he received, then the physician has every reason to feel happy about what he's done." Indeed, Dr. Sweet doubted that he would even examine a patient such as Patient #1 very closely for the signs of possible addiction as long as that person is able to perform and is not harming others. (Respondent's Exhibit I, pg. 80)

Dr. Sweet uses opioids in his practice, but only after he has eliminated all other alternatives and only after thoroughly reviewing the patient's past medical records. He also is careful to determine that the patient does not have a prior history of drug abuse. Dr. Sweet testified that the control of chronic nonmalignant pain through the use of opioids is supported in the medical literature. In support of this statement he offered the group of articles marked as Respondent's Exhibit E.

Dr. Sweet testified that the Caldwell-Luc procedure has, in general, a poor success rate. Some of those who have undergone the procedure have even experienced worse pain. He also testified that the level of pain suffered by a patient will be intensified when the patient has two or more body systems producing pain.

Dr. Sweet testified that he had been infuriated by the fact that a colleague had been disciplined by the Massachusetts licensing board for his use of narcotics when, in Dr. Sweet's opinion, discipline had not been warranted.

These facts are established by the entirety of Dr. Sweet's testimony (Respondent's Exhibit I).

32. Laurens Park White, M.D., a California oncologist, testifed as an expert witness on behalf of Dr. Liss. Dr. White testified based upon his review of Respondent's Exhibit B and his review of Dr. Glasgow's testimony. He also testified that he had been "informed" of Dr. Sweet's testimony. Dr. White found Dr. Liss' prescribing of narcotic substances to Patient #1 for chronic nonmalignant pain to be reasonable care discrimination in the administration of drugs, the employment of an acceptable scientific method in the selection of drugs or other modalities for the treatment of disease, and within the minimal standards of care of similar practitioners under the same or similar circumstances.

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Dr. White disagreed with Dr. Glasgow's opinion that narcotics should only be used for acute severe pain. He testified that he knew of no literature that "convincingly" indicated that long-term pain should not be treated with opioids. Dr. White would use narcotics to treat chronic pain "if there is no way that you can successfully treat the primary cause of the pain."

Dr. White did not find any evidence of drug-seeking behavior in the record of Dr. Liss' treatment of Patient #1. He was not troubled by the fact that for a time Patient #1 had received narcotics from both Dr. Liss and Dr. Cheek, believing that Patient #1 had only received narcotics from Dr. Cheek once or twice. In fact, Patient #1 received five prescriptions for narcotic substances from Dr. Cheek (see Finding of Fact #11). Dr. White found evidence of non-drug seeking behavior in the patient record. He specifically pointed to the fact that the narcotic dosages would go up and down. In his experience, an addict would not report less pain so as to decrease his drug dosage. He also agreed with Dr. Liss that Demerol is less effective than Percocet but would not have chosen Demerol as a weaning method. Dr. White had felt that there was ample objective evidence of Patient #1's pain in the patient record.

These facts are established by the entirety of Dr. White's testimony (Tr. II 22-106).

33. James A. Hardy, M.D., a Columbus physician board certified in family practice, testifed as an expert witness on behalf of Dr. Liss. Dr. Hardy had reviewed the patient record of Patient #1 and had reviewed Dr. Glasgow's deposition testimony. It was Dr. Hardy's opinion that Dr. Liss, in his treatment of Patient #1's chronic nonmalignant pain with narcotic substances, had used reasonable care discrimination in the administration of drugs, had not failed to use acceptable scientific methods in the selection of drugs or other modalities, and had met minimal standards of care of other similarly situated practitioners.

Dr. Hardy is currently retired from private practice. He continues to review patient charts for the Bureau of Disability Determination (BDD), a part of the federal Social Security system. He has worked for BDD since 1974. He also reviewed patient records and examined claimants for the state Industrial Commission from the mid 1970's to mid 1980's. Dr. Hardy testified that through his work with BDD and the Industrial Commission, he has seen other instances of the long-term prescribing of narcotic substances for chronic nonmalignant pain situations. He did not find Dr. Liss' treatment to be different from, either in the duration of the narcotic prescribing or in the dosage amounts, from the practice of other physicians in the state of Ohio. Dr. Hardy testified that the charts reviewed and patients examined for the Industrial Commission were primarily (70% per cent) musculoskeletal or neuromusculoskeletal back injuries. The long-term prescribing that he had observed was typically for post-surgical patients. Dr. Hardy places strong faith in the anxiom that pain is the best antidote to narcotic addiction. He noted no

addicted patients in the records he had reviewed for BDD or the Industral Commission, and noted no evidence of addiction in Dr. Liss' patient record. Furthermore, he did not even note any evidence of tolerance in Patient #1's patient record. In his private practice, Dr. Hardy believed he had only had patients evidence tolerance to barbituates, not to narcotics.

These facts are established by the entirety of Dr. Hardy's testimony (Tr. Vol. I, 146-185).

34. Donald Stanslovski, Ph.D., an Ohio licensed pharmacist, testified an an expert witness for Dr. Liss in the areas of clinical pharmacology and pharmacological therapeutics. Dr. Stanslovski testified that clinical pharmacists are very familar with the properties of the various narcotic drugs on the market and would be able to make therapy recommendations to physicians. Dr. Stanslovski testified regarding the equianalgesic dosages of different narcotics for pain relief. For purposes of illustration, using the prescriptions listed in the State's citation letter, (State's Exhibit #3),he converted the narcotic agent in each of the narcotic substances prescribed by Dr. Liss to Patient #1 to miligrams of codeine. He then divided that number by 30 to arrive at the codeine equivalent to a Tylenol #3 tablet. The chart indicates the amount of narcotic available to Patient #1 on a given day with that amount expressed in terms of Tylenol #3 tablets. From his review of the patient record, Dr. Stanslovski found that spikes in his chart conformed to various pain producing events in the patient record. He also testified that oral Demerol is less potent than Percocet. In his experience as a pharmacist, it is not uncommon for Dr. Stanslovski to see long-term chronic nonmalignant pain patients maintained on narcotic pain killers. The dosage amounts he usually sees are about three Tylenol #3 per day.

These facts are established by the entirety of Dr. Stanslovski's testimony (Tr. Vol. I, 108-146).

35. Both Dr. Sweet and Dr. Liss testified that the medical literature supported their position that the use of narcotic pain medications in long-term chronic nonmalignant pain situations was acceptable medical practice. Articles reviewed were submitted as Respondent's Exhibits D and E. Basically, these articles set forth the results of studies done with selected chronic nonmalignant pain patients who were administered maintenance dosage levels of narcotics over long periods of time. The studies reported good results. Adequate pain relief was achieved by the majority of patients and very few management problems such as addition or tolerance developed.

The studies freely admit that use of narcotics in chronic nonmalignant pain situations is contrary to the majority opinion in the medical community. In his draft article, "Opioid Therapy in the Management of Chronic Back Pain," Dr. Russell Portenoy states that "[i]ntense controversy surrounds the use of chronic opioid therapy in the management

of low back pain and other nonmalignant pain syndromes. Emphatic rejection of this approach is the norm, a situation justified in the opinion of many practitiioners by the potential for opioid toxicity and physical dependence, loss of efficacy due to tolerance, and psychological dependence (addiction)." (Portenoy p. 1). The studies were uniform in indicating that further research was needed and that the treatment should follow strict guidelines.

One guideline was the need to establish a maintenance dosage level, with the patient given a set monthly amount of the drug. A steady daily dosage was important to the efficacy of the treatment, with any reported higher usage levels by a patient to be followed by a reduction in dosage until the baseline dosage was regained. Increasing dosage levels was seen as a danger signal. Portenoy and Foley stated that, "since many patients with non-malignant pain can achieve only partial relief from opioid drugs, while others obtain none, the physician must be able to make the clinical judgment that higher dosages will not be salutary in the setting of persistant pain complaints." (Portenoy and Foley pg. 184). In Dr. Portenoy's opinion, pharmacologic tolerance resulting in rapidly escalating dosage levels would indicate that opioid maintenance therapy was not a viable option. (Portenoy p. 5)

These facts are established by Respondent's Exhibits D and E.

CONCLUSIONS

Respondent's Exhibits D and E sufficiently rebut Dr. Glasgow's opinion that narcotic substances can never be used in chronic nonmalignant pain situations. The bulk of the articles in those exhibits set forth studies done showing the relatively successful management of chronic pain through use of narcotic pain killers for periods of time at least as long as, if not longer than, the time periods involved in this Matter. These articles are all in agreement, however, that this mode of treatment, albeit valid, is quite controversial. The mainstream of thought in the medical community is still that narcotics ought not be used in chronic pain situations because of the dangers of habituation, tolerance, and addiction. Further research is needed. A practitioner deciding upon a trial of opioids for the management of chronic pain needs to proceed cautiously and to adhere to strict guidelines. While the preponderance of the evidence would indicate that Dr. Liss' decision to proceed with opioid management was not, in and of itself, a violation of law, throughout the course of his treatment of Patient #1 he did not maintain the sufficient control over the patient and his intake that the controversial nature of the treatment required.

The record as a whole does not indicate that Patient #1 had been engaging in drug seeking behavior. Patient #1 testified that he was not necessarily resistant to consultations, he was resistant to surgery. As far as the consultation with the ear, nose and throat specialist is concerned Patient #1 had suffered from chronic sinusitis for 15 years

before seeking treatment with Dr. Liss. Furthermore, being a physician, Patient #1 had a much better idea than the average patient of the alternatives that were available. There was testimony regarding the relatively poor success rate of the Caldwell-Luc procedure. Patient #1 was not resistant to a myringotomy; it was not performed because Dr. Hood found the degree of hearing loss to have diminished. Patient #1 had also had advice regarding his lower back problems. He did have an EMG done in December 1986, an x-ray in October 1986, and a CT scan of his back in October 1986. He did see an orthopedic specialist, Dr. Fankhauser in December 1986. It was undisputed that a pain specialist such as Dr. Richard Leak would have nothing to offer Patient #1 as far as his chronic sinusitis was concerned. The first suggestion by Dr. Liss to see a pain specialist is found in the patient record on November 11, 1986. Patient #1 did see Dr. Leak three months later.

The record also does not support the contention that Patient #1 had sought narcotic substances from other physicians. If drug acquisition had been Patient #1's goal with the maxilofacial surgeon, Dr. Cheek, than he would not have reported to him that he was already receving Percocet from Dr. Liss. Patient #1 accurately reported his narcotic usage to Dr. Leak. Granted, the letter from Dr. Hood does not indicate that Patient #1 had told him of his use of Percocet. However, that letter also does not indicate that Patient #1 made any request or demands for narcotics from Dr. Hood. There is also no indication of a request for narcotics made to Dr. Fankhauser.

The record indicates that Patient #1 was not addicted to these narcotics. At times dosages decreased. Patient #1 testified that he had not used the medication everyday and had not noted withdrawal symptoms when not using the narcotics. No withdrawal symptoms were noted by Dr. Liss in the patient record in February 1987 after the narcotic prescribing ceased. Further, Dr. Leak noted no physical symptoms akin to withdrawal following his examination of Patient #1 on February 10, 1987, just 13 days after the last prescription for 50 Demerol 100 mg. Patient #1 had been able to perform successfully during his residency. Lastly, evidence of nonaddiction would be the fact that Patient #1 did not seek narcotics from another physician after February, 1987 and continued to treat with Dr. Liss.

Dr. Liss' treatment thankfully did not produce an individual addicted to narcotics. However, considering the controversial nature of the treatment and its inherent dangers, Dr. Liss did not use reasonable care discrimination in the administration of drugs when he continued to prescribe narcotics despite the patient's tolerance. It is clear that the patient had developed a tolerance as early as February or March 1986. The patient record for that time indicates Dr. Liss' displeasure with the efficacy of the Percocet. Dr. Liss continued to prescribe large amounts of narcotics until January 28, 1987. Dr. Liss' own evidence cautioned against continued prescribing once tolerance had occurred. Dr. Liss never established a maintenance dosage of narcotic pain medication, an essential element of the studies included within Respondent's Exhibits D and E.

Patients in those studies were titrated to a maintenance dosage, and once that dosage was established, received monthly prescriptions. The prescriptions allowed for some leeway in the event of escalated pain, however, a return to the baseline was always required. Such was not the case with Dr. Liss and Patient #1.

Further evidence of Dr. Liss' failure to establish firm control over his patient is demonstrated by the prescriptions for narcotic substances that Patient #1 received from Dr. Cheek. Dr. Liss may have known of the original one or two prescriptions from Dr. Cheek since the patient record for January 16, 1986 notes "no relief from pain meds at home." However, it is doubtful that Dr. Liss knew of the prescriptions Patient #1 had received from Dr. Cheek on January 16 and January 21. Those prescriptions were for Percocet, the medication that was providing relief. There is no indication that Dr. Liss kept Dr. Cheek's prescribing in mind when he prescribed Percocet to Patient #1 on January 18 and January 25. There is absolutely no need for such double prescribing. Dr. Liss should have either asked and received more details from Patient #1 regarding the extent of Dr. Cheek's prescribing, or insisted that Patient #1 receive narcotics only from himself. This is the only way to maintain control over the patient's usage and should be done regardless of the physician's trust of his patient. Dr. Portenoy would recommend ceasing narcotic treatment if the patient receives narcotics from another source. Dr. Liss allowed Patient #1 to stockpile the narcotics, further evidence of his lack of sufficient control over Patient #1's intake. Prescriptions were written even when Dr. Liss knew that Patient #1 still had an ample supply from a previous prescription.

Accordingly, it is concluded that the acts, conduct, and/or omissions of Richard W. Liss, M.D., in failing to establish a maintenance dosage, failing to establish control over Patient #1's usage, and continuing to prescribe ever higher amounts of narcotics once tolerance had developed, as set forth in Findings of Fact 7 through 24, and 35, above, constitute:

1. "Failure to use reasonable care discrimination in the administration of drugs", and "failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease", as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code; and

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

* * * *

At all times Dr. Liss had the well being of his patient as his primary concern. He appeared conscientious and diligent, maintaining good patient records and engaging in ongoing research. Only one patient was involved here, a patient who had been a good friend. Dr. Liss testified that he would be reluctant to engage in this form of treatment with an average patient because of the limited opportunities for observation. This was not a drug-seeking patient engaging in deceptive tricks in order to acquire drugs. The pain was real and its objective signs were amply demonstrated in the patient record.

PROPOSED ORDER

It is hereby ORDERED:

That Richard W. Liss, M.D., be placed on probation for a period of three (3) years under the following terms and conditions:

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

2. Dr. Liss shall submit quarterly declarations under penalty of perjury stating whether there has been compliance with all the conditions of probation;

3. Dr. Liss shall appear in person for interviews before the full Board or its designated representative at six (6) month intervals, or as otherwise directed by the Board;

4. In the event that Dr. Liss should leave Ohio for three (3) continuous months, or reside or practice outside the state, Dr. Liss must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of this probationary period;

5. Dr. Liss shall complete at least one program per year for each year of the probationary period of approved Category I Continuing Medical Education related to the violations noted in this decision. The exact number of hours per year shall be determined by the Board or its designee and shall not total less than 25. These programs shall be in addition to the Continuing Medical Education requirements for relicensure. The programs shall be submitted to the Board or its designee for prior approval. Dr. Liss shall provide documentary proof satisfactory to the Board of successful completion of these courses.

6. Upon successful completion of probation, Dr. Liss' certificate will be fully restored.

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

Joan Irwin Fishel
Attorney Hearing Examiner

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

EXCERPT FROM THE MINUTES OF SEPTEMBER 12, 1990

REPORTS AND RECOMMENDATIONS

All Enforcement Coordinators left the meeting at this time.

.....

Dr. Kaplansky asked if each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of Manuel E. Lopez, M.D.; Richard W. Liss, M.D.; Edward B. Blackmon, M.D.; Jaime Blasquez, M.D.; and Mathew I. Charms, M.D. A roll call was taken:

ROLL CALL:	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- aye
	Mr. Jost	- aye
	Dr. Ross	- aye
	Dr. Rauch	- aye
	Mr. Albert	- aye
	Dr. Daniels	- aye
	Dr. Agresta	- aye
	Dr. Kaplansky	- aye

Mr. Jost stated that he did not read the record in the matter of Jaime Blasquez, M.D., due to a conflict of interest regarding this case.

.....

REPORT AND RECOMMENDATION IN THE MATTER OF RICHARD W. LISS, M.D.

.....

MR. ALBERT MOVED TO APPROVE AND CONFIRM MS. FISHEL'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF RICHARD W. LISS, M.D. MR. JOST SECONDED THE MOTION.

.....

A roll call vote was taken on Mr. Albert's motion:

ROLL CALL VOTE:	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- nay
	Mr. Jost	- aye
	Dr. Ross	- aye
	Dr. Rauch	- abstain
	Mr. Albert	- aye
	Dr. Daniels	- aye
	Dr. Agresta	- aye

The motion carried.

STATE OF OHIO
THE STATE MEDICAL BOARD
77 SOUTH HIGH STREET
17TH FLOOR
COLUMBUS OH 43215

January 10, 1990

Richard W. Liss, M.D.
2391 West Broad Street
Columbus, OH 43204

Dear Doctor Liss:

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

(1) You were the treating physician of Patient 1, as identified in the attached patient number key (key to be withheld from public disclosure), from at least February 5, 1985 to on or about February 2, 1987.

In response to complaints of sinusitus, low back pain, sciatica and a fall on the ice, as the treating physician of Patient 1, you did prescribe the following controlled substances on or about the dates and in the amounts indicated below:

DATE	CONTROLLED SUBSTANCE	AMOUNT
03/20/85	Percocet	?
04/10/85	Percocet	100
05/16/85	Tylenol 3	10
06/02/85	Percocet	50
07/15/85	Percocet	50
08/26/85	Percocet	50
08/30/85	Percocet	30
09/13/85	Valium 5	30
09/13/85	Percocet	50
09/27/85	Percocet	30
10/12/85	Percocet	30
12/12/85	Percocet	30

January 10, 1990

DATE	CONTROLLED SUBSTANCE	AMOUNT
12/19/85	Percocet	30
12/19/85	Valium 5	20
12/30/85	Valium 5	30
12/30/85	Percocet	30
01/15/86	Percocet	30
01/15/86	Demerol 50	30
01/18/86	Percocet	50
01/18/86	Demerol	100
01/25/86	Darvocet N-100	50
01/25/86	Darvon	30
02/04/86	Percocet	50
02/23/86	Percocet	50
02/27/86	Percocet	50
02/27/86	Demerol	100
03/08/86	Percocet	50
03/08/86	Tylenol 4	50
03/22/86	Vicodin	50
03/29/86	Percocet	15
04/05/86	Demerol 100	30
06/06/86	Demerol 100	50
06/15/86	Valium 5	30
06/17/86	Tylenol 4	30
06/22/86	Percocet	50
07/05/86	Percocet	30
07/10/86	Percocet	30
07/13/86	Percocet	30
07/13/86	Valium 10	50
07/19/86	Percocet	50
07/25/86	Percocet	30
07/25/86	Valium 10	50 x 2R.
07/29/86	Percocet	30
08/05/86	Percocet	50
08/11/86	Percocet	30
08/21/86	Percocet	30
08/21/86	Demerol 50	30
08/25/86	Percocet	30
08/30/86	Percocet	30
09/05/86	Percocet	30
09/20/86	Percocet	50
10/01/86	Percocet	50
10/09/86	Percocet	50
10/21/86	Percocet	30
10/28/86	Valium 5	50
11/05/86	Percocet	50
11/09/86	Percocet	30
11/11/86	Valium 5	50
11/11/86	Percocet	50

January 10, 1990

DATE	CONTROLLED SUBSTANCE	AMOUNT
11/18/86	Percocet	50
11/18/86	Percocet	50
11/26/86	Valium 10	50
11/26/86	Percocet	50
11/28/86	Demerol 100	30
11/28/86	Percocet	50
12/04/86	Percocet	30
12/04/86	Demerol 100	30
12/08/86	Demerol 100	50
12/14/86	Demerol 100	30
12/17/86	Valium 10	50
12/17/86	Demerol 100	50
12/22/86	Demerol 100	50
12/27/86	Valium 10	50
12/27/86	Demerol 100	50
12/31/86	Demerol 100	30
01/02/87	Demerol 100	50
01/06/87	Valium 5	30
01/06/87	Demerol 100	50
01/11/87	Valium 10	30
01/11/87	Demerol 100	50
01/16/87	Valium 10	50
01/16/87	Demerol 10	50
01/26/87	Demerol 100	30
01/28/87	Valium 5	30
01/28/87	Demerol 100	50

Such acts, conduct, and/or omissions as alleged in the above paragraph (1), individually and/or collectively, constitute "failure to use reasonable care discrimination in the administration of drugs," and "failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

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

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

January 10, 1990

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

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

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Henry G. Cramblett, M.D.
Secretary

HGC:jmb

Enclosures

CERTIFIED MAIL #P 746 510 124
RETURN RECEIPT REQUESTED