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

August 16, 1991

Melvin Monroe, M.D.
850 West High Street
Lima, Ohio 45801

Dear Doctor Monroe:

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 August 14, 1991, including Motions amending the Conclusions of Law of the Hearing Examiner, and adopting an amended Order.

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

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board of Ohio and the Franklin County Court of Common Pleas within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12 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 290 319 338
RETURN RECEIPT REQUESTED

cc: Robert E. Tait, Esq.

CERTIFIED MAIL NO. P 290 319 339
RETURN RECEIPT REQUESTED

Mailed 8/21/91

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CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; attached copy of the Report and Recommendation of Joan Irwin Fishel, Attorney Hearing Examiner, State Medical Board; and an excerpt of Minutes of the State Medical Board, meeting in regular session on August 14, 1991, including Motions amending the Conclusions of the Hearing Examiner and adopting an amended Order, constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Melvin Monroe, 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.

(SEAL)

Henry G. Cramblett, M.D.
Secretary

August 16, 1991
Date

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BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *

*

MELVIN MONROE, M.D. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio the 14th day of August, 1991.

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 modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board for the above date.

It is hereby ORDERED that Melvin Monroe, M.D., be placed on probation for a period of two (2) years under the following terms and conditions:

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

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

3. Dr. Monroe 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. Dr. Monroe shall complete at least one program per year for each year of the probationary period of approved Category I Continuing Medical Education related to medical recordkeeping. The exact number of hours per year shall be determined by the Board or its designee and shall not total less than 25.

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Melvin Monroe, M.D.

These programs shall be in addition to the Continuing Medical Education requirements for re-registration. The programs shall be submitted to the Board or its designee for prior approval. Dr. Monroe shall provide documentary proof satisfactory to the Board of successful completion of these courses.

5. Dr. Monroe shall keep a log of any controlled substances purchased, prescribed, dispensed, or administered. Further, Dr. Monroe shall make his patient records with regard to such prescribing available for review by an agent of the State Medical Board upon request.

6. Upon succesful completion of probation, Dr. Monroe's certificate shall be fully restored.

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

Henry G. Cramblett, M.D.
Secretary

(SEAL)

August 16, 1991
Date

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REPORT AND RECOMMENDATION
IN THE MATTER OF MELVIN MONROE, M.D.

The Matter of Melvin Monroe, M.D., came on for hearing before me, Joan Irwin Fishel, Esq., Hearing Examiner for the State Medical Board of Ohio, on May 21 and 22, 1991.

INTRODUCTION AND SUMMARY OF EVIDENCE

I. Basis for Hearing

A. By letter dated March 13, 1991 (State's Exhibit #1), the State Medical Board notified Melvin Monroe, M.D., that it proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio for one or more of the following reasons:

1. In the routine course of his practice, he kept inadequate patient records which did not properly reflect whether examinations were performed or physical findings made to justify the medications prescribed to Patients 1-4 (patients listed on a confidential key attached to State's Exhibit #1);

2. He excessively prescribed controlled substance narcotic analgesics, controlled substance depressants and other controlled substances and dangerous drugs without taking into account the drugs' potential for abuse, the possibility the drugs may lead to dependence, the possibility the patients may obtain the drugs for nontherapeutic use or to distribute to others, and the possibility of an illicit market for the drugs; and

3. The medications prescribed were frequently inappropriate for the treatment of these patients' reported pain, illness or injury and was frequently done without utilization of diagnostic testing or other methods of evaluating the validity, nature or severity of the patients' complaints. Instances of such practices include, but are not necessarily limited to, the treatment rendered to Patients 1-4 as disclosed by the patient record and/or the prescription list by patient number attached to State's Exhibit #1.

These acts, conduct, and/or omissions were alleged by the Board to 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; "selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in Section 4731.22(B)(3), Ohio Revised Code; "a departure from, or the failure to conform to, minimal standards of care of similar

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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; and for those activities taking place on or after November 17, 1986, "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(C) and (D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, a violation of any provision of that rule also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code, and further, a violation of Rule 4731-11-02(C), Ohio Administrative Code, also constitutes a violation of Section 4731.22(B)(3), Ohio Revised Code, if such violation is committed purposely, knowingly, or recklessly.

B. By letter received by The State Medical Board on April 11, 1991 (State's Exhibit #2), Robert E. Tait, Esq., requested a hearing on behalf of Dr. Monroe.

II. Appearances

A. On behalf of the State of Ohio: Lee Fisher, Attorney General, by Lisa A. Sotos, Assistant Attorney General

B. On behalf of the Respondent: Robert E. Tait, Esq., and Alan T. Radnor, Esq.

III. Testimony Heard

A. Presented by the State

1. Craig T. Pratt, M.D.

B. Presented by the Respondent

1. Robert L. DuPont, M.D.

2. Ronald W. Whisler, M.D.

3. Nicholas Votolato, Ph.D.

4. Eric Fisher, M.D.

5. Melvin Monroe, M.D.

IV. Exhibits Examined

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

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A. Presented by the State

1. State's Exhibit #3: April 11, 1991 letter to Attorney Tait from the State Medical Board advising that a hearing initially set for April 25, 1991, was postponed pursuant to Section 119.09, Ohio Revised Code.

2. State's Exhibit #4: April 18, 1991 letter to Attorney Tait from the State Medical Board scheduling the hearing for May 21, 1991.

3. State's Exhibit #5: Notice of Appearance of Counsel for State.

4. State's Exhibit #6: State's Request for List of Witnesses and Documents.

5. State's Exhibit #7: Curriculum vitae of Craig T. Pratt, M.D.

6. State's Exhibit #8: Excerpts from the Physicians' Desk Reference (PDR) (1985 edition) for Darvocet-N 100 and Darvon.

7. State's Exhibit #9: Excerpts from the PDR (1989 edition) for Darvocet-N 100 and Darvon.

8. State's Exhibit #10: Compilation of articles and/or excerpts from texts relied upon by Dr. Pratt: "Propoxyphene Hydrochloride", from a drug evaluation guide of the American Society of Hospital Pharmacists, Inc., 1990; three chapters from a textbook on pain edited by Melzack and Walls - "Pain and Litigation", Brena, Steven S. and Chapman, Stanley L., "Counseling the Patient and Family", Jeans, M. E. and Rowat K. M., and "Intensive Group Psychotherapy", Crue, Benjamin L. and Pinsky, Jack F.; "Roundtable Discussion - The Management of Low Back Pain," The Clinical Journal of Pain, 5(Suppl. 2), 1989; "Psychiatric Aspects of Pain", France, Randal D., The Clinical Joural of Pain, 5(Suppl. 2), 1989; "The Assessment and Treatment of Pain in the Emergency Room", Boisaubin, Eugene V., The Clinical Journal of Pain, 5(Suppl. 2), 1989; "Federal Government Faces Painful Decision on Darvon", Smith, Jeffrey R., Science, Vol. 203, 1979; "An Overview of Chronic Pain", Kraus, Robert F. and Miller, Thomas W., Hospital and Community Psychiatry, Vol. 41, 1990; and "Chronic Pain: Lifetime Psychiatric Diagnoses and Family History; Egan, Kelly, Katon, Wayne, and Miller, Donna, American Journal of Psychiatry, 142:10, 1985.

* 9. State's Exhibit #11: Dr. Monroe's records for Patient #1.

* 10. State's Exhibit #12: Prescriptions and prescription printout for Patient #1.

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* 11. State's Exhibit #13: Dr. Monroe's records for Patient #2.

* 12. State's Exhibit #14: Prescriptions and prescription printout for Patient #2.

* 13. State's Exhibit #15: Dr. Monroe's records for Patient #3.

* 14. State's Exhibit #16: Prescriptions and prescription printout for Patient #3.

* 15. State's Exhibit #17: Dr. Monroe's records for Patient #4.

* 16. State's Exhibit #18: Prescriptions and prescription printout for Patient #4.

B. Presented by the Respondent

1. Respondent's Exhibit A: "Benzodiazepine Dependency", Salzman, Carl, Psychopharmacology Bulletin, Vol. 26, No. 1, 1990.

2. Respondent's Exhibit B: Curriculum vitae of Robert L. DuPont, M.D.

3. Respondent's Exhibit C: "Addictive Potential of Benzodiazepines 'Overrated'", reprint from Clinical Psychiatry News, July, 1990.

4. Respondent's Exhibit D: Curriculum vitae of Ronald W. Whisler, M.D.

5. Respondent's Exhibit E: Curriculum vitae of Nicholas Votolato, Ph.D.

6. Respondent's Exhibit F: Demonstrative graphs used by Dr. Votolato.

7. Respondent's Exhibit G: Forward from the 1990 PDR.

* 8. Respondent's Exhibit H: Letter from Patient #2.

9. Respondent's Exhibit I: "Use and Abuse of Benzodiazepines; Issues Relevant to Prescribing", Katz, Jonathan L., Winger, Gail, and Woods, James H., Journal of the American Medical Association, December 16, 1988, Vol. 260, No. 23.

* 10. Respondent's Exhibit J: Chart used for demonstrative purposes during testimony of respondent and respondent's witnesses.

11. Respondent's Exhibit K: Written list of drugs prepared by Patient #2.

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12. Respondent's Exhibit L: Affidavit of L. Y. Soo, M.D.

13. Respondent's Exhibit M: Affidavit of Thomas C. Linn, M.D.

(NOTE: The above exhibits marked with an asterisk (*) have been sealed to protect patient confidentiality).

V. Other Matters

A. The record in this Matter had been held open for the testimony of Drs. Soo and Linn. Because scheduling difficulties prevented the taking of depositions in lieu of live testimony, affidavits of Drs. Soo and Linn were submitted. The parties submitted written closing arguments rather than reconvening the hearing. By Entry dated June 18, 1991 the receipt of the affidavits and the written closing arguments was acknowledged and the record closed as of June 14, 1991. That Entry will hereby be considered part of the record in this Matter.

B. There are documents within State's Exhibit #11 which do not reflect care received by Patient #1. Rather, these documents, specifically an emergency room record for October 7, 1987, a test request and test results for ova and parasites in the stool in October, 1988, and an emergency room record for October 13, 1988, are for Patient #1's son.

FINDINGS OF FACT

1. Melvin Monroe, M.D., has been a family practitioner in Lima, Ohio since late 1983. The preceding thirteen years he worked as a pathologist in a Philadelphia hospital. He changed his specialty to family practice after realizing that he missed patient contact. During a period of approximately two years he attended intensive review courses and continuing medical education in areas pertinent to family practice, such as pediatrics and cardiology.

   These facts are established by the testimony of Dr. Monroe (Tr. Vol. II 60-62).

2. Dr. Monroe first saw Patient #1, then an unemployed 36 year-old man, on July 23, 1986. Patient #1 had been a patient of Dr. Noble. He reported a history of an aneurysm on the brain and reported present usage of Valium 5 mg., Darvocet-N 100, and Dilantin. Dr. Monroe recorded a history of grand mal seizures with claimed muscles spasms. Dr. Monroe testified that the patient had had a hard time verbalizing his history and complaints. This he noted in the patient record "can't explain". The July 23 entry does not note a present complaint of headaches nor a history of headaches. No physical examination was noted that day other than vital signs, height and weight. No treatment plan was set forth. Dr. Monroe prescribed 100 Darvocet-N 100 and 100 Dilantin 100.

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Patient #1's next office visit was October 8, 1986. Prior to that visit, however, he made three telephone requests to Dr. Monroe's office for Darvocet refills. He complained of headaches when he called on September 3. Dr. Monroe phoned in a prescription for 60 Darvocet N-100 on that date but did not the other two times. On October 8 the patient record indicates that an appointment had been made for Patient #1 with a neurosurgeon, Dr. L. Y. Soo.

These facts are established by State's Exhibit #11.

3. Dr. L. Y. Soo had operated on Patient #1's giant aneurysm of the anterior communicating artery in 1979. Patient #1 had had seizures prior to the surgery. The surgey had been a success and Dr. Soo had instructed the patient to take Dilantin. Following his October 21, 1986 examination of Patient #1, Dr. Soo reported to Dr. Monroe that the patient wanted disability and had complained of memory loss and headaches. There is no description of the headaches in Dr. Soo's letter to Dr. Monroe. Dr. Soo considered the subjective complaints of memory loss and headaches difficult to evaluate and an insufficient basis to support a disability application.

   The CT scan of the brain ordered at that time by Dr. Soo showed a calcified aneurysm but no new lesions. Dr. Soo found no objective neurological evidence of abnormalities in Patient #1. Dr. Soo had reported to Dr. Monroe that an EEG would be done, however, there are no EEG results in the record. Dr. Soo was prepared to support a disability application for Patient #1 that was based upon the results of psychological testing. Psychological testing had indicated that Patient #1 was at the upper level of borderline mental capacity.

   These facts are established by State's Exhibit #11.

4. From July 23, 1986 to April 10, 1990 Dr. Monroe made available to Patient #1 approximately 4,220 dosage units of Darvocet-N 100. From November 3, 1986 through April 10, 1990 Dr. Monroe made available to Patient #1 approximately 3,600 dosage units of Valium 5 mg. Valium was not prescribed until Patient #1's third office visit, three months after his first appointment. There is nothing in the office notes for that day indicating why Valium was prescribed.

   Dr. Monroe testified that Darvocet-N 100 was prescribed for Patient #1's headaches. Valium was prescribed for the patient's chronic anxiety and as an adjunct to Dilantin for seizure control. Dr. Monroe never documented a diagnosis of chronic anxiety in the patient record. At hearing he pointed to the entry for the July 13, 1989 office visit which states "reports no seizures, very anxious". An application for disability determination, dated March 23, 1987 and completed and signed by one of Dr. Monroe's office employees, states that Dr. Monroe was treating Patient #1 for seizure disorder, headache disorder and anxiety. Dr. Monroe felt the diagnosis of chronic anxiety was apparent

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because of the patient's borderline mental capacity (see Finding of Fact #3). According to Dr. Monroe, such individuals do not "handle life very well".

These facts are established by State's Exhibit #11 and by the testimony of Dr. Monroe (Tr. Vol. II 70-72).

5. Patient #1 exhibited drug-seeking behavior. Within the first year of treatment with Dr. Monroe, he made eleven telephone requests for refills on his Darvocet and/or Valium. Dr. Monroe acceded to those requests and phoned in prescriptions on five occasions. (September 3, 1986, March 5, 1987, June 12, 1987, June 25, 1987, and July 14, 1987). Additionally, on April 17, 1987, an Officer Pastone called requesting medications for Patient #1. The note recording the call indicates that a return call should be made to the jail. Dr. Monroe testified he did not know why Patient #1 had been in jail. On that occasion Dr. Monroe phoned in a prescription for 16 Valium 5 mg. and 24 Darvocet-N 100. On December 16, 1986 Patient #1 called Dr. Monroe's office and requested refills stating that there had been a fire at his house. On November 3, 1989 he requested replacement of the medication that he claimed had fallen in the water when he was fishing.

   Prior to his aneurysm surgery in 1979, Patient #1 had been drinking heavily. On two occasions Patient #1 had an elevated GGTP level. This is a liver enzyme test and elevation can be an indication of high alcohol usage. The test is not specific for that purpose, however. The elevation also could have been the result of Dilantin use, but the same blood work showed the level of Phenytoin (Dilantin) to be low. Indeed, it would appear that Dr. Monroe had doubts as to whether the patient was taking his Dilantin.

   These facts are established by State's Exhibit #11, by the testimony of Dr. Pratt (Tr. Vol. I 67), and by the testimony of Dr. Votolato (Tr. Vol. II 15).

6. Dr. Monroe frequently informed Patient #1 that he had to have an office visit in order to get a prescription for Darvocet or Valium. The majority of telephone requests for controlled substances were denied. Also, two of the prescriptions phoned in were for only the amount necessary to carry the patient over to the next appointment. He never gave Patient #1 more than one refill.

   These facts are established by State's Exhibit #11.

7. Dr. Monroe did not attempt any other treatment methods for Patient #1's headaches, including the use of nonsteroidal anti-inflammatory drugs. The medical records do not indicate that Patient #1 had any stomach problems which would preclude the use of that type of medication. There was no description in the record of Patient 1's headaches, either their location, their etiology, or their frequency. There was no description of the type of pain or the duration of the pain from the

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headaches, nor a description of how disabling the pain was to the patient. There were no diagnostic tests ordered or performed by Dr. Monroe other than the CT scan ordered by Dr. Soo in 1986 (It is not clear whether an EEG was done).

Dr. Monroe did not refer Patient #1 to any type of counseling for his chronic anxiety. Though the July 13, 1989 entry notes the patient was "very anxious", there is no description of the patient's anxiety in the record on that day or any other day. If Dr. Monroe engaged in any counseling of the patient, it is not documented.

These facts are established by State's Exhibit #11 and by the testimony of Dr. Monroe (Tr. Vol. II 72).

8. Dr. Monroe did not take an extensive history, particularly a family history, from Patient #1 before prescribing controlled substances to him. He did not note how long Patient #1 had been taking Darvocet and Valium before seeing him, nor did he record Patient #1's prior dosage levels. There is no indication that Dr. Monroe asked Patient #1 about his prior use of addictive substances, including alcohol, or the prior use of other family members. Dr. Monroe admitted at hearing that he did not know at the outset of treatment that Patient #1 was related to Patient #4. In fact, from at least April 1988 through October 1989, Patient #1 lived in the same household as Patient #4. On October 9, 1989, Patient #4 came to the office to pick up Patient #1's Darvocet prescription.

   These facts are established by State's Exhibit #11 and by the testimony of Dr. Monroe (Tr. Vol. II 94-95).

9. Dr. Monroe first saw Patient #2, then a 73 year-old woman, on April 25, 1986. The patient presented Dr. Monroe with a list of her current medications which included: blood pressure medication, Sinequan, Premarin, Insulin, Percodan, and Talwin, among others. On her patient registration sheet she listed Darvocet-N 50 as a current medication. Dr. Monroe recorded that she had been in the hospital a couple weeks earlier for a kidney infection and "? over drug ?". The only objective finding other than the patient's vital signs and weight is a notation that she was very nervous. Dr. Monroe did not record a complete history of the patient's prior use of controlled substances. Dr. Monroe prescribed 100 Darvocet-N 50. He did not note a treatment plan. On her first visit, Patient #2 signed releases so that Dr. Monroe could obtain her records from her previous physician and her records from a hospitalization in April, 1986. The medical record Dr. Monroe gave to the State (State's Exhibit #13) contains the hospital documents but does not contain any records from Patient #2's previous physician.

   These facts are established by State's Exhibit #13.

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10. The entire medical record, including hospital admissions and consultation notes, indicates that Patient #2 was a very sick woman. She suffered from hypertension and severe osteoarthritis, her right knee had been replaced in 1983. She had been diabetic since 1972, insulin dependent since 1983, and she experienced diabetic neuropathy. She had a gastric ulcer in 1989 and she had an attack of pancreatitis in 1988. The severe osteoarthritis and diabetic neuropathy were confirmed by various evaluative tests.

    There are several notations in the record indicating that Patient #2 had a problem with depression. A consultation report of Dr. Faler, dated April 12, 1986, notes a history of depressed state. On September 28, 1988 Dr. Wolfe, a rheumotology counsult, felt that depression was playing a significant role in Patient #2's symptomatology. On October 19, 1988, Dr. Monroe noted that she was very depressed. Expert testimony at hearing was that it would not be unusual for an individual with these types of medical problems to be depressed.

    These facts are established by State's Exhibit #13.

11. Dr. Monroe testified that Darvocet had been prescribed for Patient 2's pain, primarily the arthritis and neuropathy pain. There are numerous entries and office notes documenting that Patient #2 complained of pain from arthritis and/or diabetic neuropathy. However, other than hospital physical therapy notes, and the consult of Dr. Wolfe, there are few descriptions of the nature or extent of that pain. From April 1986 through April 1990 Dr. Monroe prescribed the following controlled substances for Patient 2's pain: Soma Compound with codeine - 420 dosage units, Anexia - 240 dosage units, Tylenol #4 - 2,280 dosage units, and Darvocet - 5,650 dosage units. Dr. Monroe did not prescribe Schedule II analgesics such as Percodan and Talwin.

    These facts are established by State's Exhibit #13.

12. Patient #2's use of controlled substance analgesics escalated. At the outset of treatment with Dr. Monroe, she used approximately 4 tablets per day. By August, 1988 that use had escalated to 2 tablets every four hours, with an occasional use of Tylenol. Dr. Monroe testified that through part of 1989 until approximately April 1990, Patient #2 was using 8 to 10 Darvocet on some days. On July 7, 1988, J. P. Cleary, D. O., a physician who apparently was filling in for Dr. Monroe (See also Finding of Fact #23) examined Patient #2 at Dr. Monroe's office and noted that she had an addictive personality and had been on her medications for years. On November 15, 1989 the patient reported an unsteady gait and vertigo which Dr. Monroe attributed to an excessive use of Darvocet. According to Dr. Monroe, the Patient's usage of Darvocet began to decline in April 1990 and eventually returned to a usage of 3 to 4 tablets per day.

    These facts are established by State's Exhibit #13 and by the testimony of Dr. Monroe (Tr. Vol. II 87, 122).

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13. Dr. Monroe also prescribed Sinequan and Xanax for Patient #2 though he did not document why they were prescribed. Sinequan is a non-controlled tricyclic antidepressant indicated for depression and/or anxiety. However, tricyclic antidpressants are also occasionally used for pain control. Xanax is a Schedule IV anxiolytic indicated for the management of anxiety disorder or short term anxiety relief. On her registration sheet Patient #2 had reported use of Sinequan. Dr. Monroe first prescribed Sinequan on November 26, 1986. Prescription of Sinequan continued through October 19, 1988. The clinical summary for a hospitalization from October 29, 1988 through November 23, 1988 indicates that Xanax was one of Patient #2's medications on discharge. Dr. Monroe refiled it on December 23, 1988. Dr. DuPont assumed that the Sinequan had been prescribed in an attempt to control Patient #2's pain.

    These facts are established by State's Exhibit #13.

14. Dr. Monroe did occassionally try non-steroidal anti-inflammatory drugs for Patient #2's arthritis pain. Her gastric ulcer in June 1989 was attributed to use of that type of medication. The patient refused physical therapy on June 13, 1988 and refused a brace when she went to be fitted on December 4, 1989. He referred both Patient #3 and her husband to a dietary consult in August 1988. He referred her to a rheumatologist, Dr. Wolfe, in August 1988. Dr. Wolfe's practice was in Dayton but he occassionally traveled to Lima. Lima does not have a practicing rheumatologist. Dr. Monroe periodically prescribed Tegretol for the diabetic neuropathy.

    These facts are established by State's Exhibit #13 and by the testimony of Dr. Monroe (Tr. Vol. II 86).

15. Patient #3, then a 71 year-old man, first saw Dr. Monroe on April 25, 1986. Patient #3 is the husband of Patient #2. On his patient registration sheet, Patient #3 indicated that he had suffered two heart attacks, one in 1985 and one in 1986. He also reported present use of Darvocet. There is something illegible in Dr. Monroe's handwriting regarding the left shoulder on the patient's registration sheet. For that first office visit, Dr. Monroe recorded vital signs, height and weight, a regular heart, clear lungs and normal legs. He did not note a history of or a current complaint of arthritis pain, nor did he document a complete history regarding the patient's past use of addictive substances. Dr. Monroe did not write any prescriptions for Patient #3 on this visit. He did not document a treatment plan. Dr. Monroe had Patient #3 sign releases to obtain information from his previous doctor and from previous hospitalizations. Documents from a hospitalization in April 1986 are included within State's Exhibit 15 but there are no records from the patient's previous physician. The first prescription of Darvocet for Patient #3 was written by Dr. Monroe after the patient called on September 4, 1986 complaining of arthritis pain.

    These facts are established by State's Exhibit #15.

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16. Dr. Monroe testified that Patient #3 was in severe pain and that he prescribed Darvocet for that pain. Degenerative joint disease in the knees was not noted until an office visit of June 13, 1988. There were prior indications, however, of some shoulder pain. A hospital admission note of June 13, 1986 lists a history of significant arthritis of the right shoulder in Patient #3. There are no x-rays in the record that confirm the existence of arthritis in the knees or shoulders. Dr. Monroe did not want to prescribe nonsteroidal anti-inflammatory drugs for Patient #3 because of their effect on general circulation, particularly renal function.

    Between June 15, 1987 and December 14, 1988, an eighteen month period, approximately 1,000 dosage units of Darvocet were prescribed. Between February 14, 1989 and December 4, 1989, a ten month period, Dr. Monroe prescribed 3,000 dosage units. On numerous occassions he gave the patient four to five refills on prescriptions of 100 tablets. The refills were for when the patient would be in Florida. By February 20, 1989, the patient reported using two Darvocet tablets every four to six hours. The prescription printout (State's Exhibit #16) shows that an original Darvocet prescription for 100 tablets and its five refills were filled on the following dates: August 23, 1989, September 2, 1989, September 11, 1989, September 20, 1989, September 30, 1989 and October 11, 1989. This would indicate a usage of approximately ten tablets per day.

    These facts are established by State's Exhibits #15 and #16.

17. Patient #3's significant heart problems eventually led to his death on December 23, 1989. Over the years he had been diagnosed as suffering from congestive heart failure and arteriosclerotic heart disease. He had a heart attack in 1985, two in 1986, and double coronary bypass surgery in April, 1987. He had numerous emergency room visits and hospitalizations for shortness of breath and chest pain while treating with Dr. Monroe. He also had a history of chronic obstructive pulmonary disease and he had had his gallbladder removed at the time of his bypass surgery.

    These facts are established by State's Exhibit #15.

18. Patient #4 was a 55 year-old woman when she first saw Dr. Monroe on July 24, 1986. On her patient registration sheet she listed a history of a heart problem in 1972, a bad leg and a bad back. She also reported an aspirin allergy. The medical records indicate that over the course of almost four years, Patient #4 complained of the folloiwng medical conditions: heart problems, phlebitis, degenerative joint disease, overall leg pain, gastritis or ulcer, and gallstones. Dr. Monroe testified that she also suffered from chronic anxiety. On her first visit Dr. Monroe recorded a history of a myocardial infarction in 1972, phlebitis and injury from a job injury, disability, an ulcer, and gallstones. He recorded that she had been on her medications for years. Patient #4 had a Workers' Compensation claim for injuries to

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her right lower back, head, left elbow, and a strain of the right groin and left leg with resulting thrombophlebitis. Dr. Monroe did not know the circumstances of her job injury. On a later patient registration sheet (dated May 15, 1990) the patient stated that her injury had occurred in 1963. Dr. Monroe testified that "as he got to know her" Patient #4 demonstrated some degree of chronic pain in her left leg, along with degenerative joint disease and back pain.

Dr. Monroe testified that Darvocet was prescribed for the pain complaints and Valium for the anxiety. He also prescribed Darvocet and Valium because this patient had already been on those medications for several years. Over the course of his care of Patient #4, Dr. Monroe prescribed 3,107 dosage units of Valium 10 mg., and 3,620 dosage units of Darvocet.

These facts are established by State's Exhibit #17 and by the testimony of Dr. Monroe (Tr. Vol. II 92).

19. There are diagnostic tests in the medical record confirming that Patient #4 had a heart abnormality. There are no x-rays in the record confirming or evaluating degenerative joint disease and that condition was not mentioned in the medical record until January 26, 1988 when it was listed in a hospital history and physical. An acute episode of phlebitis is documented following a car accident in January 1988, but there are no physical findings documenting a leg problem prior to that date.

    These facts are established by State's Exhibit #17.

20. Though she had consistently complained of leg pain at her six previous office visits, the first notation of any sort of physical exam of the leg by Dr. Monroe was on February 16, 1987. That day notes, "exam-tender left leg, especially knee." Patient #4 did suffer an acute injury to her left leg as a result of a car accident on January 15, 1988. Dr. Monroe examined her on January 22, 1988 and found her left calf to be red, swollen and tender. He suspected superficial phlebitis. He pescribed Valium and Indocin, a nonsteroidal anti-inflammatory agent, and instructed her to elevate the leg, use hot towels, and rest. The leg worsened and Dr. Monroe had Patient #4 admitted to the hospital on January 26, 1988. At the hospital she was seen by a vascular surgeon who diagnosed a superficial vein thrombophlebitis of the left lower extremity. This bout with phlebitis was essentially resolved by March 29, 1988.

    A second car accident occurred on June 6, 1988. The patient complained of pain to the back of the head and the neck when she reported to the emergency room. An x-ray showed mild torticollis, possibly related to a muscle spasm. The patient only complained of neck pains for the next two office visits.

    These facts are established by State's Exhibit #17.

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21. The only specific notation of a diagnosis of chronic anxiety for Patient #4 was on a billing statement dated September 1, 1988. Dr. Monroe never recorded a description of this chronic anxiety. There is no indication that Dr. Monroe ever discussed it with the patient. Dr. Monroe never made a psychiatric referral for Patient #4's chronic anxiety. Dr. Monroe testified that he does not feel a psychiatrist is necessary for chronic anxiety patients until their Valium usage exceeds 20 mg. per day.

    These facts are established by State's Exhibit #17 and by the testimony of Dr. Monroe (Tr. Vol. II 74).

22. On numerous occasions Patient #4 telephoned Dr. Monroe's office requesting refills or replacements of medications. The bulk of these requests were denied by Dr. Monroe. Though she had received a prescription on July 24, 1986, for 60 Valium 10 mg., to be taken twice a day, on August 15, 1986 she requested additional Valium because a relative had been cremated without her knowledge. Dr. Monroe denied this request. On April 22, 1987, Dr. Monroe refused to see Patient #4 because she had been abusing her medication. On April 30, 1987 she telephoned and claimed to have lost her medication. The refill request was denied. The next day a relative called complaining that Patient #4, who took her Darvocet around the clock, did not have enough medication. The caller was told that the previous prescriptions should not be depleted. On June 1, 1987 Patient #4 called requesting a refill of her Darvocet. The request was denied. She received a prescription the next day when she had an office visit. Patient #4 called twice on August 24, 1987. One note indicates that when Darvocet and Valium were requested she was told that she had one refill on the prescriptions written July 24, 1987. The next note indicates that she claimed her purse with the refills in it had been stolen. Dr. Monroe would not refill the Darvocet. He also would not prescribe it when she called again on September 4.

    Though she had received prescriptions two months earlier for 100 Darvocet-N 100 and 200 Valium 10 mg., Patient #4 called the doctor's office on November 30, 1987 requesting refills. The request was denied and the patient made an appointment for December 2, 1987. On May 17, 1988 she requested refills of Valium and Darvocet. She had received a prescription for 60 Valium 10 mg. with one refill on March 29, 1988. Patient #4 also reported lost medication during office visits on September 8, 1987 and May 15, 1990.

    A pharmacy called Dr. Monroe on March 7, 1989 to inform him that Patient #4 had been requesting refills of Valium and Darvocet before the time they should have been needed. They were also concerned by the strange calls they had received from people calling on Patient #4's behalf and asking for refills because she had lost her pills. Despite this information, Dr. Monroe telephoned in a prescription for Valium and Darvocet on April 6, 1989 in response to Patient #4's telephone request. On the "Patient Prescription Record", Dr. Monroe's office form that lists the patient's current medications, there was a note to office staff to "watch pts. meds".

    These facts are established by State's Exhibit #17.

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23. On July 12, 1988, Patient #4 was seen in Dr. Monroe's office by J. P. Cleary, D.O. Dr. Cleary was apparently filling in at Dr. Monroe's office for a few days. (See also Finding of Fact #12) (Dr. Cleary's signature is on the Physician Statement form for the office visit of July 12, 1988). Dr. Cleary found Patient #4 "really spacey", with a flat affect and slurred speech. He prescribed 60 Darvocet-N 100 and 30 Valium 10 mg., less than the amount Dr. Monroe usually prescribed. (Office visit of May 23, 1988, Dr. Monroe prescribed 100 Darvocet-N 100 and 60 Valium 10 mg. with one refill of each).

    These facts are established by State's Exhibit #17.

24. According to the Physician's Desk Reference (PDR), Darvocet-N 100 is a Schedule IV narcotic analgesic indicated for the relief of mild to moderate pain. Its principle ingredient is propoxyphene. The PDR warns that propoxyphene products in excessive doses, either alone or in combination with other CNS depressants, are a major cause of drug-related deaths. It goes on to suggest that non-narcotic analgesics should be considered with patients who are depressed or suicidal. In stressing the importance of judicious prescribing of propoxyphene, the PDR points out that many of the propoxyphene related deaths have occurred in patients with histories of emotional disturbances and misuse of alcohol. Some deaths have occurred from accidental ingestion of excessive quantities. Patients should be warned not to exceed the recommended dose.

    If taken in higher than recommended doses over long periods of time, propoxyphene can produce drug dependence. It has an additive effect with other CNS depressants. The usual dose of Darvocet-N 100 is 100 mg. every four hours as needed for pain with a maximum recommended dosage of 600 mg. per day.

    These facts are established by State's Exhibits #8 and #9.

25. Valium is a benzodiazepine indicated for the management of anxiety disorders or for the short-term relief of anxiety symptoms. It can also be used adjunctively in convulsive disorders though its usefulness for periods greater than four months as not been clinically assessed. The PDR states that anxiety or tension associated with the stress of everyday life does not usually require treatment with an anxiolytic such as Valium. In patients who have received excessive doses over an extended period of time, withdrawal symptoms have occurred following abrupt discontinuance. The use of Valium with narcotics may potentiate the action of Valium. Abrupt withdrawal of Valium which is being used as a convulsion control adjunct can cause a temporary increase in the frequency and/or severity of seizures. Recommended adult dosage is 2 mg. to 10 mg., 2 to 4 times daily.

    These facts are established by State's Exhibits #8 and #9.

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26. Two articles submitted by the Respondent indicate that the abuse potential for benzodiazepines, when appropriately prescribed, is relatively low. A task force of the American Psychiatric Association recently reported the results of its study of the use, toxicity, dependency and abuse of benzodiazepines. The study was undertaken because of an increasing concern over the hazards associated with this class of medication. It found that benzodiazepines are poor self-reinforcers of use. They are rarely taken simply for pleasure, and consequently, they are not likely to be abused. That is not the case with alcoholics or drug abusers who use benzodiazepines to increase euphoria, decrease anxiety and withdrawal symptoms, or to ease the "crash" from cocaine-induced euphoria. Chronic use of benzodiazepines will lead to physiologic dependence characterized by withdrawal symptoms. Generally, benzodiazepines are therapeutic drugs with mild toxicity and low tendency for abuse. However, the task force also found that benzodiazepines may be inappropriately prescribed, prescribed for overly long periods, or taken by patients for long periods without clear indications for continued use. In particular, the therapeutic indications for long-term use among chronic dysphoric patients may be less clear than for other groups.

    In December, 1988, the results of a comprehensive review of the existing data on the use and abuse of benzodiazepines was published in the Journal of the American Medical Association. The authors concluded that nonmedical use of benzodiazepines was rare, though the drug is used with some frequency by those with histories of drug abuse. Psychological dependence on benzodiazepines, in the authors' opinion, was not a substantial risk and physiological dependence was not accompanied by a tendency to increase dosage. Those conclusions may not be applicable to long-term users though as more information was needed regarding long-term use. The view that benzodiazepines remain effective over longer periods and that tolerance does not develop remained controversial, in the authors' opinion. The authors agree with the APA task force on the importance of taking a thorough history prior to prescribing in order to identify those patients with histories of prior alcohol or drug abuse.

    These facts are established by Respondent's Exhibits A and I.

27. Craig T. Pratt, M.D., testified as an expert witness for the State based upon his review of the medical records for Patients 1 through 4. Dr. Pratt, a former anesthesiologist, is currently in a psychiatry residency and has spent the past eight years of his career specializing in addictionology. He is certified in addictionology by the American Society of Addiction Medicine.

    According to Dr. Pratt, chronic pain should be a diagnosis in itself rather than simply a symptom of an underlying disorder. If pain persists after six months it can generally be termed chronic rather than acute pain. A patient could then be diagnosed as suffering from chronic pain syndrome. Once a diagnosis of chronic pain syndrome is

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made, a physician should outline a thorough treatment plan, which would include: comprehensive neuropsychological evaluation; psychological testing; psychometric evaluation; psychiatric evaluation; electrophysiologic or electromyographic studies of the patient's pain distribution; occupational and physical therapy; and counseling. Only with such a plan can the physician define the boundaries of care to be provided. The physician's goal with a chronic pain syndrome patient should be a lessening of the patient's pain behavior rather than an attempt to remove the pain entirely. Dr. Pratt emphasized the importance of a complete history. The physician should inquire as to whether other family members suffer from a chronic pain situation.

Because of the potential for addiction and tolerance, Dr. Pratt believes that Darvocet and Valium have no utility in a chronic pain situation. Particularly in elderly patients, these controlled substances can compromise cognitive ability and emotional stability. Effects of withdrawal could have serious health complications, particularly stress on the autonomic system and cardiovascular system. Furthermore, according to Dr. Pratt, addictionologists find propoxyphene, the principle ingredient of Darvon and Darvocet, to be an addiction facilitating medication and a poor analgesic. It also lowers the seizure threshold. The prescribing of that medication poses more risk than benefit as there is not much room for error in terms of a minimal lethal dosage. Dr. Pratt feels that Benzodiazepines, such as Valium, are not the best agents for the treatment of anxiety and panic. He did admit, however, that there is a division of opinion on the long-term use of benzodiazepines. These drugs should not be prescribed by a physician simply because a patient reports previous usage. It is not the physician's role to be an on-going chemical prescriber.

In Dr. Prattt's opinion, the care rendered by Dr. Monroe in these four cases constituted failure to use reasosnable care discrimination in the administration of drugs, failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease, and a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances. Dr. Pratt found Dr. Monroe's patient records to be inadequate; they did not properly reflect examinations performed or physical findings made. Dr. Pratt found all of the four medical records to be illegible and difficult to track. Dr. Pratt was not able to discern the reason for the prescribing of the controlled substances. He noted a pervasive lack of sensitivity to addiction awareness throughout all the medical records. In Dr. Pratt's opinion, Dr. Monroe excessively prescribed controlled substances without taking into accouont their potential for abuse, the possibility of dependence, and the possibility the patients may obtain the drugs for a nontherapeutic use or for distribution to others. Further, Dr. Pratt felt that the medications were inappropriately prescribed and were prescribed without the utilization of diagnostic testing.

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With regard to each particular patient, Dr. Pratt opined as follows:

a. Patient #1: there was evidence of alcoholism in the record, specifically elevated GGTP levels. The quantity prescribed and the frequency of the prescriptions indicated drug-seeking behavior. The patient seemed more interested in the acquisition of the drug than with the resolution of the problem. Addiction was a primary concern to be ruled out with this patient. At times, Dr. Monroe questioned what was going on with the drugs but took no appropriate action. The need for the Valium and the Darvocet cannot be determined from the medical record. Further, those substances should never be prescribed on a long-term basis. Darvocet was contraindicated because it tends to lower a person's seizure threshold. Because of the potential alcohol problem with this patient, he was at higher risk of oversedation and overdose. Overdose should have also been a concern because of this patient's emotional problems. The ongoing prescribing of the same controlled substances to two persons living in the same household presented a high risk situation.

b. Patient #2: Dr. Monroe managed this patient on a day-to-day basis rather than with a long-term plan. There was some redundancy with the eight to ten medications that Patient #2 was taking. Dr. Monroe should have engaged in a re-evaluation of these medications. This patient was a "pharmacologic nightmare".

c. Patient #3: Dr. Monroe should have been more concerned about the use of Darvocet because of this patient's cardiac status. Should the patient go into withdrawal, he was at risk of cardiac failure. He saw no evidence of concern on Dr. Monroe's part regarding possible confusion with the medications.

d. Patient #4: There was little doubt that this patient was sedative and opioid dependent. The records seem to document that she was using her medications inappropriately; there were requests for premature refills and other people calling for refills in her behalf. There was evidence of drug-seeking behavior. Dr. Monroe did not document why these medications were prescribed. Gallbladder pain is not chronic. There was no indication for the prescribing of Valium. Again, the drugs were contraindicated because of the patient's cardiac status. There should have been a psychiatric evaluation and a referral for evaluation for detoxification. Only one hospital note documenting degenerative joint disease was found.

These facts are established by the testimony of Dr. Pratt (Tr. Vol. I 13-150).

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28. Robert L. DuPont, M.D., testified as an expert witness for the Respondent. His testimony was based upon a review of the records and a discussion with Dr. Monroe. Dr. DuPont is a board certified psychiatrist specializing in chemical dependence and anxiety disorders. He is certified in addictionology by the American Society of Addiction Medicine. Dr. DuPont has served as an adviser to the federal government in the area of drug abuse.

In Dr. DuPont's opinion, Benzodiazepines such as Valium, have no abuse potential whatsoever among people who are not chemically dependent. He acknowledged that the drug can be a problem for alcoholics and drug addicts. He believes that Benzodiazepines are currently underused in medical practice due to fear of addiction. He is comfortable with any prescribing of Valium that is within 20 mg. per day. Valium would be an appropriate medication for a diagnosis of chronic anxiety. Darvocet, or Propoxyphene, also has low abuse potential. This drug is commonly prescribed for chronic pain and to so prescribe is within normal medical practice.

Dr. DuPont drew a distinction between physical dependence and addiction with addiciton being a "liking" of the drug, a loss of control of the use of the substance, and physical dependence being a simple cellular adaptation to the drug. After reviewing Dr. Monroe's records for Patients 1 through 4, Dr. DuPont saw no evidence of addiction though some of these four patients could have been physically dependent. Signs of addiction would be taking lots of different drugs, the concomitant use of alcohol, obtaining drugs from several different doctors, lying to the doctor, or life problems created by the drugs. If these had been questionable patients, Dr. DuPont would have wanted to see much more record keeping. With all four patients, Dr. DuPont found Dr. Monroe's prescribing to be neither excessive nor inappropriate. Furthermore, he felt that the medical records were quite complete and accurate.

None of these four patients were "typical" drug abusers, in Dr. DuPont's opinion. Those individuals tend to be young, male, and otherwise healthy. From the review of the record, it was Dr. DuPont's opinion that Dr. Monroe had established a legitimate, bonafide physician-patient relationship with these individuals.

Dr. DuPont could not specifically recall seeing the word "headache" in the record of Patient #1, but he stated that post-aneurysm patients often suffer headaches and his overall impression from reading the record was that the patient had suffered from headaches. He also could not pinpoint exactly where a diagnosis of chronic anxiety for Patient #1 could be found in the record, but the patient "appeared to have lots of problems." It was his assumption that the Darvocet prescribed for Patient #3 had been for his osteoarthritis. He did not know whether there was pain associated with this patient's arteriosclerotic heart disease; any pain from the congestive heart failure would have been sporadic; angina from the coronary artery disease would have been acute, not chronic. Dr. DuPont has reviewed the records of a family

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physician on five or six occasions. He admitted that the kind of record keeping required of a family physician is "an art form that I don't have and don't aspire to."

Dr. DuPont found Dr. Monroe's care in these four cases to have exceeded minimal standards. He felt Dr. Monroe had used reasonable care in the prescribing of medications and that he had ordered or performed the appropriate diagnostic tests.

These facts are established by the testimony of Dr. DuPont (Tr. Vol. I 207-286).

29. Ronald W. Whisler, M.D., testified as an expert witness for the Respondent. Dr. Whisler is a professor of internal medicine at Ohio State University and is board certified in both internal medicine and rheumatology. The bulk of his time is spent in the rheumatology field. All of Dr. Whisler's patients are referrals, consequently he has had numerous occasions to review the records of family practitioners. He found Dr. Monroe's records to have been fairly typical of the type he has seen. In his experience, patients suffering from arthritis often do not even know how to describe the pain they are experiencing. When a family practitioner or internist notes "arthritis" in the patient record, it means that the patient has pain. He does not feel that nonsteroidal anti-inflammatory drugs would be sufficient for any patient whose arthritis is severe enough to warrant a knee replacement.

Dr. Whisler personally does not like or use Darvocet. In his experience, patients tend to rely on Darvocet-N 100 more than they do on some of the other Darvon compounds. With patients suffering from the chronic pain of osteoarthritis or rheumatory arthritis, Dr. Whisler uses injections rather than controlled substance analgesics.

These facts are established by the testimony of Dr. Whisler (Tr. Vol. I 306-325).

30. Nicholas A. Votolato, Ph.D., testifed as an expert witness on behalf of the Respondent. Dr. Votolato is a clinical pharmacist and professor of pharmacology at the College of Medicine, Ohio State University. His specialty is psychopharmacy, or the study of drugs that affect the central nervous system. He reviews the records of physicians to determine the appropriateness of medications for the recorded and indicated diagnoses. Dr. Votolato routinely advises physicians on the use of drugs such as Darvocet and Valium.

In Dr. Votolato's opinion, Valium usage that is within 20 mg. per day is rarely a problem for the patient. Dr. Votolato believes that most chronic use of Benzodiazepines appears to be medically appropriate and does not lead to dose escalation or abuse.

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Dr. Votolato saw no dosage escalation in any of these four cases, nor did he have a problem determining the diagnoses or treatment from his review of the medical records. He found Dr. Monroe's prescribing in these four cases to have been within ordinary care. He believed Dr. Monroe evidenced a monitoring process over these patients.

These facts are established by the testimony of Dr. Votolato (Tr. Vol. II 6-43).

31. Eric Fisher, M.D., a Lima internist specializing in cardiology, testified regarding his treatment of Patients #2 and #3. Dr. Fisher consulted with Dr. Monroe on Patient #2 during her hospitalizations for abdominal and chest pain. Dr. Fisher saw Patient #3 in his office on a routine basis for his cardiology problems. Dr. Fisher knew that Dr. Monroe had been prescribing Darvocet for Patient #3. Indeed, he also prescribed Darvocet for Patient #3. He recalled a specific office visit where Patient #3 had been so debilitated by his arthritis pain that he had barely been able to walk across Dr. Fisher's examining room. He saw no indications of abuse or adverse effect of the medication with either Patients #2 or #3. He believes that the Darvocet was indicated for both patients' pain from severe arthritis. Dr. Fisher does not agree with Dr. Pratt's opinion that Darvocet is contraindicated in an individual with heart problems.

These facts are established by the testimony of Dr. Fisher (Tr. Vol. II 45-52).

32. Dr. L. Y. Soo treated Patient #1 for his aneurysm and its after affects. Dr. Soo is board certified in neurosurgery. Dr. Soo performed the original surgery in 1979 and saw the patient three times that year. He saw the patient in 1986 and 1987 after Dr. Monroe's referral for evaluation of Patient #1's complaint of headaches. Tests were performed and Dr. Soo further referred the patient for psychological testing. Other than the statement in Dr. Soo's affidavit, there is no indication that he treated Patient #1 for "generalized anxiety". Dr. Soo believes the Darvocet and Valium prescribed by Dr. Monroe to have been appropriate, however, there is nothing in the record to indicate that he was aware of the duration or extent of the prescribing.

These facts are established by Respondent's Exhibit L.

33. Dr. Thomas C. Linn is board certified in neurology and consulted on Patient #2. He assisted Dr. Monroe in the treatment of her diabetic peripheral neuropathy. In Dr. Linn's opinion, the neuropathy, coupled with the osteoarthritis, caused the patient to be in significant pain. Over the course of a year and one half he saw the patient eleven times. He was aware of Dr. Monroe's prescribing of Darvocet-N 100 and found it to be appropriate. There is nothing in the record to indicate that Dr. Linn was aware of Patient 2's use of 8 Darvocet-N 100 per day.

These facts are established by Respondent's Exhibit M and by State's Exhibit #15.

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CONCLUSIONS

1. The acts, conduct, and/or omissions of Melvin Monroe, M.D., as set forth in the above Findings of Fact, in compiling medical records for Patients #1 through #4, constitute:

   a. "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; and

   b. "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or the 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, "a physician shall complete and maintain accurate medical records reflecting his examination, evaluation, and treatment of all his patients. Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based." This conclusion applies to the records kept by Dr. Monroe on and after November 17, 1986, the effective date of the Rule.

Dr. Monroe's medical records do not meet the minimum standard required of practitioners. That standard may not require the notation of a chronic disorder on each office visit. However, Dr. Monroe did not note certain diagnoses even once. Dr. Monroe never wrote a diagnosis of chronic anxiety for Patient #1 or Patient #4. Describing a patient as "very anxious" almost two years after the first prescription for Valium was written for Patient #1 hardly constitutes sufficient documentation. Nor does it satisfy minimum standards of record keeping to have an employee note a diagnosis of "anxiety" on Patient #1's disability application five months after treatment with Valium had commenced. For purposes of documenting care rendered, the physician's copies of billing statements do not constitute part of the medical record. Consequently, Dr. Monroe's notation of chronic anxiety reaction on a billing sheet dated September 1, 1988 for Patient #4 does not meet the minimal standards of care.

A specific diagnosis of headaches as a result of aneurysm surgery is never documented in Patient #1's medical record. Headache is noted on September 4, 1986 when the patient called the office, however that note does not say "post-aneurysm headache". Dr. Soo qualified the headache as a subjective complaint and found no objective confirmation.

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For months Patient #4 complained of left leg pain and all that can be gleaned from the medical record is that she had had a worker's compensation claim that included the left leg. The initial job accident and resulting injury are never described in the record yet from the outset of treatment, Dr. Monroe prescribed Darvocet for pain. If any of the Darvocet prescriptions prior to January 1988 had been for arthritis pain, than no reviewing physician would have known this. Degenerative joint disease is not mentioned in the record until January 26, 1988.

Dr. Monroe may have indeed engaged in thorough physical examinations of the patients each time they came to his office. No such examinations are documented in the record, however. With a few exceptions, the bulk of the office visits simply record the patient's presenting complaint or note that the visit was a routine checkup, and then list the prescriptions written. Even the presenting complaints are poorly documented. Patient #1's headaches are never described; Patient #4's arthritic pain is never described; Patient #4's leg pain is not described; Patient #1 and #4's chronic anxiety is not described.

2. The acts, conduct, and/or omissions of Melvin Monroe, M.D., as set forth in the above Findings of Fact, in prescribing Valium and Darvocet-N 100 to Patients #1 and #4, and Darvocet-N 100 to Patients #2 and #3, constitute:

   a. "Failure to use reasonable care discrimination in the administration of drugs," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code;

   b. "Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in Section 4731.22(B)(3), Ohio Revised Code;

   c. "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; and

   d. "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 Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(C), Ohio Administrative Code, "a physician shall not utilize a controlled substance without taking into account the drug's potential for abuse, the possibility the drug may lead to dependence, the possibility the patient will obtain the drug for a nontherapeutic use or to distribto others, and the possibility of an illicit market for the drug."

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Dr. Monroe excessively pescribed Darvocet to Patients #2 and #3 and, thus, failed to exhibit reasonable care discrimination in the administration of drugs and fell below minimal standards of care. Darvocet in excess of the recommended dosage is very dangerous, particularly in a patient with a history of depression such as Patient #2. Furthermore, Darvocet, as a central nervous system depressant, has significant effect on the cognitive ability of elderly patients. Dr. Monroe allowed Patients #2 and #3 to escalate their use of Darvocet to up to ten tablets per day.

Dr. Monroe failed to document the diagnosis of chronic anxiety in Patients #1 and #4. He failed to engage in the thorough history necessary to make such a diagnosis. He admitted at hearing that he had prescribed the Valium partly because the patients had already been taking it. That may be reason to prescribe increasingly smaller amounts to prevent withdrawal symptoms but it is not a sufficient basis to justify the prescribing of Valium over a three year period. Consequently, by prescribing Valium to those patients, Dr. Monroe failed to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. The long-term prescribing of Valium to these patients was simply not indicated. There is nothing in their records to document the need. Even if there truly was chronic anxiety, as the APA pointed out, the therapeutic indications for long term use of Valium for chronic dysphoria is not clear. It was also not indicated in light of Patient #1's possible alcohol problem and in light of the abuse demonstrated by Patient #4. Further, there are no evaluative tests in the record nor are there descriptions of any physical examinations done by Dr. Monroe of Patient #4's complaints of leg pain prior to her automobile accident in January, 1988. Consequently, the prescribing of Darvocet for this pain constituted failure to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease.

It cannot be said that Dr. Monroe totally discounted the possibility of dependency of or the potential for abuse with these drugs. He did refuse demands for refills and he did exhibit a knowledge of the drugs' properties at hearing. However, this awareness was not properly acted upon. Dr. Monroe did not sufficiently take into account the potential for abuse and the possibility of dependence by refusing to issue refills when requested. This may have kept the patient to a certain maximum number of pills per month or per two months, but it did not guarantee that the usage of those pills during that time period would be appropriate. By continuously calling in early for refills, Patient #4 documented that she was not using her Valium appropriately. Dr. Monroe may have guaranteed that she went for a week or so without Valium until she came in for an appointment but he did not guarantee that she took only two tablets per day. Furthermore, there was ample evidence of drug seeking behavior on the part of Patient #4. A pharmacy had even called Dr. Monroe to notify him of inappropriate requests for medication for Patient #4, yet the record does not reflect that Dr. Monroe ever discussed her medication usage with the patient.

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He did nothing in the face of Dr. Cleary's documentation that she had seemed spacey and had slurred speech. Dr. Monroe continued to prescribe Darvocet to Patients #2 and #3 after their usage exceeded the recommended daily dosage. He continued to prescribe to Patient #2 even after Dr. Cleary described her as having an addictive personality and even after he himself attributed her unsteady gait and vertigo to Darvocet usage.

The testimony of Dr. DuPont that the prescribing of Dr. Monroe was appropriate is not persuasive. Dr. DuPont was satisfied with the prescribing of Dr. Monroe partly because Dr. Monroe was picking the medications. In fact, the opposite was true. All the patients were on Darvocet and/or Valium when they began treating with Dr. Monroe. Indeed, their prior use of those medications was part of the reason Dr. Monroe continued to prescribe them. Further, Dr. DuPont was not troubled by the prescribing because these patients were all being seen by other physicians who would have been in a position to monitor Dr. Monroe's care. Patient #1 was seen by Dr. Soo and Dr. Scherger for purposes of evaluation, not treatment. Furthermore, his visits with those doctors were in late 1986 or early 1987. No additional physicians, other than emergency room physicians, saw Patient #1. Other than a hospital admission for syncope, evaluation of the acute episode of thrombophlebitis and various emergency room visits, Patient #4 was not seen by any other physicians. In Dr. DuPont's opinion these patients were not likely to be successful candidates for behavior modification. He stated "you don't usually send sick, older patients who are taking medicines like this..." At the outset of treatment, Patient #1 was 36 years old, just three years older than the patient given as an example of a successful behavior modification candidate by Dr. DuPont. In rendering his opinion that Dr. Monroe's dosage levels had been within what he considered an acceptable amount, Dr. DuPont referenced Respondent's Exhibit J, the chart used at hearing, which lists an average daily dosage of Darvocet for Patient #2 of 3.06 pills per day and for Patient #3 of 4.37 pills per day. Dr. DuPont failed to address the fact that is clear from the medical records that these patients took 8 to 10 Darvocet per day for a considerable length of time. Dr. DuPont could not point to a specific diagnosis of chronic anxiety in the medical record of Patient #1. He based his belief that that had been the diagnosis on the fact that "the patient himself appeared to have, I don't what, lots of problems, he was a troubled guy." The only "problems" or "troubles" presented in the record for Patient #1 was that he was of upper level borderline intelligence, that his ex-wife called once saying he had emotional problems and that when he saw Dr. Soo he had poor hygiene. Dr. DuPont's assumptions about Patient #1's chronic anxiety are more likely based on his discussion with Dr. Monroe than on a review of the record.

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PROPOSED ORDER

It is hereby ORDERED that:

1. The certificate of Melvin Monroe, M.D., to practice medicine and surgery in Ohio shall be REVOKED. Such revocation is stayed, and Dr. Monroe's certificate is hereby SUSPENDED for an indefinite period of time, but not less than one year.

2. The State Medical Board shall not consider reinstatement of Dr. Monroe's certificate to practice medicine and surgery in Ohio unless and until all of the following minimum requirements are met:

   a. Dr. Monroe shall submit an application for reinstatement, accompanied by appropriate fees. Dr. Monroe shall not make such application for at least one (1) year from the effective date of this Order.

   b. Dr. Monroe shall provide documentation of successful completion of thiry (30) hours of Continuing Medical Education courses in the area of chronic pain management, and chemical dependecy recognition in management. Such courses are to be approved in advance by the Board and shall not count toward fulfillment of the Continuing Medical Education required by Section 4731.281, Ohio Revised Code.

   c. In the event that Dr. Monroe has not been engaged in the active practice of medicine and surgery for a period in excess of two (2) years prior to application for reinstatement, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of Dr. Monroe's fitness to resume practice.

   d. Dr. Monroe shall provide evidence satisfactory to the Board of successful completion of a course in pharmacology to be approved in advance by the Board or its designee.

3. Upon reinstatement, Dr. Monroe's license shall be subject to the following probationary terms, conditions, and limitations for a period of five (5) years:

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

   b. Dr. Monroe shall submit quarterly declarations under penalty of perjury stating that there has been compliance with all the terms of probation.

   c. Dr. Monroe shall appear in person for interviews before the full Board or its designated representative at three (3) month intervals, or as otherwise requested by the Board.

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d. Dr. Monroe shall keep a log of any controlled substances purchased, prescribed, dispensed, or administered. Further, Dr. Monroe shall make his patient records with regard to such prescribing available for review by an agent of the State Medical Board upon request.

e. In the event that Dr. Monroe should leave Ohio for three (3) consecutive months, or reside or practice outside the state, Dr. Monroe must notify the State Medical Board in writing of the dates of departure and return. Periods of time spent outside of Ohio will not apply to the reduction of this probationary period, unless otherwise determined by motion of the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.

4. If Dr. Monroe violates the terms of this Order in any respect, the Board, after giving Dr. Monroe notice and an opportunity to be heard, may set aside the stay order and impose the permanent revocation of his certificate.

5. Upon successful completion of probation, Dr. Monroe's license will be totally restored. This Order shall become effective thirty (30) days from the date of mailing of notification of approval by the State Medical Board of Ohio. In the thirty (30) day interim, Dr. Monroe shall not undertake the care of any patient not already under his care.

Joan Irwin Fishel
Attorney Hearing Examiner

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EXCERPT FROM THE MINUTES OF AUGUST 14, 1991

REPORTS AND RECOMMENDATIONS

Mr. Albert stated that the Findings and Orders appearing on today's agenda are those in the matters of: Sylvester L. Casta, M.D.; Melvin Monroe, M.D.; Nigel K. Roberts, M.D.; Rita Sue Carnevale; and Paula Elizabeth West.

Mr. Albert asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and orders, and any objections filed in the matters of Sylvester L. Casta, M.D.; Melvin Monroe, M.D.; Nigel K. Roberts, M.D.; Rita Sue Carnevale; and Paula Elizabeth West. A roll call was taken:

ROLL CALL:	Dr. Cramblett	- abstain
	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- aye
	Mr. Jost	- abstain
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Ms. Rolfes	- aye
	Dr. Agresta	- aye
	Mr. Albert	- aye

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

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REPORT AND RECOMMENDATION IN THE MATTER OF MELVIN MONROE, M.D.

Mr. Albert advised that a motion for permission to have a court reporter present during the Board's deliberations in this matter has been filed by Dr. Monroe's attorney.

DR. O'DAY MOVED TO GRANT THE REQUEST WITH THE UNDERSTANDING THAT A COPY OF THE TRANSCRIPT WILL BE PROVIDED TO THE BOARD PROMPTLY, AND THAT THE BOARD'S MINUTES SERVE AS THE OFFICIAL RECORD OF THIS MEETING. DR. GARG SECONDED THE MOTION. A roll call vote was taken:

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ROLL CALL VOTE:	Dr. Cramblett	- abstain
	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- aye
	Mr. Jost	- abstain
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Ms. Rolfes	- aye
	Dr. Agresta	- aye

The motion carried.

Mr. Albert stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and order in the above matter. No objections were voiced by Board Members present.

DR. HOM MOVED TO APPROVE AND CONFIRM MS. FISHEL'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF MELVIN MONROE, M.D. DR. AGRESTA SECONDED THE MOTION.

Mr. Albert asked if there were any questions concerning the proposed findings of fact, conclusions, and order in the above matter.

Dr. O'Day stated that she disagreed with some of the conclusions and findings of fact. She added that she is not in a position at this time to offer an alternative, but would like to discuss the matter before tabling it to prepare an alternative.

Dr. Monroe's attorney, Robert E. Tait, Esq., indicated that he had filed a motion to address the Board at the same time he filed the request for permission to have a court reporter present. It was indicated that that motion was not received. Mr. Tait indicated that he did have a time-stamped copy of that motion at his office.

Dr. Stephens asked whether the Board could move to grant his request, even though the Board does not have the request in its file.

Mr. Albert noted that there is already a motion on the floor which would need to be withdrawn.

DR. HOM WITHDREW HER MOTION. DR. AGRESTA, AS SECOND, AGREED.

DR. STEPHENS MOVED TO GRANT MR. TAIT'S REQUEST TO ADDRESS THE BOARD. DR. GARG SECONDED THE MOTION. A roll call vote was taken:

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ROLL CALL VOTE:	Dr. Cramblett	- abstain
	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- aye
	Mr. Jost	- abstain
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Ms. Rolfes	- nay
	Dr. Agresta	- aye

The motion carried.

Mr. Albert reminded Mr. Tait that the Board is not going to retry the case. The Board is only interested in anything new beyond what is already in the transcript.

Mr. Tait stated that he understood, and indicated that he would be brief. He stated that he knows that the Board has indicated that it has reviewed the findings and the record in this case. He asked that before the Board takes any action with respect to this matter it does review the record. There are over 500 pages of transcript and 1,000 pages of exhibits. Mr. Tait noted that many times the Board has doctors before it who are guilty of over-prescribing medicine, and many times are guilty of criminal conduct. He added that this is not that type of case.

Mr. Tait advised that the testimony presented in this case was all expert testimony. In addition to Dr. Monroe, there was testimony from three Board-certified specialists who consulted on the four patients in question, two professors of medicine from Ohio State Medical School, who had no relationship to Dr. Monroe at all, and the former drug czar of the United States, who is perhaps one of the foremost experts in addictionology in the United States. All of them felt the medical care in this case, and in particular the prescribing of Darvocet and Valium, was appropriate and indicated medical care for the four individuals in question. Unless the Board decrees that prescribing Darvocet and Valium in and of itself is substandard medical practice, there isn't any evidence in this case that Dr. Monroe was guilty of overprescribing or substandard medical practice.

Mr. Tait continued that the only evidence at all was the testimony of the State's medical expert, Dr. Pratt, who has never completed a residency, has never been in private practice, and who acknowledges that he has a drug problem.

Mr. Albert indicated that Dr. Pratt is not here to defend himself, and he is not the subject of this hearing.

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Mr. Tait stated that Dr. Pratt's opinions are tainted by his history, and this is something of which the Board should be cognizant.

Mr. Tait stated that the evidence was overwhelming that there was no overprescribing in this case. Five recognized independent experts testified. Mr. Tait asked that the Board give due consideration to the testimony.

Mr. Albert asked Ms. Sotos whether she wished to respond.

Ms. Sotos stated that the Findings of Fact and Conclusions of Law of the Hearing Examiner are an accurate reflection of what occurred in this case. Her conclusions are based on law, and the recommended discipline is reasonable. This case concerned four patients and violations of minimal standards with respect to both the records kept for these patients and the amount and duration of drugs prescribed. The records reflect that there was no reason to prescribe the Darvocet and Valium for these patients. There was no evaluation of the patients, there was excessive prescribing, there was drug-seeking behavior, and there was addiction, which was not addressed. Ms. Sotos urged the Board to adopt the Hearing Officer's Proposed Findings of Fact, Conclusions of Law, and Order.

DR. STEPHENS MOVED TO TABLE THIS MATTER. HE THEN WITHDREW THE MOTION.

DR. HOM MOVED TO APPROVE AND CONFIRM MS. FISHEL'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF MELVIN MONROE, M.D. DR. AGRESTA SECONDED THE MOTION.

Mr. Albert asked if there were any questions concerning the proposed findings of fact, conclusions, and order in the above matter.

Dr. O'Day stated that she had some problems with this case, having to do somewhat with the medical recordkeeping. She did not feel that Dr. Monroe misprescribed. She added that if the Board holds the recordkeeping standard to one of another physician being able to pick up the record and take over the patient's care, she believes Dr. Monroe's records clearly document that all of these patients had chronic pain and there were indications for prescribing Darvocet. She did have problems with Dr. Monroe's prescribing Valium for patients 1 and 4, in particular. She did not have any problem with his prescribing for patients 2 and 3. Dr. O'Day stated that the problem, as she sees it, is the adherence to a different standard when it comes to recordkeeping for scheduled drugs. Although Darvocet is only a Schedule IV, it is still a controlled substance. Under those circumstances, it is important to document the response to therapy. Dr. O'Day stated that there is a high standard for recordkeeping that goes along with the continued prescription of Schedule IV drugs. Dr. O'Day stated that it is also important that the Board recognize that the management of chronic pain in the community, particularly by

family practitioners, is difficult and necessary. She stated that she saw nothing wrong in Dr. Monroe's management of the four patients. Her quarrel is with the recordkeeping concerning patients 1 and 4.

Dr. Garg agreed with Dr. O'Day.

Dr. Heidt stated that Dr. Monroe certainly keeps poor records. Dr. Heidt noted that Dr. Monroe is a family practitioner, and there is a question of whether family practitioners should be looked upon less stringently than other practitioners. In the practice of medicine physicians deal with taking care of people and they must keep good records. Dr. Heidt stated that there was some sloppiness in prescribing so much Darvocet. He added that Darvocet is not too bad of a drug. It is not spectacular for pain relief, but side effects are minimal. Dr. Heidt stated that he understands Darvon is addictive, but Darvocet is not. Dr. Heidt stated that he felt revocation in this case is too harsh as far as he was concerned.

Dr. Stephens stated that physicians who treat patients with chronic pain are faced with a dilemma. He did not share Dr. Monroe's opinion on the use of Valium, but he did not see a whole lot wrong with Dr. Monroe's use of Darvocet. Dr. Stephens stated that it would behoove Dr. Monroe to be more cautious in his prescribing this type of drug, but he doesn't think that this particular case deserves revocation.

Dr. Gretter stated that, on the positive side, Dr. Monroe did see the patients on a regular basis, and on a regular basis he did manage to get basic information concerning the patients. He didn't manage to document a lot of particulars concerning why the patient was there, the objective findings, reasons for prescribing, etc. He did, however, according to some of the phone conversation notes available, maintain a discussion with the patients, and he was concerned about the possibility of addiction. Dr. Gretter stated that upon looking at the record where patients were seen other places, by other specialists, or in other emergency rooms, an overall picture of what was happening begins to develop.

Dr. Gretter continued that, on the negative side, Dr. Monroe was the family practitioner and the primary care physician, and there was very little information in the records to assess the ongoing longitudinal care of these particular patients.

Dr. Gretter stated that another concern was that, although the amount of Darvocet prescribed did not seem to be a lot and was well within the realm of "non-excessive," when such medication is used over long periods of time there is the possibility of other things, other organ systems, going wrong on the basis of the medicine. None of this was looked at. There was no documentation that Dr. Monroe looked at all of this. Dr. Gretter stated that those aspects must be considered.

Dr. Hom stated that, as a family practitioner, she didn't appreciate the thought

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that a family physician should be held to a lower standard of medical recordkeeping. She didn't find that Dr. Monroe's records were adequate to even inform another physician on continuation of care. Dr. Hom stated that she had significant concerns. She noted that Dr. Monroe had a patient with pancreatitis, and Darvocet may have caused pancreatitis. Dr. Hom stated that physicians need to take into account the effects of the medication. Dr. Monroe didn't document alternative therapies that he could have, or possibly had reasons not to, use for these patients. Dr. Hom agreed that the use of Darvocet on a limited basis for continuing care for chronic pain is a legitimate use in an appropriate setting, but physicians must clearly identify the situation. It should not be used in every case of chronic pain. There are patients with specific contraindications for alternative therapy.

DR. O'DAY MOVED TO TABLE THE MATTER OF MELVIN MONROE, M.D. DR. GARG SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. Cramblett	- abstain
	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- aye
	Mr. Jost	- abstain
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Ms. Rolfes	- aye
	Dr. Agresta	- aye

The motion carried.

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DR. O'DAY MOVED TO REMOVE THE MATTER OF MELVIN MONROE, M.D., FROM THE TABLE. DR. GRETTER SECONDED THE MOTION. A roll call vote was taken:

ROLL CALL VOTE:	Dr. Cramblett	- aye
	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- aye
	Mr. Jost	- aye
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Ms. Rolfes	- aye

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Dr. Agresta - aye

The motion carried.

DR. O'DAY MOVED THAT THE CONCLUSIONS IN THE MATTER OF MELVIN MONROE, M.D., BE AMENDED BY SUBSTITUTING THE FOLLOWING FOR CONCLUSION #2:

2. Although Dr. Monroe's prescribing practices in these instances are questionable, particularly with respect to Patients #1 and #4, there is insufficient evidence in the record to justify the conclusion that Dr. Monroe's prescribing to these patients constituted violations of Sections 4731.22(B)(2), 4731.22(B)(3), 4731.22(B)(6), Ohio Revised Code, and/or Section 4731.22(B)(20), Ohio Revised Code, with respect to Rule 4731-11-02(C), Ohio Administrative Code.

DR. O'DAY FURTHER MOVED THAT THE PROPOSED ORDER IN THE MATTER OF MELVIN MONROE, M.D., BE AMENDED TO READ AS FOLLOWS:

It is hereby ORDERED that Melvin Monroe, M.D., be placed on probation for a period of two (2) years under the following terms and conditions:

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

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

3. Dr. Monroe 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. Dr. Monroe shall complete at least one program per year for each year of the probationary period of approved Category I Continuing Medical Education related to medical recordkeeping. 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. Monroe shall provide documentary proof satisfactory to the Board of successful completion of these courses.

5. Dr. Monroe shall keep a log of any controlled substances purchased, prescribed, dispensed, or administered. Further, Dr. Monroe shall make

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his patient records with regard to such prescribing available for review by an agent of the State Medical Board upon request.

6. Upon successful completion of probation, Dr. Monroe's certificate shall be fully restored.

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

DR. STEPHENS SECONDED THE MOTION.

Dr. O'Day stated that she really felt there were significant problems with Dr. Monroe's recordkeeping with respect to controlled substances. She feels it is incumbent that records document the reason for prescribing, the patient's response to the medication, and reasons for represcribing the medication. Dr. O'Day stated that she hoped a medical recordkeeping course and some monitoring would correct the deficiencies she saw in Dr. Monroe's records.

Dr. Cramblett asked that "reregistration" replace the word "relicensure" in paragraph 4. Dr. O'Day agreed to the change.

Dr. Heidt asked whether there are C.M.E. courses in recordkeeping. Dr. O'Day indicated that there are, and they are usually included under medical/legal topics and risk management courses.

A roll call vote was taken on Dr. O'Day's motion to amend:

ROLL CALL VOTE:	Dr. Cramblett	- abstain
	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- aye
	Mr. Jost	- abstain
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Ms. Rolfes	- aye
	Dr. Agresta	- aye

The motion carried.

DR. GRETTER MOVED TO APPROVE AND CONFIRM MS. FISHEL'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED IN THE MATTER OF MELVIN MONROE, M.D. DR. STEPHENS SECONDED THE MOTION.

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Dr. Hom stated for the record that she has talked with several members of the Board who are very concerned about Dr. Monroe's prescribing practices. Even though there wasn't agreement on all of the problems, there were multiple problems. Dr. Hom recommended that Dr. Monroe take further steps to educate himself on chronic pain management and how controlled substances are used.

A roll call vote was taken on Dr. Gretter's motion:

ROLL CALL VOTE:	Dr. Cramblett	- abstain
	Dr. O'Day	- aye
	Dr. Gretter	- aye
	Dr. Stephens	- aye
	Mr. Jost	- abstain
	Dr. Garg	- aye
	Dr. Kaplansky	- aye
	Dr. Heidt	- aye
	Dr. Hom	- aye
	Ms. Rolfes	- aye
	Dr. Agresta	- aye

The motion carried.

Dr. O'Day stated that she was bothered by references made to Dr. Pratt's prior history. She advised Mr. Tait that the Board believes in rehabilitation and believes a physician can be fully restored to practice. In no way does that kind of history impugn someone's credibility before this Board.

Mr. Albert stated that he appreciates Dr. O'Day's comments. He stated that he also felt some of the comments directed toward Dr. Pratt were uncalled for.

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March 13, 1991

Melvin Monroe, M.D.
850 West High St.
Lima, OH 45801

Dear Doctor Monroe:

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) In the routine course of your practice, you kept inadequate patient records which did not properly reflect whether examinations were performed or physical findings made to justify the medications prescribed to Patients 1-4 who are listed on the attached Patient Key (Key confidential, not subject to public disclosure).

(2) You excessively prescribed controlled substance narcotic analgesics, controlled substance depressants and other controlled substances and dangerous drugs without taking into account the drugs' potential for abuse, the possibility the drugs may lead to dependence, the possibility the patients may obtain the drugs for nontherapeutic use or to distribute to others and the possibility of an illicit market for the drugs.

(3) The medications prescribed were frequently inappropriate for the treatment of these patients' reported pain, illness or injury and was frequently done without utilization of diagnostic testing or other methods of evaluating the validity, nature or severity of the patients' complaints. Instances of such practices include, but are not necessarily limited to, the treatment rendered to Patients 1-4 as disclosed by the patient record and/or the Prescription List By Patient Number attached.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) above, 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.

Mailed 3/14/91

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Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) above, individually and/or collectively constitute "selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in Section 4731.22(B)(3), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (3) 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 paragraphs (1) through (3) above, individually and/or collectively, as pertaining to prescriptions written on or after November 17, 1986, for Patients 1 through 4 constitute "(v)iolating 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(C) and (D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, a violation of any provision of Rule 4731-11-02, also violates Sections 4731.22(B)(2) and (6), Ohio Revised Code, and further, a violation of Rule 4731-11-02(C), Ohio Administrative code, also constitutes a violation of Section 4731.22(B)(3), Ohio Revised Code, if such violation is committed purposely, knowingly, or recklessly.

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

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

March 13, 1991

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 #055 328 506
RETURN RECEIPT REQUESTED

MELVIN MONROE, M.D.

PRESCRIPTION LIST BY PATIENT NUMBER

Patient Number	Date	Drug/Schedule	DU	Refill	Total DU
1	09/19/88	Valium 5 mg./IV	60	1	120
	09/19/88	Darvocet N-100/IV	60	1	120
	11/21/88	Darvocet N-100/IV	100	0	100
	11/21/88	Valium 5 mg./IV	60	0	60
	11/21/88	Valium 5 mg./IV	60	1	120
	11/21/88	Darvocet N-100/IV	100	1	200
	01/30/89	Valium 5 mg./IV	60	1	120
	01/30/89	Darvocet N-100/IV	100	1	200
	03/29/89	Darvocet N-100/IV	100	0	100
	03/29/89	Valium 5 mg./IV	60	0	60
	06/02/89	Darvocet N-100/IV	100	1	200
	07/13/89	Darvocet N-100/IV	100	0	100
	07/13/89	Valium 5 mg./IV	60	0	60
	08/16/89	Darvocet N-100/IV	100	0	100
	08/16/89	Valium 5 mg./IV	100	0	100
	09/14/89	Darvocet N-100/IV	100	0	100
	09/14/89	Valium 5 mg./IV	100	0	100
	10/09/89	Valium 5 mg./IV	100	1	200
	10/09/89	Darvocet N-100/IV	100	1	200
2	08/09/88	Sinequan 25mg./NC	30	2	90
	05/01/89	Darvocet N-100/IV	100	5	600
	09/15/89	Darvocet N-100/IV	100	5	600
	11/09/89	Darvocet N-100/IV	100	5	600
3	05/30/89	Darvocet N-100/IV	100	1	200
	08/23/89	Darvocet N-100/IV	100	5	600
	12/04/89	Darvocet N-100/IV	100	0	100
4	02/14/89	Darvocet N-100/IV	100	1	200
	02/14/89	Valium 10 mg./IV	60	1	120
	04/06/89	Valium 10 mg./IV	30	0	30
	04/06/89	Darvocet N-100/IV	60	0	60
	04/21/89	Valium 10 mg./IV	120	0	120
	04/21/89	Darvocet N-100/IV	100	1	200
	06/26/89	Valium 10 mg./IV	60	0	60
	06/26/89	Darvocet N-100/IV	100	0	100
	07/28/89	Darvocet N-100/IV	100	1	200
	07/28/89	Darvocet N-100/IV	50	2	150
	07/28/89	Valium 10 mg./IV	60	1	120
	09/25/89	Darvocet N-100/IV	100	1	200
	09/25/89	Valium 10 mg./IV	60	1	120