The Supreme Court of Ohio

FILED
FEB 16 2005
MARCIA J. MENGEL, CLERK
SUPREME COURT OF OHIO

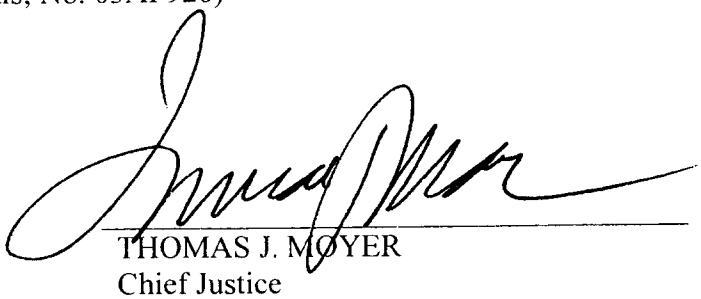
Wallace C. Adamson, M.D.,
Appellant,
v.
Ohio State Medical Board,
Appellee.

Case No. 04-1920

ENTRY

Upon consideration of the jurisdictional memoranda filed in this case, the Court declines jurisdiction to hear the case and dismisses the appeal as not involving any substantial constitutional question.

(Franklin County Court of Appeals; No. 03AP926)



THOMAS J. MOYER
Chief Justice

IN THE SUPREME COURT OF OHIO

04-1920

WALLACE C. ADAMSON, M.D.,	)	S. Ct. Case No. _____
	)	
Appellant,	)	
	)	On Appeal from the Franklin
v.	)	County Court of Appeals
	)	Tenth Appellate District
OHIO STATE MEDICAL BOARD,	)	
	)	Court of Appeals
Appellee.	)	Case No. 03 APE 09 926

NOTICE OF APPEAL OF APPELLANT, WALLACE C. ADAMSON, M.D.

Paul J. Coval (0022781), Counsel of Record
Gregory D. Russell (0059718)
Darrell A.H. Miller (0075950)
Vorys, Sater, Seymour and Pease LLP
52 East Gay Street
P. O. Box 1008
Columbus, Ohio 43216-1008
Tel. (614) 464-6400
Fax (614) 464-6350
pjcoval@vssp.com

Counsel for Appellant,
Wallace C. Adamson, M.D.

Jim Petro (0022096), Attorney General of Ohio
Mary K. Crawford (0021451)
Rebecca J. Albers (0059203)
Assistant Attorneys General
Health & Human Services Section
State Office Tower, 26th Floor
30 East Broad Street
Columbus, Ohio 43215-3428
Tel. (614) 466-8600
Fax (614) 466-6090

Counsel for Appellee,
Ohio State Medical Board

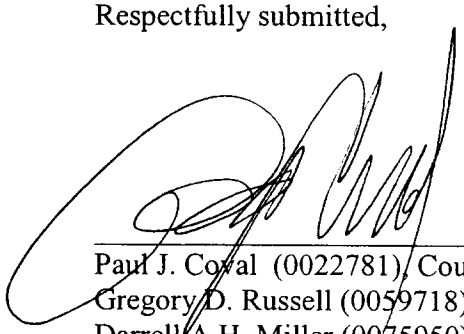
FILED
NOV 12 2004
MARCIA J. MENGEL, CLERK
SUPREME COURT OF OHIO

NOTICE OF APPEAL OF WALLACE C. ADAMSON, M.D.

Appellant Wallace C. Adamson, M.D., hereby gives notice of appeal to the Supreme Court of Ohio from the judgment of the Franklin County Court of Appeals, Tenth Appellate District, entered in Court of Appeals case No. 03 APE 09 926, on September 30, 2004.

This case raises a substantial constitutional question and is one of public or great general interest.

Respectfully submitted,

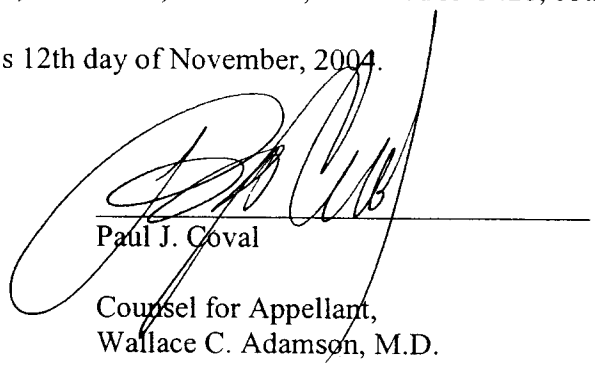


Paul J. Coval (0022781), Counsel of Record
Gregory D. Russell (0059718)
Darrell A.H. Miller (0075950)
Vorys, Sater, Seymour and Pease LLP
52 East Gay Street
P. O. Box 1008
Columbus, Ohio 43216-1008
Tel. (614) 464-6400
Fax (614) 464-6350
pjcoval@vssp.com

Counsel for Appellant,
Wallace C. Adamson, M.D.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing Notice of Appeal was served by mail upon Jim Petro, Attorney General, Mary K. Crawford and Rebecca J. Albers, Assistant Attorneys General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3428, counsel for the Ohio State Medical Board, this 12th day of November, 2004.



Paul J. Coval

Counsel for Appellant,
Wallace C. Adamson, M.D.

11/12/2004 - 9569219

16347I15

FILED
COURT OF APPEALS
OHIO
04 SEP 30 PM 3:22

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Wallace C. Adamson, M.D.,	:	
Appellant,	:	
v.	:	No. 03AP-926 (C.P.C. No. 02CVF12-14459)
Ohio State Medical Board,	:	(REGULAR CALENDAR)
Appellee.	:	

JUDGMENT ENTRY

For the reasons stated in the opinion of this court rendered herein on September 30, 2004, appellant's first, second, and third assignments of error are moot, the fourth, fifth, and sixth assignments of error are not well-taken and are overruled, and it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs assessed against appellant.

WATSON, J., BRYANT & PETREE, JJ.

By M H Watson
Judge Michael H. Watson

2004

FILED
COURT OF APPEALS
FRANKLIN COUNTY, OHIO
04 SEP 30 PM 3:04
CLERK OF COURTS

OCT 4 2004
SERVED

IN THE COURT OF APPEALS OF OHIO

TENTH APPELLATE DISTRICT

Wallace C. Adamson, M.D.,	:	
Appellant,	:	
v.	:	No. 03AP-926 (C.P.C. No. 02CVF12-14459)
Ohio State Medical Board,	:	(REGULAR CALENDAR)
Appellee.	:	

OPINION

Rendered on September 30, 2004

Vorys, Sater, Seymour and Pease LLP, *Paul J. Coval*, *Gregory D. Russell*, and *Darrell A.H. Miller*, for appellant.

Jim Petro, Attorney General, *Mary K. Crawford* and *Rebecca J. Albers*, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

WATSON, J.

{¶1} Appellant, Wallace C. Adamson, M.D. (hereinafter "appellant"), appeals from the August 11, 2003, decision and entry of the Franklin County Court of Common Pleas affirming the December 11, 2002, order of appellee, Ohio State Medical Board (hereinafter "Board" or "appellee"), permanently revoking appellant's license to practice medicine. For the reasons which follow, we affirm the judgment of the trial court.

{¶2} A physician assistant (hereinafter "PA") is a dependent practitioner; he or she may not practice medicine. The role of a PA is to assist a physician as he or she practices medicine. A PA is to perform services in accordance with a PA utilization plan.

A supervising physician may not authorize a PA to perform services which are not in accord with the plan. Moreover, a supervising physician may not allow a PA to perform services which are prohibited by statute.

{¶3} Appellant employed Robin Hawn[1], a PA, in his medical practice. Hawn was to perform services in accordance with two PA utilization plans (hereinafter collectively "Plans") which appellee approved by poll vote on January 6, 1997.

{¶4} On May 9, 2001, the Board notified appellant of its intention to determine whether or not to take disciplinary action against his license based upon allegations he violated certain provisions of R.C. 4731 during a period from 1999 to 2000. Specifically, the Board alleged appellant allowed Hawn to initiate her own treatment plans for established patients with "new conditions," contrary to Ohio law.

{¶5} Evidentiary hearings were held in March, 2002. On October 7, 2002, the Hearing Examiner issued his Report and Recommendation (hereinafter "Report") which proposed appellant's medical license should be permanently revoked.

{¶6} Appellant filed objections to the Report. On December 11, 2002, the Board met to consider the Report and appellant's objections. At the hearing, appellant and Hawn denied they violated the Plans or any Ohio law. Appellant testified none of the treatment Hawn rendered, including prescribing for patients, exceeded her authority as a PA, the terms of the Plans, or under his protocols.

{¶7} The Board argued appellant allowed Hawn to treat patients with new conditions without appellant personally seeing or evaluating the patient prior to treatment.

---

[1] Appellant and Robin Hawn are married. However, for clarity, Robin Hawn will be referred to by her maiden name.

Appellant's records revealed a pattern of his failing to countersign Hawn's orders. Further, appellant allowed Hawn to practice independently when he was out of town. She consistently: (1) saw patients, assessing, and rendering diagnoses of diseases or ailments; (2) prescribed treatment or regimens for patients which had not been previously prescribed or set forth by appellant for that patient; (3) called in prescriptions; and (4) dispensed sample dangerous drugs not ordered by appellant.

{¶8} After consideration of the Report and objections, the Board permanently revoked appellant's license to practice medicine.

{¶9} Additionally, on December 11, 2002, a motion was made to retroactively ratify the decisions approving the applications for licensure, registration, or PA utilization plan approval which were previously approved by the poll vote procedure[2] (hereinafter "motion"). The motion carried. This retroactive ratification affected appellant's medical license and the Plans.

{¶10} On December 27, 2002, appellant appealed the Board's decision to the Franklin County Court of Common Pleas, pursuant to R.C. 119.12. On August 11, 2003, the trial court affirmed in part and reversed in part the decision of the Board.

{¶11} Appellant timely appeals and asserts the following assignments of error:

> [1.] The Court of Common Pleas erred when it held that the State Medical Board may validly approve physician

---

[2] The Board utilized a poll vote procedure to approve the Plans. The poll vote procedure was implemented in 1973 to expedite the approval process of medical licenses and PA utilization plans. The process involved the Board staff sending individual licensure application materials and PA utilization plans to Board members for review. The Board members would review the materials and return their individual vote to the Board staff. The Board members neither met to discuss nor deliberated over the approval of the licenses and/or PA utilization plans. There was no contact between Board members, either in person or by telephone. Upon return by the Board members of a unanimous affirmative poll vote, the Board staff would issue approvals. The approvals of licenses and PA utilization plans which were the result of the poll vote process were not ratified by appellee on the record during an open meeting. Additionally, approval was not reflected in the official minutes.

> assistant utilization plans under Ohio's Sunshine Law as long as the approval is made without deliberation.
>
> [2.] The Court of Common Pleas erred when it held that the State Medical Board may retroactively "cure" its failure to approve the physician assistant plans at issue in accord with Ohio's Sunshine Law.
>
> [3.] The Court of Common Pleas erred when it held that the Board's violation of Ohio's Sunshine Law was moot with respect to Dr. Adamson's case.
>
> [4.] The Court of Common Pleas erred by failing to conclude that the Board's knowing introduction of false evidence and failure to correct that evidence once introduced violated Dr. Adamson's right to due process.
>
> [5.] The Court of Common Pleas erred by permitting the Board to discipline Dr. Adamson based on its December 11, 2002 definition of "new condition" in violation of Dr. Adamson's due process rights.
>
> [6.] The Court of Common Pleas erred when it failed to reverse the State Medical Board for failing to transmit a complete record as required by Ohio Revised Code 119.12.

{¶12} Under R.C. 119.12, when a common pleas court reviews an order of an administrative agency, it must consider the entire record and determine whether the agency's order is supported by reliable, probative, and substantial evidence and is in accordance with law. *Univ. of Cincinnati v. Conrad* (1980), 63 Ohio St.2d 108, 110-111.

{¶13} The evidence required by R.C. 119.12 can be defined as follows:

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

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

{¶14} The common pleas court's "review of the administrative record is neither a trial *de novo* nor an appeal on questions of law only, but a hybrid review in which the court 'must appraise all the evidence as to the credibility of the witnesses, the probative character of the evidence, and the weight thereof.' " (Emphasis sic.) *Lies v. Veterinary Med. Bd.* (1981), 2 Ohio App.3d 204, 207, quoting *Andrews v. Bd. of Liquor Control* (1955), 164 Ohio St. 275, 280. Furthermore, even though the common pleas court must give due deference to the administrative agency's resolution of evidentiary conflicts, the findings of the agency are not conclusive. *Conrad,* supra, at 111.

{¶15} An appellate court's standard of review in an administrative appeal is even more limited than that of a common pleas court. *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 621. In *Pons*, the Supreme Court of Ohio stated:

> * * * While it is incumbent on the trial court to examine the evidence, this is not a function of the appellate court. The appellate court is to determine only if the trial court has abused its discretion, *i.e.*, being not merely an error of judgment, but perversity of will, passion, prejudice, partiality, or moral delinquency. Absent an abuse of discretion on the part of the trial court, a court of appeals may not substitute its judgment for [that of an administrative agency] or a trial court. Instead, the appellate court must affirm the trial court's judgment. * * *

Id., citing *Lorain City School Dist. Bd. of Edn. v. State Emp. Relations Bd.* (1988), 40 Ohio St.3d 257, 260-261. (Emphasis sic.)

{¶16} Nonetheless, an appellate court does have plenary review of purely legal questions in an administrative appeal. *Big Bob's, Inc. v. Ohio Liquor Control Comm.*, 151

Ohio App.3d 498, 2003-Ohio-418, at ¶15. Therefore, we must also determine whether the common pleas court's decision is in accordance with law.

{¶17} We begin our analysis with appellant's fourth assignment of error. Appellant argues false evidence was introduced at the administrative hearing or relied upon by the Board in its order. Appellant argues the Board, as of December 11, 2002, knew it failed to approve the Plans in compliance with the Sunshine Law in early 1997, as alleged. Nevertheless, appellant maintains the Board and its counsel, permitted the contrary, and false evidence, to be relied upon to find the Plans had been approved in early 1997.

{¶18} The cases upon which appellant relies do not support the finding the Plans' approvals were false evidence when introduced at appellant's administrative hearing. We are not faced with false testimony given by a witness under oath, *Napue v. Illinois* (1959), 360 U.S. 264, 79 S.Ct. 1173 (witness testified falsely that he had received no promise of consideration in return for his testimony, and prosecutor, knowing of promised consideration, did not correct testimony); *Giglio v. United States* (1972), 405 U.S. 150, 92 S.Ct. 763; *Beltran v. Cockrell* (2002), 294 F.3d 730 (eyewitnesses were allowed to falsely testify that they consistently identified defendant as the gunman); or with prosecutorial misconduct in stating the physical evidence in a case, *Miller v. Pate* (1967), 386 U.S. 1, 87 S.Ct. 785 (prosecutor knowingly advanced the theory the defendant's shorts were stained with blood when he knew at the time it was paint). We do not have before us the situation where the Board engaged in a deception with respect to the approvals. Instead, we are faced with Plans which the Board in good faith approved pursuant to the poll vote process, which was arguably an insufficient procedure to approve the Plans. This does

not constitute false evidence in the manner considered by the court faced with due process violations resulting from the introduction of false evidence.

{¶19} Accordingly, appellant's fourth assignment of error is not well-taken and is overruled.

{¶20} Appellant argues in his fifth assignment of error the trial court erred by permitting the Board to discipline him based on its December 11, 2002, definition of "new condition" in violation of his due process rights. Specifically, appellant contends the Board had not adopted a uniform definition of the term "new condition." In its December 11, 2002, order, the Board adopted the definition of "new condition" advanced by its witness, Dr. Gardner. The Board then used Dr. Gardner's definition to find appellant committed a punishable act by permitting his PA to treat patients presenting years before with "new conditions." Appellant asserts the trial court did not address this error.

{¶21} A legislative body need not define every word it uses in an enactment. See *Kiefer v. State* (1922), 106 Ohio St. 285. Moreover, any term left undefined by statute is to be accorded its common, everyday meaning. As stated in *Eastman v. State* (1936), 131 Ohio St. 1, paragraph five of the syllabus, "[w]ords in common use will be construed in their ordinary acceptation and significance, and with the meaning commonly attributed to them." Furthermore, when faced with statutes pertaining to a select group of individuals with specialized knowledge of the regulated subject matter, the focus is whether the statutory language "sufficiently conveys a definite warning as to the proscribed conduct, when measured by common understanding and commercial practice." *United States ex rel. Schott v. Tehan* (1966), 365 F.2d 191, 198.

{¶22} In this matter, the term "new condition" was within the common understanding and commercial practice of appellant. As stated by the Hearing Examiner, "[w]hen read in that [legislative] context, the term 'new condition' should hold no mystery for a reasonable practitioner." (Report at 202.) Moreover, Dr. Gardner testified her expert opinion was based upon the fact "new condition" is a "general phrase used in every day language." (Tr. at 240.) As such, appellant's due process rights were not violated by the Board's application of the meaning commonly attributed to "new condition."

{¶23} Accordingly, appellant's fifth assignment of error is not well-taken and is overruled.

{¶24} In his sixth assignment of error appellant maintains the trial court erred when it failed to reverse the Board for failing to transmit a complete record as required by R.C. 119.12. Specifically, appellant argues the motion needed to be transmitted with the record as it is the signal evidence of the validity of appellant's Plans. While the trial court allowed the motion to be entered by stipulation, appellant contends this does not cure the violation. In support, appellant relies upon *Bergdahl v. Ohio State Bd. of Psychology* (1990), 70 Ohio App.3d 488.

{¶25} In *Bergdahl,* the Ohio State Board of Psychology (hereinafter "OSBP") denied her request for admission to the examination for a psychology license. Ms. Bergdahl appealed and, subsequently, filed a motion to submit additional evidence requesting that certified copies of the official minutes of OSBP's meetings be included in the official record. The trial court concluded the minutes of the meeting were essential in determining the merits of the appeal. As such, it ordered them submitted within 30 days. OSBP failed to comply and the trial court granted Ms. Bergdahl's motion to remand. In

affirming the trial court's decision, the *Bergdahl* court concurred with the trial court's conclusion the minutes of the meetings were a necessary part of the certified record.

{¶26} Appellant's reliance upon *Bergdahl* is misplaced. The situation in this matter is not analogous to *Bergdahl*. The trial court did not order the motion submitted by the Board. The trial court did not opine the motion was a necessary part of the record. It was based upon this reasoning that the *Bergdahl* court affirmed the remand. Furthermore, the *Bergdahl* case stands in direct contradiction with appellant's assertion that a violation of R.C. 119.12 cannot be cured. The trial court in *Bergdahl* ordered OSBP to submit the minutes within 30 days. As such, recognizing the need to review the minutes, the trial court gave OSBP the opportunity to cure its failure in submitting the minutes. Thus, *Bergdahl* actually supports the conclusion that a violation of R.C. 119.12 can be cured. As such, any alleged violation of R.C. 119.12 which occurred due to the failure of the Board to initially transmit the motion was remedied by the trial court allowing the motion entered by stipulation.

{¶27} Accordingly, appellant's sixth assignment of error is not well-taken and is overruled.

{¶28} We now turn to appellant's first, second, and third assignments of error which involve the application of R.C. 122.22, the Sunshine Law, to the Board's utilization of the poll vote procedure to approve appellant's Plans and the December 11, 2002 retroactive ratification of the plans.

{¶29} The charges levied against appellant by the Board were premised upon numerous statutory violations. Many of the statutory violations do not require the plans to be validly approved in order for appellant to be found to have violated them. Therefore,

as long as there is reliable, probative, and substantial evidence to support these statutory violations, the issue of whether the approval of the Plans by the poll vote process violates the Sunshine Law is irrelevant.

{¶30} Upon consideration, the trial court did not abuse its discretion in affirming the Board's decision. An examination of the evidence in this matter reveals reliable, probative, and substantial evidence to support appellant's violations of the charged statutes, independent of whether the plans were validly approved. See e.g. R.C. 4731.22(B). The evidence established appellant, on numerous occasions, failed to supervise Hawn, allowing her to independently diagnosis patients and prescribe treatments not previously approved by appellant. Additionally, evidence was presented that Hawn repeatedly acted on her own in ordering prescription medication for patients without meaningful review from appellant.

{¶31} As there is reliable, probative, and substantial evidence to support these statutory violations, we decline to examine the issue of whether the poll vote process violated the Sunshine Law and invalidated the Plans' approvals.

{¶32} Accordingly, appellant's first, second, and third assignments of error are moot.

{¶33} Based on the foregoing, appellant's first, second, and third assignments of error are moot and the fourth, fifth, and sixth assignments of error are not well-taken and are overruled, and the judgment of the Franklin County Court of Common Pleas is affirmed.

Judgment affirmed.

BRYANT and PETREE, JJ., concur.

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

WALLACE C. ADAMSON, M.D.,	:	
Appellant,	:	Judge John P. Bessey
v.	:	Case No. 02CVF-12-14459
OHIO STATE MEDICAL BOARD,	:	Ohio Revised Code § 119.12 Appeal
Appellee.	:	

NOTICE OF APPEAL

Notice is hereby given that Wallace C. Adamson, M.D., hereby appeals to the Court of Appeals of Franklin County, Ohio, Tenth Appellate District, from the judgment of the trial court affirming the Medical Board's Order, and which was entered in this action on August 26, 2003. Copies of the judgment and incorporated decision are attached at Exhibit A hereto.

Counsel of record for Appellee are Mary K. Crawford and Rebecca J. Albers, Assistant Attorneys General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3428.

Respectfully submitted,

VORYS, SATER, SEYMOUR AND PEASE LLP

By: _____

Paul J. Coval (0022781), *Trial Counsel*
Gregory D. Russell (0059718)
52 East Gay Street
P. O. Box 1008
Columbus, Ohio 43216-1008
Tel. (614) 464-5635
Fax (614) 464-6350
Counsel for Appellant,
Wallace C. Adamson, M.D.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing was served by regular U.S. mail, postage prepaid, upon Mary K. Crawford and Rebecca J. Albers, Assistant Attorneys General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3428, counsel for the State Medical Board, this 19th day of September, 2003.

09/18/2003 - 9326215

FINAL APPEALABLE ORDER

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

TRANSMITTAL NO. 18
BY hm 8/20/03

WALLACE C. ADAMSON, M.D.	:	
Appellant	:	
v.	:	Case No. 02CVF-12-14459
STATE MEDICAL BOARD OF OHIO	:	JUDGE J. BESSEY
Appellee	:	

HEALTH & HUMAN SERVICES SECTION
AUG 29 2003

JUDGMENT ENTRY

This case, pursuant to R.C. 119.12, is before the Court on appeal of the December 11, 2002 order of the State Medical Board permanently revoking the license of Wallace C. Adamson, M.D., to practice medicine in Ohio. For the reasons stated in the Court's August 11, 2003 decision, which reasons are incorporated as if fully rewritten herein, it is hereby

ORDERED, ADJUDGED and DECREED that the December 11, 2002 order of the State Medical Board in the above-referenced matter is hereby AFFIRMED IN PART AND REVERSED IN PART. It is further ORDERED, ADJUDGED and DECREED that the partial reversal of the Board's Order does not support remanding the appeal back to the Board for further consideration of any modification of penalty. Costs to Appellant.

IT IS SO ORDERED.

FILED
COMMON PLEAS COURT
FRANKLIN COUNTY, OHIO
2003 AUG 26 PM 12:42
CLERK OF COURTS

08-20-03
Date

JUDGE J. BESSEY

JIM PETRO (0021451)
Attorney General

Mary K. Crawford

Mary K. Crawford (0021451)
Rebecca J. Albers (0059203)

Paul J. Coval (0022781)
Gregory D. Russell (0059718)

HEALTH & HUMAN
AUG 13 2003
SERVICES SECTION

STATE MEDICAL BOARD OF OHIO
2003 AUG 14 P 3:36

COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

WALLACE C. ADAMSON, M.D.,	:	CASE NO. 02CVF-12-14459
APPELLANT,	:	JUDGE BESSEY
vs.	:	
OHIO STATE MEDICAL BOARD,	:	
APPELLEE.	:	

CLERK OF COURTS
2003 AUG 11 PM 2:55
COMMON PLEAS COURT FRANKLIN COUNTY OHIO

DECISION AND ENTRY ON MERITS OF APPEAL

Entered this 13 day of August, 2003.

The Court has for consideration the appeal filed by Wallace C. Adamson, M.D. from the December 11, 2002 Order of the State Medical Board ("Board"). That Order permanently revoked Appellant's license to practice medicine. The record of proceedings from below and arguments of counsel for the parties has been tendered for the Court's review. The instant appeal has been brought under the provisions of R.C. 119.12. The Court has ruled on a number of issues prior to addressing the merits of the appeal. Appellant has recently filed a "Renewed Motion of Appellant, Wallace C. Adamson, M.D., for Entry Reversing Order of the State Medical Board." It was believed that the issue of the record of the Board's other actions on December 11, 2002 had been laid to rest. The Courts have rejected Appellant's contention that the entire board minutes from a particular meeting must be presented to the Court. *Goldman v. State Medical Bd.* (1996), 110 Ohio App. 3d 124, 673 N.E.2d 677; Dismissed by, Discretionary appeal not allowed by: *Goldman v. State Medical Bd.* (1996), 77 Ohio St. 3d 1411, 670 N.E.2d 1001; Appeal after remand at: *Goldman v. State Med. Bd.* (Oct. 20, 1998), Franklin App. No. 98AP-238. This Court likewise

rejects Appellant's Motion for Reversal and will consider the issues raised in this appeal.

The procedural history of this matter is not in dispute. The Board notified Appellant on May 9, 2001 that disciplinary action was being considered for violations under R.C. 4731.22. More specifically, Appellant was charged with allowing his wife, formerly Robin Rae Hawn, who was also a physician assistant in his practice, to violate previously approved physician assistant utilization plans and Appellant allowed her to initiate her own treatment plans for patients who presented with new conditions. A Hearing Officer for the Board conducted hearings during the month of March, 2001.

This Court's review of a decision of an administrative agency, such as the Board, is governed by R.C. 119.12 and the multitude of cases addressing that section. The most often cited case is that of *Univ. of Cincinnati v. Conrad* (1980), 63 Ohio St. 2d 108, 407 N.E.2d 1265. The *Conrad* decision states that in an administrative appeal filed pursuant to R.C. 119.12, the trial court must review the agency's order to determine whether it is supported by reliable, probative and substantial evidence and is in accordance with the law.

The Court states at pages 111 and 112 that "In undertaking this hybrid form of review, the Court of Common Pleas must give due deference to the administrative resolution of evidentiary conflicts. For example, when the evidence before the court consists of conflicting testimony of approximately equal weight, the court should defer to the determination of the administrative body, which, as the fact-finder, had the opportunity to observe the demeanor of the witnesses and weigh their credibility. However, the findings of the agency are by no means conclusive. Where the court, in its

appraisal of the evidence, determines that there exist legally significant reasons for discrediting certain evidence relied upon by the administrative body, and necessary to its determination, the court may reverse, vacate or modify the administrative order. Thus, where a witness' testimony is internally inconsistent, or is impeached by evidence of a prior inconsistent statement, the court may properly decide that such testimony should be given no weight. Likewise, where it appears that the administrative determination rests upon inferences improperly drawn from the evidence adduced, the court may reverse the administrative order."

The *Conrad* case has been cited with approval numerous times. *Ohio Historical Soc. v. State Emp. Relations Bd.* (1993), 66 Ohio St. 3d 466, 471, 613 N.E.2d 591 noted *Conrad* and stated that although a review of applicable law is de novo, the reviewing court should defer to the agency's factual findings. See *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 614 N.E.2d 748. Rehearing denied by: *Pons v. State Medical Bd.* (1993), 67 Ohio St. 3d 1439, 617 N.E.2d 688. Despite the paramount importance of the Court's decision to Appellant, the Court is not free to simply substitute its judgment for that of the Board.

Appellant has submitted ten separately stated assignments of error. Seven of these are posited as errors of law, and three are offered bases upon Appellant's assertion that the Board's action lacks reliable, probative, and substantial evidence for support. They are set forth as excerpted from Appellant's brief.

ASSIGNMENT OF ERROR No. 1.
The State Medical Board's Failure to Previously Approve the Physician Assistant Utilization Plans at Issue Makes Unlawful Most of the Board's Discipline of Dr. Adamson.

ASSIGNMENT OF ERROR No.2.

The State Medical Board's Reliance on the Testimony of Dr. Gardner Is Contrary to Law.

ASSIGNMENT OF ERROR No.3.
The Definition of "New Condition" Adopted by the State Medical Board at the December 11, 2002, Meeting Cannot Be Applied to Discipline Dr. Adamson for the Conduct at Issue.

ASSIGNMENT OF ERROR No.4.
The State Medical Board Disciplined Dr. Adamson for Conduct that It Never Charged in its Notice of Opportunity for Hearing.

ASSIGNMENT OF ERROR No.5.
It is Uncontroverted that Each of the Medications at Issue Was Given for a Legitimate Medical Purpose, and Thus Dr. Adamson Did Not Engage in the Crime of Selling Dangerous Drugs.

ASSIGNMENT OF ERROR No.6.
The State Medical Board Retroactively Applied R.C. 4730.21(D) to Conduct that Occurred Prior to the Statute's Enactment.

ASSIGNMENT OF ERROR No.7.
The State Medical Board Never Found that Dr. Adamson "Recklessly" Allowed his Physician Assistant to Perform Services in a Manner Inconsistent with the Utilization Plans, Making its Findings as to a Violation of R.C. 4731.22(B)(12) Insufficient as a Matter of Law.

ASSIGNMENT OF ERROR No.8.
The State Medical Board's Finding that the Utilization Plans Had Been Approved by the Board is Not Supported by a Preponderance of Reliable, Probative and Substantial Evidence.

ASSIGNMENT OF ERROR No.9.
The Board's Finding that the Treatment and Medication Orders at Issue Did Not Come from Dr. Adamson is Not Supported by a Preponderance of Reliable, Probative and Substantial Evidence.

ASSIGNMENT OF ERROR No. 10.
The Accusation that Certain Patients Had Specific, Identified Medical Conditions is Not Supported by a Preponderance of Reliable, Probative and Substantial Evidence.

The Assignments of Error No. 1 and 8 are both premised upon the contention by Appellant that the Board never validly approved utilization plans, including that of Appellant. The Board adopted a policy beginning in 1973 whereby individual Board

members reviewed licensure applications which encompassed medical, osteopathic, podiatrist, anesthesiologist and physician assistants, and physician assistant utilization plans. If by written vote there was unanimous approval, the Board considered approval granted and took no further action. The Board opted to retroactively approve all of these licensures and plans at its December 11, 2002 meeting. While the Court recognizes the meritorious purpose of the Board's actions in using poll votes in matters where there was unanimous approval, the necessity of retroactive approval of some 57,500 licenses and plans at first blush appears irregular.

Appellee has offered the case of *Monarch Constr. Co. v. Ohio Sch. Facilities Comm'n*, 150 Ohio App. 3d 134, 2002 Ohio 6281, 779 N.E.2d 844, (Franklin County); appeal denied in *Monarch Constr. Co. v. Ohio Sch. Facilities Comm.*, 98 Ohio St. 3d 1511, 2003 Ohio 1572, 786 N.E.2d 62 in support of its position that the actions of the Board in retroactively approving licensures and utilization plans were valid. The *Monarch* Court concluded that if agents of the state exceeded their authority, the state had the option to ratify or repudiate their actions. Appellee likens that case, involving school construction contracts, to retroactive approval as conducted by the Board. Appellant has offered that the *Monarch* case is not analogous because it involves contract ratification and the authority of an agent as opposed to a violation under R.C. 121.11. The Court must first observe that if Appellant's argument in this regard were accepted in entirety, then Appellant would be guilty of unauthorized practice of medicine, and so would his assistants, since his argument is that the Board could not retroactively approve licenses which would include his own. The Board chose to remedy its past procedure by

taking action formally in session. Had the Board not done so, no one would likely have been the wiser.

R.C. 121.22, the Sunshine Law or Open Meetings Act, has been the subject of a multitude of cases. The relevant language to this matter is as follows:

121.22 Meetings of public bodies to be public; exceptions.
"(A) This section shall be liberally construed to require public officials to take official action and to conduct all deliberations upon official business only in open meetings.
***
(H) A resolution, rule, or formal action of any kind is invalid unless adopted in an open meeting of the public body. A resolution, rule, or formal action adopted in an open meeting that results from deliberations in a meeting not open to the public is invalid unless the deliberations were for a purpose specifically authorized in division (G) or (J) of this section and conducted at an executive session held in compliance with this section. A resolution, rule, or formal action adopted in an open meeting is invalid if the public body that adopted the resolution, rule, or formal action violated division (F) of this section.
***
(I)(1) Any person may bring an action to enforce this section. An action under division (I)(1) of this section shall be brought within two years after the date of the alleged violation or threatened violation. Upon proof of a violation or threatened violation of this section in an action brought by any person, the court of common pleas shall issue an injunction to compel the members of the public body to comply with its provisions."

State ex rel. Delph v. Barr (1989), 44 Ohio St.3d 77, 541 N.E.2d 59 is cited for the proposition that an act taken in violation of R.C. 121.22 is void. However, that case involved a writ of quo warranto to remove a police chief whose appointment was held invalid by operation of R.C. 121.22(H). The Court has found no case law specifically analogous to the instant facts. The case of *Wheeler Corp. v. Columbus*, 147 Ohio App. 3d 460, Franklin Cty., 2001 Ohio 8751, 771 N.E.2d 263; appeal denied *Wheeler Corp. v. Columbus & Ohio River RR. Co.* (2002), 95 Ohio St. 3d 1436, 766 N.E.2d 1002 rejected the argument that decisions stemming from private meetings may be cured. It was concluded that such private meetings were not technical violations. While it was opined that cure is not possible where private deliberations were conducted, the holding if taken

to its logical conclusion would forever invalidate a board's ability to subsequently consider and take action upon an issue. This Court will not presume that such a result would be intended.

The statutory language specifically grants the right to seek injunctive relief to have the public body comply with the provisions of the act (R.C. 121.22(I)(1). Manifestly, the provisions of the act are to have an open meeting consideration of the heretofore private deliberations. In *Steingass Mech., Inc. v. Warrensville Heights Bd. of Educ.*, 151 Ohio App. 3d 321, 2003 Ohio 28, 784 N.E.2d 118, it was stated that the nature and purpose of R.C. 121.22 support the interpretation that the statute is intended to apply to those situations where there has been actual formal action taken; to wit, formal deliberations concerning the public business. In *Danis Montco Landfill Co. v. Jefferson Township Zoning Comm'n* (1993), 85 Ohio App. 3d 494, 620 N.E.2d 140, cited by Appellant, the Court addressed private deliberations and discussions. The only evidence in this action is that the Board conducted written poll votes which were considered approved without further proceedings when all voting members voted yes. There is no indication that the Board entered into any type of discussion or colloquy on these votes.

Appellant seeks not to enforce the provisions of R.C. 121.22 to force the Board to comply with the intent of an open deliberative process, but rather to invalidate the plan under which he operated since 1997. This was not the intent or purpose behind the Sunshine statute. It would not accomplish any legitimate purpose to have the Board's December 11, 2002 actions invalidated. Raising any protest as to the 1997 approval of the physician assistant plan in 1997 has long since lost any efficacy. In *Pontiac Motor Div., General Motors Corp. v. Motor Vehicle Dealers Bd.* (September 15, 1987) Franklin

County App. No. 87AP-48, the Court held that its decision was founded upon a simple, albeit well-recognized, application of the mootness doctrine. It determined that the law was abundantly clear that "the time and energy of this court should not be expended in doing a vain thing." Citing *Travis v. Public Util. Comm.* (1931), 123 Ohio St. 355.

While Appellant contends that the Board never legally adopted the plan, it is uncontested that during the hearing, Appellant offered evidence that he conformed to the plans provisions. If the 1997 plan was not valid, then under what authority did his physician assistants work? If taken through logical steps, the Court could find that Appellant did not violate a previously approved physician assistant plan because none had ever been validly approved. (R.C. 4730.02 et seq.) The Board could then file charges that Appellant allowed a physician assistant to practice without an approved plan. The ultimate resolution would undoubtedly be the same. The Court chooses not travel that avenue.

Appellee has countered that Appellant may not raise the issue of retroactive approval because it was not raised in the proceedings below. Since that action took place at the same meeting in which Appellant's charges were considered, Appellant never had an opportunity to raise the issue. However, this conclusion is not dispositive in light of the finding that the Board acted appropriately in its pro forma approval of the licenses and plans. The Court will not assign as error, the Board's attempt to cure any past technical remissions. Appellant's assignments of error, numbers 1 and 8 are therefore not well-taken.

Appellant's Assigned Error 2 contends that Board's reliance on the testimony of Dr. Gardner is contrary to law. Appellant posits that Dr. Gardner propounded a new and

personal definition of the term "new condition" and applied it to determine whether Appellant complied with Ohio law. The Court will note that strenuous argument and substantial testimony was offered on this issue. The Hearing Officer concluded, as did the Board, that Appellant allowed his physician assistant to treat established patients who presented with new conditions. The Court will first note that a line of cases has held that the Board members may utilize their own expertise in considering whether discipline is warranted. See *Snyder v. State Medical Bd.* (1984),18 Ohio App. 3d 47, 480 N.E.2d 496, and

Weiner v. State Med. Bd., (November 19, 1998), Franklin App. No. 98AP-605. The Court in *State ex rel. DeMuth v. State Bd. of Educ.*(1996), 113 Ohio App. 3d 430; 680 N.E.2d 1314 reiterated that due deference must be given to an "administrative interpretation formulated by an agency that has accumulated substantial expertise in the particular subject area and to which the General Assembly has delegated the responsibility of implementing the legislative command." Citing *Opus III-VII Corp. v. Ohio State Bd. of Pharmacy* (1996), 109 Ohio App. 3d 102. See also *Jones Metal Products Co. v. Walker* (1972), 29 Ohio St. 2d 173, 181, 281 N.E.2d 1.

Second, the statutory sections addressing medical practice, or the analogous administrative code sections would be of treatise size if medical terminology were all defined word for word. The Hearing Officer rejected Appellant's and his experts' definitions for new condition. Appellant sets forth additionally as error that the Board failed to establish that new conditions as defined by Ohio law were in fact treated by the physician assistant. The very context of the argument and testimony at hearing established that there was no precise definition of new condition in statute or code.

However, a review of the record gives support to the conclusion of the Board that Appellant did in fact allow patients to be treated with new conditions without his seeing the patients before treatment was commenced.

R.C. 4730.21(D) states in pertinent part: "(D) A patient new to a physician's practice may be seen by a physician assistant only when a supervising physician is on the premises, except in those situations specified in a standard or supplemental utilization plan under which the presence of the physician is not necessary. A patient new to a physician's practice or an established patient of a physician with a new condition shall be seen and personally evaluated by a supervising physician prior to initiation of any treatment plan proposed by a physician assistant for the new patient or the established patient's new condition." The record is replete with patient records and testimony that supports the Board's determination that Appellant allowed treatment of new conditions without his personal evaluation of the patient.

Appellant also contends that Dr. Gardner's definition was not announced in the pre-hearing report and should not have been admitted. The Court finds no basis to adopt this assignment of error. Appellant was fully apprised of the nature of the charges in the May 9, 2001 notice of charges. While Dr. Gardner did not define new condition the pre-hearing report, no sound basis in law requires such procedure. The record belies the argument that Dr. Gardner developed her own personal definition. The Hearing Officer and Board had ample support to find that the violations occurred on numerous occasions.

Appellant charges in his Error 4 that the State Medical Board disciplined him for conduct not charged. This relates to the use of the terminology new complaint as opposed to new condition. While masterfully argued in the hearing and the briefs, the

Court is still disinclined to find that Board was confused as to this issue. The evidence of record supports the Board's finding that new conditions, as evidenced by new complaints, were treated without Appellant's seeing those patients. As the record reflects, on some occasions Appellant was not even in the office or even the same state. (Transcript pages 1298-1299, 1304-1310)

Appellant has offered in Assignment of Error No.5. that the Board had no evidence to support that he violated R.C. 4731.22(B)(10). As to this issue, Appellant contends that the Board had to offer evidence to show that as to the issuance of medications in the professional context, the State must show that the medications were issued "not in the course of bona fide treatment of patients." Appellant contends that there was no evidence the medications had been issued for anything other than legitimate medical purposes and therefore the Board cannot discipline him for engaging in the crime of selling dangerous drugs. Appellant was charged with complicity, R.C. 2923.03, for allowing his physician assistant to dispense prescription medications or call in prescriptions to pharmacies without a valid order from a physician. Appellant cites to *Warrick Barrett, M.D. v. Ohio State Medical Board* (May 23, 2002) Case No. 01CVF-08-8376, Franklin County Court of Common Pleas, Judge Crawford in support of this assigned error. The above case, referencing *State v. McCarthy* (1992), 65 Ohio St.3d 589, determined that criminal intent must be found in order to find a violation for sale of dangerous drugs under R.C. 4729.51(C). While there is substantial evidence to warrant a finding that Appellant allowed his physician assistant to dispense or call in prescriptions, no evidence is of record to support a finding of criminal intent. There is evidence that

Appellant's lack of supervision fell below the standard of care required, but without more, the Board's finding in this regard must be reversed.

Appellant has assigned as error, identified as No. 6 that the State Medical Board disciplined Dr. Adamson under R.C. 4730.21(D) for conduct that occurred prior to that statute's enactment. As a consequence, that discipline violates both Ohio statutory law and the Ex Post Facto Clauses of the Ohio and United States Constitutions. Appellee has responded that of 200 individual examples off conduct, only 2 appeared to be prior to the 1996 enactment. In his reply brief, Appellant does not address the numerical disparity. Upon review of the record, the Court must find Appellee's position correct. The overwhelming numbers of incidents are after 1996. This error is not well-taken.

Appellant in Error No.7 asserts that the State Medical Board disciplined Dr. Adamson for having committed a misdemeanor by allowing his physician assistant to perform services that violated the physician assistant utilization plans. R.C. 4731.22(B)(12) Appellant maintains that since there was no finding of recklessness on his part there was no violation. Appellant's desire to have a reckless standard imposed is not supported by the statutory language. As reflected above, there is overwhelming evidence to support the Board as to this charge.

Appellant's Error 9 is his dispute with the Board's finding that the treatment and medication orders were not Dr. Adamson's, but his physician assistant's as to the patient's identified in the charges. Appellant states that "the mere fact that a subordinate provider gives treatment or medication to a patient does not mean that the order for that treatment did not originate from a physician." This statement is a truism that the Court will accept. Nonetheless, where evidence supports a finding that a physician assistant was allowed to

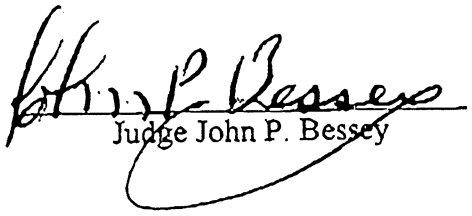
repeatedly act own her own, without meaningful review from her supervising physician, in circumstances that require a patient to be seen and personally evaluated by the physician, the Board is within its authority to levy discipline. Throughout Appellant's arguments, Appellant has contended that standing orders as to specific presentations by patients, either individually or by type of condition, serve to suffice for his involvement in treatment. The Hearing Officer questioned whether such orders existed, since none were shown to be written. The Hearing Officer also concluded (at page 196 of his report) that testimony as to verbal or standing orders for specific patients was not credible. The Court recognizes that Appellant and his wife may have developed a close working relationship. This recognition does not dispense with Appellant's obligation to act pursuant to law as a supervising physician. Reliable, probative, and substantial evidence supports the Board and not Appellant's Assigned Error 9.

Appellant's Assignment of Error No. 10 is that "in a number of instances, the independent, objective medical evidence contained in the chart established that the patient did not have the medical condition alleged by the Board." Appellant individually identified patient No. 21 who was listed on the Notice of Opportunity, as Patient 21, with a date of Aug. 3, 1999, and a new condition of GERD with a prescription order by the physician assistant of Tagamet Rx. At the hearing it was determined that a later laboratory report showed duodenitis, a medical condition different from the one charged by the Board. The Hearing Officer addressed the substance of this circumstance by reflecting that Ms. Adamson had "assessed" patient 21's condition as GERD even though the assessment was not under assessment, but diagnosis. A later lab report reflected duodenitis. The chart was not amended to reflect the lab report. Regardless of this one

specific divergence, the record has volumes of testimony and evidence as to patient diagnoses done by Ms. Adamson, without any supervision by Appellant, with conditions that the Hearing Officer and the Board found, as this Court does likewise to be new conditions that should have warranted Appellant's observation and evaluation. The Court finds that this error is not supported.

The Court has reflected above that the Board's action of permanent revocation of Appellant's license to practice medicine is one which deserves severe scrutiny. Upon full review of the record and consideration of the arguments of counsel, only Assigned Error No. 5 is found well-taken. When viewed in context, although a serious charge, reversing the Board as to that error does not support remanding the appeal back to the Board for further consideration of any modification of penalty. The totality of circumstances which include the number of patients, interval of time, and seriousness of the actions mandates that the Court leave the penalty as imposed by the Board. *Landefeld v. State Med. Bd.* (June 15, 2000), Franklin App. No. 99AP-612; Stay granted: *Landefeld v. State Med. Bd.* (2000), 89 Ohio St. 3d 1440, 731 N.E.2d 686; Dismissed by: *Landefeld v. State Med. Bd.* (2000), 89 Ohio St. 3d 1474, 733 N.E.2d 249.

Counsel for Appellee shall prepare and circulate a Judgment Entry pursuant to Local Rule 25. Costs are assessed to Appellant.



Judge John P. Bessey

Appearances:

Paul J. Coval
Gregory D. Russell
P.O. Box 1008

52 East Gay Street
Columbus, OH 43215-1008
Attorneys for Appellant

Rebecca J. Albers
Mary K. Crawford
30 East Broad Street, 26th Floor
Columbus, OH 43215-3428
Attorneys for Appellee

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

WALLACE C. ADAMSON, M.D.,	:	
Appellant,	:	CASE NO. 02CVF12-14459
vs.	:	JUDGE BESSEY
OHIO STATE MEDICAL BOARD,	:	
Appellee.	:	

2003 JAN 17 PM 1:04
CLERK OF COURTS

DECISION AND ENTRY DENYING APPELLANT'S MOTION FOR SUSPENSION OF AGENCY ORDER, FILED DECEMBER 31, 2002

This matter is before the Court upon the Motion for Suspension of Agency Order, filed by Appellant, Wallace C. Adamson, M.D. (hereinafter "Appellant"), on December 31, 2002. On January 8, 2003, Appellee, State Medical Board of Ohio (hereinafter "Appellee"), filed a Memorandum Contra Appellant's Motion for Suspension of Agency Order.

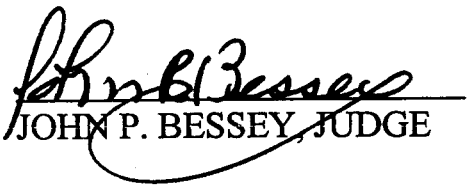
On December 27, 2002, Appellant, as authorized by R.C. 119.12, filed a Notice of Appeal of Appellee's December 11, 2002 Order, which permanently revoked Appellant's license to practice medicine and surgery. Appellant now requests, also pursuant to R.C. 119.12, that the Court issue an order staying the effect of Appellee's December 11, 2002 Order during the pendency of his appeal. R.C. 119.12 provides in pertinent part as follows:

> The filing of a notice of appeal shall not automatically operate as a suspension of the order of an agency . . . In the case of an

> appeal from the state medical board . . . the court may grant a suspension and fix its terms if it appears to the court that an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal and the health, safety, and welfare of the public will not be threatened by suspension of the order. This provision shall not be construed to limit the factors the court may consider in determining whether to suspend an order of any other agency pending determination of an appeal.

In the case at hand, the Court finds that although Appellant has set forth several arguments concerning the merits of Appellee's Order, Appellant has failed to show the Court that he will suffer any unusual hardship if Appellee's Order is not stayed, or that his continued ability to practice medicine will not threaten the health, safety, and welfare of the public. As such, the Court finds, that pursuant to R.C. 119.12, Appellant has failed to meet the criteria for a suspension of Appellee's Order, and accordingly hereby **DENIES** Appellant's Motion for Suspension of Agency Order.

IT IS SO ORDERED.



JOHN P. BESSEY, JUDGE

Copies to:

Paul J. Coval
Attorney for Appellant

Rebecca J. Albers
Mary K. Crawford
Attorney for Appellee

BEFORE THE STATE MEDICAL BOARD OF OHIO

02CVF12 14459

WALLACE C. ADAMSON, M.D., 2202 Wingate Drive Delaware, Ohio 43015, Appellant, v. OHIO STATE MEDICAL BOARD, 77 South High Street, 17th Floor Columbus, Ohio 43215-6127, Appellee.	:	Judge _____ Case No. _____ Ohio Rev. Code § 119.12 **Notice of Appeal**

Pursuant to Section 119.12 of the Ohio Revised Code, Wallace C. Adamson, M.D., through undersigned counsel, hereby gives notice of his appeal of the Ohio State Medical Board's Order issued December 11, 2002, and mailed to Dr. Adamson on December 13, 2002 (a true and accurate copy of which is attached hereto as Exhibit A). Dr. Adamson appeals that Order on the following grounds:

1. It is not supported by reliable, probative and substantial evidence; and,
2. It is not in accordance with law.

Among the numerous errors committed by the Board that compel a reversal, and by way of background, and without limitation to the legal and factual errors to be raised on appeal, are the following:

- For nearly thirty years, the State Medical Board has repeatedly violated Ohio's Sunshine Law, Ohio Rev. Code § 121.22, by purporting to approve professional licenses, including certificates to practice medicine in Ohio, as well as other professional applications, including Physician Assistant Utilization Plan

FILED COMMON PLEAS COURT FRANKLIN COUNTY OHIO 2002 DEC 27 PM 1:57 CLERK OF COURTS-CIVIL DIV.
STATE MEDICAL BOARD OF OHIO 2003 JAN -7 A 11:17

applications, by "poll" votes rather than at open meetings as required by Ohio law, making all such actions invalid as a matter of law. Ohio Rev. Code § 121.22(H).

- As a consequence, the State Medical Board had no authority to act in this proceeding: Because of the State Medical Board's violations of Ohio's Sunshine Law, its physician members – needed to have a quorum for any Board action – were not, and are not, duly licensed to practice medicine in the State of Ohio. Such members therefore failed to meet the statutory requirements for appointment by the Governor contained in Ohio Rev. Code § 4731.01, depriving the Board of the quorum necessary to lawfully act. See Ohio Rev. Code § 4731.01 (setting forth the criteria that the Ohio General Assembly found that members of the State Medical Board must satisfy in order to be appointed to the Board by the Governor, with the advice and consent of the Senate).

- The State Medical Board's attempt to manage those Sunshine Law violations – only minutes before taking action in Dr. Adamson's case – by retroactively approving the medical licenses of its physician members by motion at the December 11, 2002, Board meeting fails as a matter of law. Not only is there no statutory authority for the Board to act retroactively, and not only does that attempt violate the Ohio Constitution, but the Board also had no duly constituted quorum that would have enabled it to otherwise legally act, as required by Ohio Rev. Code §§ 4731.01 and 4731.06.

- The State Medical Board never duly approved the Physician Assistant Utilization Plan(s) upon which it based its prosecution of Dr. Adamson, contrary to both Ohio law and its charging instrument in this proceeding.

STATE MEDICAL BOARD OF OHIO
2003 JAN -4 A 11: 17

- The State Medical Board's attempt to manage its violation of Ohio's Sunshine law with respect to those Physician Assistant Utilization Plans by purporting to retroactively approve them only minutes before ruling in Dr. Adamson's case too fails as a matter of law for the reasons stated above.

- The administrative regulations upon which the State Medical Board based its prosecution of Dr. Adamson were unlawfully promulgated and are therefore of no force and effect as a matter of law.

- The Notice of Opportunity for Hearing issued by the State Medical Board in this proceeding, and which forms the basis of the Board's prosecution in this matter, was unlawfully issued by a State Medical Board that was improperly constituted under Ohio law, and was and is therefore of no force and effect as a matter of law.

- And, again, among other legal and factual errors to be raised on appeal, the State Medical Board violated Dr. Adamson's right to due process and deprived him of a fair hearing on the Board's accusations against him, guaranteed to him by both the Ohio and United States Constitutions, by presenting evidence through its counsel that it knew or should have known was untrue, and then attempting to manage those violations retroactively at the Board meeting after the administrative hearing on those issues had closed.

Accordingly, for these and other reasons to be raised in this appeal, including, but not limited to, each and every reason raised by Dr. Adamson at the disciplinary proceeding below, the State Medical Board's Order must be reversed and vacated as

STATE MEDICAL BOARD OF OHIO
2003 JAN -6 A 11: 17

not supported by a preponderance of reliable, probative and substantial evidence and not in accordance with law.

Respectfully submitted,

VORYS, SATER, SEYMOUR AND PEASE LLP

By: _____
Paul J. Coval (0022781)

52 East Gay Street
P. O. Box 1008
Columbus, Ohio 43216-1008
(614) 464-6400

Counsel for Appellant,
Wallace C. Adamson, M.D.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing was served by regular U.S. mail, postage prepaid, upon Mary K. Crawford and Rebecca J. Albers, Assistant Attorneys General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215-3428, counsel for the State Medical Board, this 27th day of December, 2002.

_____

STATE MEDICAL BOARD OF OHIO
2003 JAN -7 A 11: 17

State Medical Board of Ohio

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

December 11, 2002

Wallace C. Adamson, M.D.
2202 Wingate Drive
Delaware, OH 43015

Dear Mr. Adamson:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 11, 2002, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

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

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

THE STATE MEDICAL BOARD OF OHIO

Pitambar Somani MD

Pitambar Somani, M.D.
Acting Secretary

PB:jam
Enclosures

CERTIFIED MAIL RECEIPT NO. 7000 0600 0024 5148 4876
RETURN RECEIPT REQUESTED

Cc: Paul J. Coval, Esq.
CERTIFIED MAIL RECEIPT NO. 7000 0600 0024 5148 4845
RETURN RECEIPT REQUESTED

Mailed 12/13/02

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 11, 2002, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the Matter of Wallace C. Adamson, 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.

Pitambar Somani MD

Pitambar Somani, M.D.
Acting Secretary

(SEAL)

December 11, 2002
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*
	*
WALLACE C. ADAMSON, M.D.	*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on December 11, 2002.

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

It is hereby ORDERED that:

> The certificate of Wallace C. Adamson, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

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

Pitambar Somani MD

Pitambar Somani, M.D.
Acting Secretary

(SEAL)

December 11, 2002
Date

STATE MEDICAL BOARD
OF OHIO

2002 OCT -7 P 1:42

REPORT AND RECOMMENDATION
IN THE MATTER OF WALLACE C. ADAMSON, M.D.

The Matter of Wallace C. Adamson, M.D., was heard by R. Gregory Porter, Attorney Hearing Examiner for the State Medical Board of Ohio, on March 6 through 8, 11, 14 through 16, 18 through 22, 25, and 26, 2002.

INTRODUCTION

I. Basis for Hearing

A. By letter dated May 9, 2001, the State Medical Board of Ohio [Board] notified Wallace C. Adamson, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on allegations pertaining to Dr. Adamson's supervision of Robin Rae Hawn, P.A., (who is now known as Robin Rae Adamson, P.A.) The Board alleged that Dr. Adamson's conduct constitutes:

- For conduct that occurred prior to March 9, 1999, "'[c]ommission of an act that constitutes a misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice,' as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Section 4730.02(E), Ohio Revised Code. Pursuant to Section 4730.99, Ohio Revised Code, a violation of Section 4730.02, Ohio Revised Code, constitutes a misdemeanor offense."

- For conduct that occurred on or after March 9, 1999, "'[c]ommission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed,' as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 4730.02(E), Ohio Revised Code. Pursuant to Section 4730.99, Ohio Revised Code, a violation of Section 4730.02, Ohio Revised Code, constitutes a misdemeanor offense."

- "'[f]ailure of a physician supervising a physician assistant to maintain supervision in accordance with the requirements of Chapter 4730. of the Revised Code and the rules adopted under that chapter,' as that clause is used in Section 4731.22(B)(32), Ohio Revised Code, to wit: Section 4730.21(D), Ohio Revised Code."

- "'violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,' as that clause is used in Section

4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-4-03(A) and (B), Ohio Administrative Code, as in effect prior to September 1, 2000."

- "'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 4731-4-03(B) and (C), Ohio Administrative Code, as in effect prior to September 1, 2000."

- For conduct that occurred prior to March 9, 1999, "'[c]ommission of an act that constitutes a misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice,' as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code. Pursuant to Section 4731.99, Ohio Revised Code, as in effect prior to March 9, 1999, a violation of Section 4731.41, Ohio Revised Code, constitutes a misdemeanor offense."

- For conduct that occurred after March 9, 1999, "'[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,' as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code. Pursuant to Section 4731.99(A), Ohio Revised Code, a violation of Section 4731.41, Ohio Revised Code, constitutes a felony offense."

- "'[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,' as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4729.51(C), Ohio Revised Code, Persons who may sell, purchase, distribute, or deliver dangerous drugs."

Accordingly, the Board advised Dr. Adamson of his right to request a hearing in this matter. (State's Exhibit 60A)

B. By document received by the Board on June 6, 2001, Paul J. Coval, Esq., requested a hearing on behalf of Dr. Adamson. (State's Exhibit 60B)

II. <u>Appearances</u>

A. On behalf of the State of Ohio: Betty D. Montgomery, Attorney General, by Mary K. Crawford and Rebecca J. Albers, Assistant Attorneys General.

B. On behalf of the Respondent: Paul J. Coval, Esq.

III. Consolidation

Upon the motion of the State, and with no objection from any party, the matters of Wallace C. Adamson, M.D., and Robin Rae Hawn, P.A., (who is now known as Robin Rae Adamson, P.A.), were consolidated for hearing by Entry dated June 26, 2001.

EVIDENCE EXAMINED

I. Testimony Heard

A. Presented by the State

1. Robin Rae Adamson, P.A., as upon cross-examination
2. Wallace C. Adamson, M.D., as upon cross-examination
3. April Gardner, D.O.
4. Patient 30
5. Lilian Ng
6. Lucinda Schmidt
7. Patient 52
8. Patient 24
9. Patient 7
10. Mark A. Buddie, M.D.
11. Patient 57
12. Patient 8
13. Molly McCale
14. Patient 9

B. Presented by the Respondents

1. Robin Rae Adamson, P.A.
2. Wallace C. Adamson, M.D.
3. Stanley Worth Borg Jr., D.O.
4. Patient 11

II. Exhibits Examined

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

A. Presented by the State

* 1. State's Exhibits 1 through 59: Patient records.

2. State's Exhibits 60A through 60LLL, 60PPP through 60YYY, 60BBBB, 60CCCC, and 60EEEE: Procedural exhibits. [Note that State's Exhibits 60RR through 60JJJ, 60LLL, 60PPP, and 60BBBB have been sealed to protect patient confidentiality.]

3. State's Exhibits 60MMM through 60OOO, and 60AAAA: Copies of stipulations of the parties concerning the authenticity of copies of written interrogatories, deposition transcripts, prescriptions, and patient medical records.

4. State's Exhibit 60DDDD: Copy of a March 19, 2002, Motion from the State, with attached list of patient numbers, dates, exhibit numbers, and page numbers, submitted by the State in lieu of live testimony concerning allegations contained in paragraph 3 of the May 9, 2001, notice of opportunity for hearing for Dr. Adamson.

5. State's Exhibit 60FFFF: June 26, 2002, Agreement. (See Procedural Matters 3, below)

6. State's Exhibits 61A and 61B: Not admitted. (See Procedural Matters 3, below.)

7. State's Exhibit 62: Copy of the minutes of the December 4, 1997, meeting of the Physician Assistant Policy Committee.

8. State's Exhibit 63: Copy of the Physician Assistant Utilization Plan and related documents for Wallace C. Adamson, M.D., Inc., maintained by the Board. [Note that this document contains errors. A corrected copy was admitted to the record as State's Exhibit 76. This exhibit has been admitted only for the limited purpose of providing continuity between testimony offered at hearing and State's Exhibit 76. (See Procedural Matters 4, below.)]

9. State's Exhibit 64: Copy of the Physician Assistant Utilization Plan and related documents for Wallace C. Adamson, M.D., and American Health Network of Ohio, maintained by the Board. [Note that this document contains errors. A corrected copy was admitted to the record as State's Exhibit 77. This exhibit has been admitted only for the limited purpose of providing continuity between testimony offered at hearing and State's Exhibit 77. (See Procedural Matters 4, below.)]

10. State's Exhibit 65: Not admitted.

11. State's Exhibit 66: Copy of The State Medical Board of Ohio's First Set of Interrogatories Directed to Wallace C. Adamson, M.D., including Dr. Adamson's April 25, 2000, responses.

12. State's Exhibit 67: Copy of The State Medical Board of Ohio's Second Set of Interrogatories Directed to Wallace C. Adamson, M.D., including Dr. Adamson's October 18, 2000, responses.

* 13. State's Exhibits 68 through 68D: Confidential patient keys for Patients 1 through 59, corresponding to the notices of opportunity for hearing issued to Dr. Adamson and Ms. Adamson, respectively.

14. State's Exhibit 69: Admitted under different exhibit numbers. (See Procedural Matters 7, below.)

* 15. State's Exhibits 70 and 70A: Copies of prescriptions.

16. State's Exhibit 71: Curriculum vitae of April Gardner, D.O.

* 17. State's Exhibit 72: Copy of Dr. Gardner's April 3, 2001, report, with some information redacted by the State prior to the hearing.

18. State's Exhibits 73 through 75: Excerpts from the Ohio Revised Code and the Ohio Administrative Code.

19. State's Exhibit 76: Copy of the Physician Assistant Utilization Plan and related documents for Wallace C. Adamson, M.D., Inc., maintained by the Board. [Note: This is a corrected copy of State's Exhibit 63. (See Procedural Matters 4, below.)]

20. State's Exhibit 77: Copy of the Physician Assistant Utilization Plan and related documents for Wallace C. Adamson, M.D., and American Health Network of Ohio, maintained by the Board. [Note: This is a corrected copy of State's Exhibit 64. (See Procedural Matters 4, below.)]

21. State's Exhibits 78 through 82: Not admitted. (See Proffered Exhibits, below.)

22. State's Exhibits 83A and 83B: Excerpts from the transcripts of the October 25, 2000, deposition of Robin Rae Hawn, P.A.; and the October 26, 2000, deposition of Wallace C. Adamson, M.D.

23. State's Exhibit 84: Closing argument of the State.

24. State's Exhibit 85: Response of the State to the closing argument of the Respondents.

B. Presented by the Respondent

1. Respondents' Exhibit A: Bench Brief - Confidential Investigatory Depositions.

* 2. Respondents' Exhibit B: Copy of a February 28, 2001, letter to Dr. Gardner from the Board.

* 3. Respondents' Exhibit C: Unredacted copy of Dr. Gardner's April 3, 2001, report.

4. Respondents' Exhibits H, I, and K: Copies of the minutes of the Physician Assistant Policy Committee for May 14, 1998; January 15, 1998; and July 10, 1997.

5. Respondents' Exhibit L: Sketch of the floor plan of Dr. Adamson's office, drawn by Ms. Adamson. [Note: This exhibit shall be available for viewing by Board members at the offices of the Board.]

* 6. Respondents' Exhibit N: Copy of PA Log, Quality Improvement and Utilization Review Plan, Apple Health Sports and Family Medicine.

7. Respondents' Exhibit O: Curriculum Vitae of Wallace C. Adamson, M.D.

8. Respondents' Exhibit P: Copy of Expert Report of Stanley W. Borg, D.O.

9. Respondents' Exhibits Q and R: Copies of two documents presented at hearing by the Respondents, both entitled Bench Brief - Testimony of Expert Witness.

10 Respondents' Exhibit T: Closing argument of the Respondents

11. Respondents' Exhibit U: Response of the Respondents to the closing argument of the State.

C. Presented by the Attorney Hearing Examiner

State's Exhibit MM: Procedural exhibit not presented or admitted during the hearing, consisting of a copy of the State's January 11, 2002, motion for a prehearing conference.

PROFFERED EXHIBITS

1. State's Exhibit 78: Copy of an application of Stanley W. Borg, D.O., to the Colorado State Board of Medical Examiners. (See Hearing Transcript at pages 2216-2223)

2. State's Exhibits 79 through 82: Copies of meeting minutes of the Physician Assistant Policy Committee. (See Hearing Transcript at pages 2235-2289)

3. Respondents' Exhibit S: Proffer of the Respondents concerning the testimony of Patient 52. (See Procedural Matters 6, below.)

PROCEDURAL MATTERS

1. The Board issued separate notices of opportunity for hearing to Dr. Adamson and Ms. Adamson. (State's Exhibits 60A and 60K) By motions of the State, and with the agreement of the Respondents, the matters were consolidated. (State's Exhibits 60I, 60S, and 60U)

2. The record in this matter was held open until June 26, 2002, in order to give the parties an opportunity to file written closing arguments and replies to closing arguments. These documents were timely filed and admitted to the record as State's Exhibits 84 and 85, and Respondents' Exhibits T and U.

3. State's Exhibits 61A and 61B consist of copies of the transcripts of the October 25, 2000, deposition of Robin Rae Hawn, P.A.; and the October 26, 2000, deposition of Wallace C. Adamson, M.D., respectively. The Respondents objected to the admission of these complete transcripts. However, the parties agreed at hearing to submit excerpts from these transcripts that included only the testimony that was referenced at hearing. Accordingly, State's Exhibits 61A and 61B were not admitted to the record.

   On June 26, 2002, the State submitted excerpts from the transcripts of the October 25, 2000, deposition of Robin Rae Hawn, P.A.; and the October 26, 2000, deposition of Wallace C. Adamson, M.D., marked as State's Exhibits 83A and 83B, respectively. Along with these exhibits, the parties submitted an Agreement to the admission to the record of State's Exhibits 83A and 83B, subject to the objections the Respondents made at hearing. Accordingly, State's Exhibits 83A and 83B are admitted. [Note that the June 26, 2002, Agreement of the parties had been marked as State's Exhibit 60EEEE. Because another document had already been admitted as State's Exhibit 60EEEE[1], the Hearing Examiner renumbered the June 26, 2002, Agreement to State's Exhibit 60FFFF and admitted it to the hearing record.]

4. During hearing, State's Exhibits 63 and 64—which are copies of the Physician Assistant Utilization plans and related documents for Wallace C. Adamson, M.D., Inc., and the American Health Network—were noted to contain errors. Among other things, some of the pages were mixed between the two exhibits. Corrected copies of these documents were obtained and admitted to the record as State's Exhibits 76 and 77. Accordingly, State's

[1] The Respondents' March 20, 2002 Request for Issuance of Subpoena to Ms. Hacker.

Exhibits 63 and 64 were admitted to the record only for the limited purpose of providing continuity between witness testimony (for which State's Exhibits 63 and 64 had been used) and State's Exhibits 76 and 77. (See Hearing Transcript at 1689-1695)

[Note that pages 4 and 5 of State's Exhibit 64 are now State's Exhibit 76, pages 8 and 9. Further, pages 15 and 16 of State's Exhibit 63 are now State's Exhibit 77, pages 45 and 46. (See Hearing Transcript at 1692-1694)]

5. The State's motion to strike, given at pages 2029-2030 of the Hearing Transcript, is denied.

6. During the hearing, the Respondents proffered testimony concerning Patient 52. (See pages 2228 and 2229 of the Hearing Transcript.) This testimony has been separated from the Hearing Transcript and will be held as proffered material for the Respondents. Further, the Hearing Examiner marked this item for identification purposes as Respondents' Exhibit S.

7. State's Exhibit 69 consisted of copies of prescriptions pertaining to several of the patients identified in the patient key. Rather than admitting these items together as State's Exhibit 69, they were instead distributed among the individual patient medical records and renumbered accordingly.

SUMMARY OF THE EVIDENCE

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

Background Information

Wallace C. Adamson, M.D.

1. Dr. Adamson obtained his medical degree in 1982 from the Ohio State University College of Medicine. From 1982 until 1985, he participated in a residency in family practice at Grant Medical Center [Grant] in Columbus, Ohio. From 1985 until 1986, Dr. Adamson participated in a fellowship in sports medicine at that same institution. Dr. Adamson was certified by the American Board of Family Practice in 1985, and was recertified in 1993 and 2000. Further, Dr. Adamson holds a Certificate of Additional Qualification in Sports Medicine from the American Board of Family Practice. Moreover, Dr. Adamson was certified by the American Society of Addiction Medicine in 1987. Dr. Adamson testified that he was licensed to practice medicine in Ohio in 1983. (Respondent's Exhibit [Resp. Ex.] O; Hearing Transcript [Tr.] at 593-595)

   Dr. Adamson testified that, in 1985, at the same time he entered the sports medicine fellowship, he began a part-time private practice in partnership with another physician,

Dr. Ratcliff, a faculty member at the family practice residency at Grant. The name of Dr. Ratcliff's practice was Village Family Physicians. (Tr. at 593-595)

2. Dr. Adamson testified that, from 1986 through 1994, he had been the first program director for the sports medicine fellowship program at Grant, and also became the first medical director for the Grant Fitness Center. Dr. Adamson also continued to work at Village Family Physicians. Dr. Adamson testified that, around March 1, 1994, he left Grant, and Village Family Physicians, which by that time had been purchased by Grant. He began working at Family Practice Outreach, which was owned by another physician, Dr. Griggs, and which was located at 4278 Indianola Avenue, Columbus, Ohio. Dr. Adamson purchased Family Practice Outreach on January 1, 1995, and renamed the practice Apple Health Sports and Family Medicine, Inc. [Apple Health]. Dr. Adamson practiced at Apple Health until April 30, 2000, when he left private practice to work for Anthem Blue Cross and Blue Shield [Anthem]. (Resp. Ex. O; Tr. at 595-596)

   Dr. Adamson testified that his practice at Apple Health had been a general family practice. Dr. Adamson further testified that he had had approximately 3000 active charts. Moreover, Dr. Adamson testified that "approximately 80 to 85 percent had some type of insurance. Approximately 10 percent were on Medicare, and 5 percent were either state-funded Medicaid or self-pay." (Tr. at 1340-1341)

   Dr. Adamson testified that his office generally saw approximately thirty patients per day, but could see as many as forty on a very busy day. Dr. Adamson testified that this remained fairly consistent throughout the time period relevant to this hearing. (Tr. at 1341-1342)

   Dr. Adamson testified that his practice "was in a very competitive health care market" and that he had had difficulty keeping staff. Dr. Adamson testified that the size of his staff, including providers, varied between five and ten people. (Tr. at 602-603)

3. Dr. Adamson testified that he sold Apple Health to American Health Network on May 1, 1995. Dr. Adamson testified that American Health Network was at that time a wholly-owned subsidiary of Anthem. Dr. Adamson further testified that everyone at the practice, including Dr. Adamson, became an employee of American Health Network at that time. Dr. Adamson testified that, subsequently, on August 1, 1998, Anthem divested itself of American Health Network, and American Health Network became a separate company. The new company, known as American Health Network, Inc., was owned by some of the affiliated physicians. Dr. Adamson testified that he was not one of the owners, but remained an employee until April 30, 2000. (Tr. at 597-598)

4. Dr. Adamson testified that when he was an employee of Anthem-owned American Health Network he had received a guaranteed salary amount. Dr. Adamson further testified that when American Health Network, Inc., took over the practice, "they went to a production-based system, but they did not administer that production-based system on any type of a consistent basis." Dr. Adamson testified that his salary nevertheless remained

fairly consistent, and only varied by three to four thousand dollars per year, during the time he worked for American Health Network, Inc. (Tr. at 598-599)

5. Dr. Adamson testified that Dr. Bryan Ghiloni had worked full-time at Apple Health from September 1995 until American Health Network transferred him to another location in fall 1997. Dr. Adamson testified that Dr. Ghiloni had been primarily responsible for the operational aspects of the office during Dr. Ghiloni's tenure there. (Tr. at 604-606, 613)

6. Dr. Adamson hired Robin Rae Hawn, P.A., who is now known as Robin Rae Adamson, P.A., in March 1991. Dr. Adamson testified that Ms. Adamson continued to work under Dr. Adamson's supervision until April 30, 2000. Dr. Adamson testified that her job function never changed as a result of the various corporate changes that took place in Dr. Adamson's practice. (Tr. at 601-602)

7. Dr. Adamson testified that, in the 1980s, in addition to his family practice, he had been a medical director of inpatient drug and alcohol treatment programs at Mercy Hospital, which later became Columbus Community Hospital. Dr. Adamson further testified that he and several counselors later formed Focus Health Care [Focus] when the company that they had worked for lost its contract with the hospital. Dr. Adamson testified that Focus remained a separate company from his family practice. It was located at 5701 North High Street, Columbus, Ohio. (Tr. at 600-601, 1343-1344)

   Dr. Adamson testified that he did consulting work at Focus, and that he "would see patients there on weekends, but rarely go there. It was mainly where the counselors worked." Dr. Adamson further testified that Ms. Adamson occasionally went to that site with specific orders concerning a patient at that site. However, Dr. Adamson testified that if patients from that site needed to be seen medically, they would generally go to Apple Health. (Tr. at 1343-1344)

8. In addition to his practices at Apple Health and Focus, Dr. Adamson testified that he had worked as a Physician Review Consultant for Community Mutual Insurance Company from 1992 to 1996, and spent approximately 10 to 25 percent of his time doing that work. Dr. Adamson further testified that, from 1996 until 2000, he had worked for Anthem as an Associate Regional Medical Director, and spent about 25 percent of his time doing that work. (Tr. at 2045-2046)

9. Dr. Adamson testified that he had been on the Board's Physician Assistant Advisory Committee from 1993 through 1995. Dr. Adamson further testified that the Physician Assistant Advisory Committee members were appointed by the Board, and reviewed Physician Assistant Utilization Plans, discussed terminology and, in 1995, discussed legislative efforts leading to new law regarding physician assistants. Moreover, Dr. Adamson testified that Dr. April Gardner, the State's expert in this matter, had also been a member of that committee. (Tr. at 1953-1955)

Dr. Adamson noted that his curriculum vitae contains an error—it states that he had been on the Board's Physician Assistant Policy Committee [PAPC] from 1994 until 1995, rather than on the Physician Assistant Advisory Committee. Dr. Adamson testified that, in fact, he had not been on the PAPC. (Resp. Ex. O at 4; Tr. at 1953)

10. Dr. Adamson testified that he is currently employed by Anthem as Medical Director, Northern and Central Ohio Health Service Area. Dr. Adamson testified that he is "responsible for the network quality and cost of care of two million Anthem members in the State of Ohio." Moreover, Dr. Adamson testified that "[t]hat means I review credentialing; I review our [provider] network; I do quality studies; I review charts; I go to meetings on cost of care; I teach insurance people what doctors do." (Resp. Ex. O at 2; Tr. at 2043-2045)

    Dr. Adamson testified that, in addition to his full-time position at Anthem, he performs volunteer activities. Dr. Adamson testified that he is on the Board of Directors of the Columbus Metro American Heart Association, a volunteer physician at the Columbus Medical Association Free Clinic, and a team physician for Olentangy High School. (Tr. at 2046)

<u>Robin Rae Adamson, P.A.</u>

11. Robin Rae Adamson, P.A., testified that she obtained a Bachelor of Arts degree and a certificate as a physician assistant in 1982 from the Lake Erie College/Cleveland Clinic Foundation P.A. Program. Ms. Adamson testified that she has also received advanced training with regard to sexually transmitted diseases [STD] with the Centers for Disease Control in Cincinnati, Ohio. (Tr. at 12-13, 1713-1718)

    Ms. Adamson testified that she took and passed her national board examination in October 1982. Ms. Adamson further testified that, per certification requirements, she has retaken the national certification examination every six years since that time. Moreover, Ms. Adamson testified that she had taken an examination for extra certification in family practice during the time when that certification was available. (Tr. at 1718-1720)

    Ms. Adamson testified that she obtained her first position as a physician assistant in September 1982, working for physicians in a general practice in Columbus, Ohio. Ms. Adamson further testified that, in June or July 1984, she left that position to take a job with the Columbus Health Department [CHD]. In March 1991, Ms. Adamson left the CHD to work for Dr. Adamson. Ms. Adamson left Dr. Adamson's practice in April 2000 when Dr. Adamson discontinued his private practice. From May through December 2000, Ms. Adamson worked for The Doctor's Office with OhioHealth. Finally, from March 2001 through the present, Ms. Adamson has worked as a product specialist for Ortho Biotech. (Tr. at 15-17, 1721-1731)

    Ms. Adamson testified that, at the CHD, she had begun as a physician extender, and had worked in an STD clinic where she "saw patients, counseled them on sexually transmitted

disease, did some community education, [and] was the chair of the quality assurance committee." Ms. Adamson testified that she was later transferred to a community health center where she worked in the perinatal program. (Tr. at 17-18, 1723-1727)

Ms. Adamson testified that she is a member of the American Academy of Physician Assistants, the Ohio Association of Physician Assistants, and the Oncology Nursing Society. Ms. Adamson further testified that, when she worked for the STD clinic, she had been a member of the National STD Association. Moreover, Ms. Adamson testified that she has held multiple offices with the Ohio Association of Physician Assistants, including Secretary, Trustee at Large, and President. (Tr. at 1731-1736)

Ms. Adamson testified that her current position is Hematopoietic Product Specialist for Ortho Biotech, where she deals with three products: Procrit, Doxil, and Duragesic. Ms. Adamson testified that she has joined the Oncology Nursing Society "to keep abreast of what's going on in oncology nursing and just get the information that I need to do my job." (Tr. at 1736)

12. Ms. Adamson testified that when she first began working for Dr. Adamson, she shadowed Dr. Adamson for the first week and watched how he worked. Ms. Adamson further testified, "We would see patients together, and when they would get to a certain point in their care, [Dr. Adamson] would say, 'Okay, I want you to follow with Robin now for this issue,' like their high blood pressure or their cholesterol. And so eventually I worked into having my own schedule." Ms. Adamson testified that, during times when she did not have patients on her schedule, she assisted Dr. Adamson with his patients. (Tr. at 18-19)

13. Ms. Adamson testified that, between 1994 and 2000, two other physician assistants were employed by Apple Health and Dr. Adamson besides her: Marsha Bendle, from September to October 1999; and Nancy Keeler, from November 1998 through spring (possibly March) 1999. (Tr. at 31-32)

14. Ms. Adamson testified that she and Dr. Adamson were married on August 9, 1998. (Tr. at 591-592)

<u>Expert Witness for the State: April Gardner, D.O.</u>

15. April Gardner, D.O., testified as an expert on behalf of the State. Dr. Gardner testified that, in 1972, she obtained a Physician Assistant degree from Cincinnati Technical College, now known as Cincinnati State, in Cincinnati, Ohio. Dr. Gardner testified that, in 1976, after having worked as a physician assistant for several years, she obtained a Registered Nurse degree. Further, in 1988, Dr. Gardner obtained her Doctor of Osteopathy degree from the West Virginia College of Osteopathic Medicine in Lewisberg, West Virginia. From 1988 until 1991, Dr. Gardner participated in an internship and residency at Grandview Hospital and Medical Center in Dayton, Ohio. Moreover, Dr. Gardner was certified in family medicine in 1994 by the American Osteopathic Board of Family Physicians. Finally,

Dr. Gardner testified that she has been licensed to practice medicine in Ohio for 14 years. (State's Exhibit [St. Ex.] 71; Tr. at 942-943, 1151)

Dr. Gardner testified that she has a general family practice, and that she sees patients "from birth to death." (Tr. at 943)

16. Dr. Gardner testified that, in her medical practice, she does not employ a physician assistant and, except for one four-week rotation of a physician assistant student several years ago, she has never had a physician assistant in her practice. Dr. Gardner further testified that she has never supervised a physician assistant, or been a party to a physician assistant utilization plan. (Tr. at 1158, 1233-1234)

    Dr. Gardner testified that, when she herself had been a physician assistant, she had worked as a surgical assistant. Dr. Gardner testified that she never worked as a physician assistant in a family practice. (Tr. at 1152-1153)

17. When Dr. Gardner agreed to provide expert services for the Board, the Board sent her a letter in which she was asked to review patient records and address the following two issues:

    "1) did the patients have new conditions, as that term is used in Ohio Revised Code [Section] 4730.21 and Ohio Administrative Code Rule 4731-4-01(A), on the dates as identified [in an attached document]?

    "2) was any treatment initiated for these patients for any new condition identified in question 1 above, as the term treatment is used in Ohio Revised Code [Section] 4730.21 and Ohio Administrative Code Rule 4731-4-01(A), on the dates specified [in an attached document]?"

    (Resp. Ex. B; Tr. at 1173-1175) Dr. Gardner testified that, although the letter had referred her to specific dates, she reviewed each chart in its entirety and rendered her opinion concerning each patient following a review of the entire patient record. (Tr. at 951-952, 960-962, 991)

<u>Expert Witness for the Respondents: Stanley Worth Borg Jr., D.O.</u>

18. Stanley Worth Borg Jr., D.O., testified as an expert on behalf of the Respondents. Dr. Borg testified that he had obtained his osteopathic medical degree in 1988 from the College of Osteopathic Medicine of the Pacific, now known as Western University, in Pomona, California. Dr. Borg completed a three-year residency in family practice at Los Angeles County King/Drew Medical Center, in Los Angeles, California. Moreover, Dr. Borg is a diplomate of the American Board of Family Practice, and is a fellow of the American Academy of Family Practice. (Resp. Ex. P; Tr. at 2119-2120)

Dr. Borg testified that, after completing his residency, he had worked as a full-time clinician for Los Angeles County and for CIGNA Health Care, and worked in emergency departments in southern California. Dr. Borg further testified that, within three or four years, he began working in the administrative side of medicine. Moreover, Dr. Borg testified that, from 1996 through late 1999, he had worked as a medical director for Anthem in Worthington, Ohio. Dr. Borg testified that, in late 1999, he was promoted to another position with Anthem and transferred to Denver, Colorado. Dr. Borg testified that he left Anthem in January 2001 to take his current position with Blue Cross and Blue Shield of Illinois. (Tr. at 2121, 2141-2143)

Dr. Borg testified that, although he is engaged in administrative medicine, he has always continued to do some clinical work. Dr. Borg testified that, at the same time he worked for Anthem in central Ohio, he had worked at an urgent care facility for one 12-hour shift per week. Dr. Borg further testified that he had volunteered Monday evenings at the Columbus Free Clinic. Moreover, Dr. Borg testified that he currently does clinical work "that is limited to volunteer work with a Denver homeless clinic on weekends." (Tr. at 2121-2122, 2146-2147)

Dr. Borg testified that his current business address is in Chicago, Illinois. Dr. Borg further testified that he continues to live in Denver, Colorado, and commutes to Chicago. (Tr. at 2119, 2122, 2143, 2151)

19. Dr. Borg testified that he has never supervised physician assistants in Ohio, or applied for a Physician Assistant Utilization Plan in Ohio. Dr. Borg further testified that he had worked with physician assistants in California, and was part of the physician assistant practice protocol, but was not a supervising physician as that term was used in California. Dr. Borg testified that, in California, only one physician in the practice was required to be designated as a supervising physician. (Tr. at 2147-2149)

20. Dr. Borg testified that, in preparation for his expert report and testimony in this hearing, he reviewed the statutes and regulations that govern the practice of physician assistants in Ohio. Dr. Borg did not indicate that he had reviewed the patient medical records that are at issue in this matter. (Resp. Ex. P; Tr. at 2124-2126)

Physician Assistant Utilization Plans

Physician Assistant Utilization Plan of Wallace C. Adamson, M.D., Apple Health Sports & Family Medicine, Inc.

21. On or about November 14, 1996, the Board received a Physician Assistant Utilization Plan for Wallace C. Adamson, M.D., Inc. [Adamson Plan]. The Adamson Plan indicated that there would be one physician under the plan. The Adamson Plan further indicated that the physician assistant would be utilized at Apple Health Sports & Family Medicine, Inc., and at Focus. The plan further indicated that the daily patient load was fifty. (St. Ex. 76 at 1-2)

22. In the section of the Adamson Plan entitled "Utilization of Physician Assistant," the Adamson Plan indicated that the physician assistant would be performing the following basic tasks:

"1. Obtain comprehensive patient histories."

"2. Take patient histories; perform physical examination, including pelvic, rectal, and genital-urinary examinations when indicated."

"3. Initiate request and/or perform routine laboratory, radiologic and diagnostic studies as indicated."

"4. Assess patients for development of treatment plans."

"5. Implement treatment plans that have been reviewed and approved by the supervising physician." This is followed by this statement:

> **Pursuant to Section 4730.21(D), O.R.C., A [sic] patient new to the supervising physicians [sic] practice or an established patient with a new condition <u>MUST</u> be seen and personally evaluated by the supervising physician prior to initiation of any treatment plan.**

"6. Monitor the effectiveness of therapeutic interventions."

"7. Provide patient education."

"8. Institute and change orders on patient charts as directed by the supervising physician." This is followed by this statement:

> [NOTE: Section 4730.21(D), O.R.C., requires the physician assistant to sign each order and to record the date and time that the order is written. The form on which the order is written must clearly identify the supervising physician.]

Following that statement, the Adamson Plan indicates a "Yes" response to the following question:

"a) Will each medical order written by the physician assistant be reviewed by a supervising physician twenty-four (24) hours after the order is written and countersign that order if the order is appropriate?"

"9. Carry out or relay the supervising physician's orders for medication, to the extent permitted under laws pertaining to drugs."

(St. Ex. 76 at 2-3) (Emphasis in original)

23. The section of the Adamson Plan entitled "Quality Assurance" begins with the following statement: "Section 4731.21(A)(2), O.R.C., requires that the supervising physician personally and actively review the physician assistant's professional activities." (St. Ex. 76 at 5) Further,

    - Question 1 asks, "How frequently will charts be reviewed?" The Adamson Plan indicates, "Daily."

    - Question 2 asks, "What percentage of charts will be reviewed?" The Adamson Plan indicates "100%."

    (St. Ex. 76 at 5)

24. The section of the Adamson Plan entitled "Monitoring Patients" begins with the following statement: "Section 4730.21(A)(3), O.R.C., requires that the supervising physician 'regularly review the condition of the patients treated by the physician assistant.'" (St. Ex. 76 at 6) Further,

    - Question 1 asks, "Will all patients new to the practice be seen by the physician assistant only when a supervising physician is physically on the premises?" The Adamson Plan indicates, "Yes." Beneath that answer, in space provided for an explanation of a negative response to question 1, the Adamson Plan states, "pending interpretation of SB 143 'immediate attention.'"

    - Question 2 asks, "Will all patients new to the practice be seen and personally evaluated by a supervising physician prior to the initiation of any treatment?" The Adamson Plan indicates, "Yes."

    - Question 3 asks, "Will all established patients with new conditions be seen and personally evaluated by a supervising physician prior to the initiation of any treatment?" The Adamson Plan indicates "Yes."

    - Question 4 asks, "Under what circumstances is the physician assistant required to refer the patient to the supervising physician?" In the Adamson Plan, boxes are checked next to the following responses:

        - "Patient requests visit with physician"
        - "Patient has new complaint"
        - "A new condition is identified by the physician assistant"
        - "Patient is not responsive to treatment"

- Question 5 states, "Explain what emergency procedures for stabilization will be followed when the supervising physician is not on the premises but a patient requires immediate attention (if written protocols, attach copy)." The Adamson Plan indicates, "call 911."

(St. Ex. 76 at 6-7)

25. By letter dated January 6, 1997, the Board informed Dr. Adamson that the Adamson Plan had been approved. (St. Ex. 76 at 16)

26. On or about January 23, 1997, the Board received a Physician Assistant Supervision Agreement signed by Robin R. Hawn, PA-C, with Dr. Adamson's signature as the supervising physician. A statement above Ms. Adamson's signature states, "I (we) have read and agree to perform only those duties as outlined in the Physician Assistant Utilization Plan submitted by the physician(s) listed below and as approved by the State Medical Board." (St. Ex. 76 at 14-15)

27. By letter dated February 14, 1997, the Board informed Dr. Adamson that his Physician Assistant Supervision Agreement for Robin Hawn had been approved by the Board effective January 31, 1997. (St. Ex. 76 at 17)

    Subsequently, by letter dated December 4, 1998, the Board informed Dr. Adamson that his Physician Assistant Supervision Agreement for Robin Hawn had been renewed through January 31, 2001. (St. Ex. 76 at 18)

<u>Physician Assistant Utilization Plan of American Health Network of Ohio, P.C.</u>

28. On or about November 14, 1996, the Board received a Physician Assistant Utilization Plan for American Health Network of Ohio, P.C. [American Health Network Plan]. The American Health Network Plan indicated that there would be 73 physicians under the plan. The American Health Network Plan further indicated that physician assistants would be utilized at, among other locations, Apple Health. (St. Ex. 77 at 5)

    - In the section entitled "Utilization of Physician Assistant," the same responses were given concerning physician assistants' basic tasks as are described above for the Adamson Plan. (St. Ex. 77 at 5-6)

    - In the section "Quality Assurance," the American Health Network Plan gave the same responses as the Adamson Plan. (St. Ex. 77 at 8)

    - In the section entitled, "Monitoring Patients," the American Health Network Plan gave the same responses as the Adamson Plan, except for question 1, where no explanation was provided. (St. Ex. 77 at 9-10)

29. By letter dated January 6, 1997, the Board informed Dr. Adamson that the American Health Network Plan had been approved. (St. Ex. 77 at 45)

30. On January 31, 1997, the Board received a Physician Assistant Supervision Agreement signed by Melinda L. Pavlechko[, P.A.]; Robin R. Hawn, PA-C; and Kimberly M. Nicholls, PA-C. The following physicians signed as supervising physicians: Wallace C. Adamson, M.D.; Bryan W. Ghiloni, M.D.; James B. Soldano, M.D.; and Charles Tweel, M.D. A statement above the signatures of Ms. Adamson and the other physician assistants states, "I (we) have read and agree to perform only those duties as outlined in the Physician Assistant Utilization Plan submitted by the physician(s) listed below and as approved by the State Medical Board." (St. Ex. 77 at 3-4)

31. By letter dated February 14, 1997, the Board informed Dr. Adamson that his Physician Assistant Supervision agreement for Ms. Pavlechko, Ms. Hawn, and Ms. Nicholls had been approved. (St. Ex. 77 at 46)

32. Dr. Adamson testified that he did not review the Physician Assistant Utilization Plan for American Health Network, Inc. prior to signing the supervision agreement for that plan. Dr. Adamson explained that "the only thing brought to me by American Health Network was the signature page" for the Supervision Agreement. (St. Ex. 77; Tr. at 1367-1368)

<u>Testimony Concerning the Physician Assistant Utilization Plans</u>

33. Dr. Adamson's responses to questions at hearing concerning what physician assistant utilization plans had been approved by the Board were evasive. (See Tr. at 2104-2112) Ms. Adamson's responses to similar questions at hearing were also evasive. (See Tr. at 1864-1888)

    Nevertheless, in earlier testimony, Dr. Adamson testified that the Adamson Plan had been in effect from November 14, 1996, until he closed his practice on April 30, 2000. Dr. Adamson further testified that he had been a supervising physician under the American Health Network Plan until April 30, 2000, as well. (St. Exs. 76 and 77; Tr. at 1370-1371)

    Further, Ms. Adamson had earlier testified that it was her belief that, from 1997 through 2000, she had worked under both the Adamson Plan and the American Health Network Plan. (St. Exs. 76 and 77; Tr. at 1887) In addition, Ms. Adamson testified as follows:

    Q. (By Ms. Crawford): And what physician assistant utilization plan were you practicing under as a physician assistant in '97, '98, '99, and 2000?

    A. (By Ms. Adamson): I had two. I had one for Wallace C. Adamson, MD, Inc., and I had one for American Health Network.

    Q. And those were plans that had been approved by the Board, correct?

A. Again, I got the letter that says that it had been approved by the Board.

Q. And so the letter that you received, State's Exhibit 77, Page 45, told you that the physician assistant utilization plan set forth in State's Exhibit No. 77 had been approved by the State Medical Board, correct?

A. Correct.

Q. And the letter that is in State's Exhibit No. 76, Page 16, notified you that the physician assistant utilization plan set forth in State's Exhibit 76 had been approved by the Board, correct?

A. That's what the letter says, correct.

(Tr. at 1875-1876)

34. Ms. Adamson testified that she had assisted in the preparation of the Adamson Plan and that that document bears her handwriting. Ms. Adamson further testified that she signed the Supervision Agreement on January 22, 1997, whereby she agreed to perform only those duties set forth in the Physician Assistant Utilization Plan. (St. Ex. 76; Tr. at 188-190) In addition, Ms. Adamson testified that she signed a Supervision Agreement for the American Health Network Plan. (St. Ex. 77; Tr. at 190-193)

35. Dr. Adamson testified that he had been Ms. Adamson's supervising physician under both the Adamson Plan and the American Health Network Plan. Dr. Adamson further testified that, by having signed supervision agreements for those plans, he had agreed to abide by the Adamson Plan and the American Health Network Plan. (Tr. at 1317-1319)

36. Dr. Adamson testified that, when he was in his office, he had worked under the Adamson Plan; when he was away and another physician was supervising, that physician would have supervised under the American Health Network Plan. (Tr. at 1317-1319)

37. In the Adamson Plan, in question 4 of the section entitled "Monitoring Patients," Dr. Adamson had indicated that the physician assistant would be required to refer a patient to the supervising physician if the patient had a new complaint. (St. Ex. 76 at 6-7) The American Health Network Plan indicated the same. (St. Ex. 77 at 9) Nevertheless, Dr. Adamson testified that a patient having a new complaint was not a situation in which he needed to see the patient. Dr. Adamson further testified:

> [T]o me, a new complaint is not a new condition. And this says, 'Refer the patient to supervising physician.' I don't know exactly what that means. Does that mean we talk about it? Does that mean I go see them?

> It doesn't—the language isn't clear. So with the language here not clear, I go back to the statute.

(Tr. at 1360-1361) Dr. Adamson further testified that Ms. Adamson had been a member of the Board's P.A. Policy Committee, and that she had tried to get more information concerning the Board's definitions through her discussions with other members of the committee and with Board staff. Moreover, Dr. Adamson testified that "there are many terms in here that were not defined, and my lack of knowledge is not because I didn't try to find out and want to do the right thing, it's because no one on the Medical Board was forthcoming with what these terms meant." When asked what was unclear about the term, "new complaint," Dr. Adamson replied, "Because of specific discussions with PA policy committee members and Medical Board members that new complaints are not new conditions and that PAs can see patients with new complaints." (Tr. at 1361-1364)

Another statement in the Adamson Plan indicated that the physician assistant would refer a patient to the supervising physician if "[a] new condition is identified by the physician assistant." (St. Ex. 76 at 6) The American Health Network Plan indicated the same. (St. Ex. 77 at 9) The following exchange occurred concerning those statements:

Q. (by Ms. Crawford): So [for patients with new conditions and/or new complaints], you agreed to have the patients be referred to the supervising physician, correct?

A. (by Dr. Adamson): Correct. And Robin would give all those charts to me. She would refer those charts to me and I would review them and sign them. So in my mind, that meets the requirement of referral on that new complaint. It does not say personal assessment. It does not say examination. It says referral.

And we actively collaborated on the practice of all these patients, so I consider that she referred patients with new complaints to me as I reviewed the charts.

Q. Okay. Did you review all your charts of all the patients that were seen?

A. That was the—that was the goal.

Q. So you made no distinction between the patients that had new complaints and just the patients that were there for no new complaint, no new condition, just on a regular basis, correct?

A. No, I reviewed them all and she referred them all to me.

Q. So to you a referral of a patient to the supervising physician just would mean reviewing the chart, correct?

A. Reviewing the chart or having a discussion.

Q. But reviewing the chart is sufficient?

A. Yes.

(Tr. at 1364-1365)

Ms. Adamson's Duties at Apple Health

38. Ms. Adamson testified that, from 1996 to 2000, her duties at Apple Health included physician assisting, personnel duties, and ordering supplies. However, Ms. Adamson testified that she never supervised other physician assistants concerning their physician assisting activities. (Tr. at 43-45, 53-55)

The State questioned Ms. Adamson's response that she had not supervised physician assistants, and produced an excerpt from an October 25, 2000, deposition of Ms. Adamson by the Board. During that deposition, Ms. Adamson had been asked if she had ever supervised other physician assistants when Dr. Adamson was out of the office. Ms. Adamson replied, "Yes." Ms. Adamson was asked which physician assistants she had supervised, and she replied that she had supervised "Nancy and Marsha." (St. Ex. 83A at 144-146; Tr. at 46-52)

Ms. Adamson testified concerning what was alleged to be a discrepancy between her testimony at hearing and at the deposition. Ms. Adamson testified that she had supervised other physician assistants concerning personnel matters, and was responsible for their time sheets. Ms. Adamson further testified that she answered their questions concerning charting and office procedures. Ms. Adamson reiterated at hearing that she had never supervised their physician assisting activities. (Tr. at 53-55)

The transcript of Ms. Adamson's October 25, 2000, deposition includes the following exchange:

Q. (person unknown): Did you ever supervise other physician assistants when Dr. Adamson was out of the office?

A. (by Ms. Adamson): Yes.

Q. And who did you supervise?

A. Nancy and Marsha.

Q. Nancy Keeler?

A. Uh-huh. And Marsha Bendle.

Q. And Marsha Bendle. These are during the relative time frames you indicated earlier?

A. Yes.

Q. So these would be like Tuesday afternoons and Thursday mornings when Dr. Adamson was out of the location?

A. Yes.

Q. And how did you supervise them?

A. How did I supervise them?

Q. In what manner did you supervise them?

A. I was there to help if they had any questions. They were both fairly new employees, so things would come up about protocol or, you know, how do you order this lab.

Q. I'm listening.

A. That's it.

Q. Did you supervise their activities in any way?

(Mr. Coval). Objection. Go ahead.

A. No.

(St. Ex. 83A at 144-146)]

39. Ms. Adamson testified that her duties as a physician assistant involved performing histories and physical examinations, managing patients with chronic illnesses, and seeing patients with self-limiting conditions. Ms. Adamson testified that "[a] self-limiting condition is something that a patient has that, in general, left untreated, they would get over it on their own." Ms. Adamson further testified that she saw Dr. Adamson's sports medicine patients for follow-up visits. Moreover, Ms. Adamson stated that she saw patients for well visits and preventative care. Finally, Ms. Adamson testified that she did a lot of patient education. (Tr. at 63-65)

Patient Scheduling

40. Ms. Adamson testified that she had had her own patient schedule, which was separate from Dr. Adamson's schedule. Ms. Adamson testified that her schedule was printed out by

computer each day and generated by the receptionist or the medical assistant. Ms. Adamson stated that it informed her what patients she would be seeing and what they were coming in for. (Tr. at 58-61)

Ms. Adamson testified that the daily appointment schedule listed the time the patient was coming to the office, the patient's chief complaint, and whether the patient was a new patient and/or whether the problem was a new problem. Ms. Adamson noted that the staff did not always get the new patient/new problem issue right. Ms. Adamson testified that she "[o]ccasionally" was assigned new patients or patients with new problems, but that those occasions were rare. (Tr. at 177-181)

41. Dr. Adamson testified that patient preference had been the first rule of determining which provider the patient would see. A patient could call and ask to see Dr. Adamson or Ms. Adamson. However, Dr. Adamson testified that, if a patient asked to see Ms. Adamson, the patient was not automatically placed on her schedule. Dr. Adamson stated that Ms. Adamson's primary role in the office was to provide well care to children and female patients, and to provide patient education to patients who needed it, primarily those facing chronic illnesses such as hypertension, diabetes, and asthma. (Tr. at 622-624)

Dr. Adamson testified that the staff had been expected to ask each patient who called for an appointment what he or she was coming in for. The staff was to make a determination concerning whether the patient was an appropriate patient to be seen by a physician assistant. Finally, Dr. Adamson testified that the staff used a "phone triage" to make that determination. (Tr. at 622-624)

Dr. Adamson testified that he had given the responsibility for developing the phone triage to Dr. Ghiloni. Dr. Adamson testified that they had been interested in making sure that "appropriate patients ended up on the physician assistant schedule because it was very difficult when they didn't." Dr. Adamson further testified that Dr. Ghiloni found an article entitled "Adult Telephone Triage" in the periodical *Family Practice Management* that addressed the physician versus mid-level provider issue. Dr. Adamson noted that that article had been presented by Dr. Ghiloni at an office staff meeting, distributed to the staff, and kept in the office minute book. Moreover, Dr. Adamson testified that a second reference used for phone triage had been a book entitled "Pediatric Telephone Guide" that contained scripted telephone calls for the staff's use. Dr. Adamson testified that it identified some potentially life-threatening situations for which a patient would need to go to an emergency room. (Tr. at 612-619, 1973-1976)

Dr. Adamson testified that the effort to develop the phone triage was important to him "[b]ecause it impacted on the quality of care that my patients received. And it also impacted on our ability to comply with the rules and things that we had to function under for physician assistants." (Tr. at 1976)

42. Dr. Adamson testified that he had told the front office staff "that the physician assistant could not see new patients when the doctor was out of the office and could not see new conditions when the doctor was out of the office * * * [u]nless the patient required immediate attention." Concerning the definition of "immediate attention," Dr. Adamson testified:

> I told the staff that that was the language in the statute in the State of Ohio and that I did not know exactly what was meant by 'immediate attention,' but my definition of immediate attention was any patient with a significant amount of discomfort that felt that they needed to be seen by us right away.
>
> So we felt—I personally felt it was patient driven, as far as do I as a patient need immediate attention or not.

(Tr. at 626) Dr. Adamson added that the staff had been instructed to use their judgment in determining whether a patient's situation actually required immediate attention, and whether the attention required was an emergency room visit. If a physician was not present in the office and Ms. Adamson was scheduled to see a patient, "then she would make a determination on what [the patient's] condition was, whether or not it was a new condition, [and] whether or not it required immediate attention." (Tr. at 627-631)

43. Ms. Adamson testified that "the phone triage included things like no new patients were to be scheduled with me, no patients with acute injuries or car accidents, chest pain, severe problems." Ms. Adamson testified that part of the phone triage was to steer patients to her schedule who were coming in for "things like physical exams, preadmission testing." Ms. Adamson testified that it had been difficult for the front desk to implement the phone triage, and it "was kind of an ongoing process." (Tr. at 19-21, 86-89)

    Ms. Adamson further testified that it had also been difficult for the front office staff to make a determination concerning existing patients with new problems. Ms. Adamson stated that "it's hard for a medically trained person to decide what's really a new problem, let alone the front office staff" because the term "new problem" is not defined anywhere. Ms. Adamson testified, "What is new? Is it new—is it new to the patient? Is it new to the physician MD—physician/PA team? Is it new in their life? Have they ever had it in their 42 years or whatever?" (Tr. at 86-89)

44. Ms. Adamson further testified that it was sometimes difficult for the front desk to determine what patients were really coming to the office for. Ms. Adamson testified that "whenever patients say they have X problem, that's really not what they have." Ms. Adamson explained that that had an effect on her practice "[b]ecause sometimes the patient would say, 'I'm coming in for a physical,' or 'My baby needs shots,' and when they get back to the room, it's something else." (Tr. at 76-77)

Ms. Adamson was asked how it had been possible for her to see patients when Dr. Adamson was out of the office if she could not have been sure what the patients were to be seen for. Ms. Adamson replied, "Because you do the best you can trying to screen them because the law says that you're allowed to see patients if [Dr. Adamson is] within 60 miles—60 minutes and because of the immediate attention clause." Ms. Adamson added that, as a physician assistant, she was always supervised, whether the supervision was on-site or not. (Tr. at 97-100)

Further, Ms. Adamson testified that, after the patient has walked in the door, "if it turns out that what they said they had—what they said they had was A, and what they really had was B, you can do that because they required immediate attention." Ms. Adamson stated that a patient requires immediate attention if the patient feels discomfort and feels that he or she needs immediate attention. Ms. Adamson further testified that if a patient called the office and said that he or she really wanted to see somebody today, then that would fulfill Dr. Adamson's definition of requiring immediate attention. (Tr. at 97-100)

45. Ms. Adamson testified that she had been allowed to see patients when Dr. Adamson was out of the office. During these times, Ms. Adamson testified that she could not see new patients, or patients with new injuries. Ms. Adamson stated that she "was supposed to see patients—follow up patients and patients that had self-limiting conditions." (Tr. at 83-84)

    Ms. Adamson testified that a "follow up patient could be a patient that was following up for the issue that they had been seen with before; then the chronic follow ups, people that were on a standard kind of treatment plan, this is what you are going to do with them forever sort of thing." Ms. Adamson testified that a follow up visit could include a patient "that had a problem, you know, an ear infection, and maybe they had it again." (Tr. at 84-85)

Testimony of Patient 24

46. Patient 24 testified that she had been an employee at Apple Health, and that her duties had included billing and scheduling patient appointments. Patient 24 testified that she had been instructed that Ms. Adamson could see a patient for any problem as long as Dr. Adamson had seen the patient for his or her initial visit. Patient 24 further testified that "they were always scheduled [as] a follow-up, but they weren't always necessarily being followed up from the previous diagnosis." (Tr. at 1443-1445)

Testimony of Patient 52

47. Patient 52 testified that she had been a front office employee at Apple Health, that she had worked there for approximately five years, and that her job duties had included scheduling patients. Patient 52 stated that Dr. Adamson was always to see new patients and patients who insisted on seeing him. Moreover, Patient 52 testified that "[i]f it was anything routine or anything not so pressing or they did not mind who they seen, we would schedule Robin

because she had more appointments available." When asked what she meant by "routine," Patient 52 replied:

> I mean, if they were just coming in for a sick visit that day or just coming in for sinusitis or just following up on back pain or anything you might call your family practice office for.
>
> If you call in for an appointment, I'll ask you, who do you want to see? And if you say Dr. Adamson, then I might have to say, well, his schedule is full today and tomorrow, but I can get you on with Robin today. So I would be able to get them in sooner if I would let them see Robin.

(Tr. at 1386-1387) Moreover, Patient 52 testified that it did not matter what the patient told her was wrong "just as long as they were not a new patient. That was it." Finally, Patient 52 testified that if Dr. Adamson was out of town, she was instructed "not to schedule new patients until he was to come back." (Tr. at 1387, 1389)

Testimony of Molly McCale

48. Molly McCale testified that she works as a medical assistant at Apple Health, and that she has held that position since January 1998. Ms. McCale testified that her duties include escorting patients to the examination rooms, taking complaints, vital signs, and performing venipuncture, injections, and EKGs. (Tr. at 1670-1672)

    Ms. McCale testified that it had been the general understanding in the office that if Dr. Adamson had seen a patient once, then Ms. Adamson could see the patient thereafter. (Tr. at 1688)

Office Procedures

49. Ms. Adamson testified that when an established patient came to the office, the medical assistant or one of the providers would take the patient back to the examination room, take the patient's vital signs and chief complaint and, if the person bringing the patient had been the medical assistant, leave the chart on the wall outside the door. (Tr. at 127-129)

    Ms. Adamson testified that when the provider saw the patient, he or she would record in the chart the history and physical examination, the assessment, and the treatment plan. When asked if a diagnosis would be recorded, Ms. Adamson testified that that depended on who saw the patient. Ms. Adamson stated that if a P.A. had seen the patient, the P.A.s assessment would be recorded on the "Diagnosis" line on the chart. (Tr. at 129-130)

    Ms. Adamson noted that after a P.A. had seen the patient and completed the chart, the chart would be left in Dr. Adamson's in-box for his signature. (Tr. at 133-134)

"New Condition" Issue

50. The Board's May 9, 2001, notices of opportunity for hearing for Dr. Adamson and Ms. Adamson included allegations that established patients with new conditions had received treatment from Ms. Adamson without first being seen and personally evaluated by Dr. Adamson. A great deal of testimony was offered at hearing concerning the meaning of the phrase "new condition" by Dr. Adamson and Ms. Adamson; by their expert, Dr. Borg; and by the State's expert, Dr. Gardner. (St. Exs. 60A and 60K)

Dr. Gardner's Definition of "New Condition"

51. In her April 3, 2001, report to the Board, Dr. Gardner stated:

> I define a new condition as:
> A.—one that has not presented before or
> B.—a condition reoccurring after having been completely resolved.

(St. Ex. 72) Dr. Gardner testified that her statement "not presented before" meant "[n]ot presented before to that particular physician." (Tr. at 963)

When asked why she had defined "new condition" as something not presented before to that particular physician, Dr. Gardner replied, "well, it's hard to comment on something that another physician has evaluated or anyone else has evaluated unless that physician evaluates it for themselves." (Tr. at 963-964)

52. Dr. Gardner testified that she had been asked by the Board to comment on care provided to specific patients for specific dates. Dr. Gardner further testified, "I looked to see on that date if the problem had ever been identified previously in the chart, number one; and, number two, if the same problem was reoccurrent, had it previously completely resolved." (Tr. at 960-962)

Dr. Gardner testified that it is important for a physician to evaluate recurrences of past conditions "[b]ecause a recurring condition can signify a reoccurrence of the same condition, or it could be a manifestation of another disease process. You don't know until you examine the patient." Dr. Gardner was asked to give an example, and replied:

> Well, the example I would use is a complaint, or, let me say, a new condition, as you will, of dizziness, okay. Just to give you a hypothetical scenario, I have a 60-year-old female who comes in and complains of dizziness, all right. I need to do an evaluation—or the physician should do an evaluation of that patient, multisystem evaluation, to figure out what is the cause of that condition. Depending upon the physical exam and the history taken, the physician can arrive at the diagnosis, okay, and treatment will follow.

> Now—so let's assume now that that has resolved, and six months later the patient also returns to the office with a complaint of dizziness, accompanied by other symptoms. The physician needs to reevaluate that problem or condition and, again, [do] a multisystem evaluation to determine if it's the same problem or any one of a multitude of other conditions. You know, I can list those for you if you want me to give you a list.
>
> * * *
>
> Dizziness can be caused from many different types of things. It can be caused from an inner ear infection, an outer ear infection, a sinus infection, an acute tonsillopharyngitis. It can be caused from a brain tumor. It can be caused from a stroke. It can be caused from high blood pressure. It can be caused from coronary insufficiency. It can be caused from a GI bleed. You know, the possibilities are endless.

(Tr. at 1100-1103)

Dr. Gardner testified that if a patient had a problem such as foot pain that the patient had seen the physician about, then, two years later, saw the physician about it again, and told the physician that the problem never went away, then that would not be a new condition. Dr. Gardner testified that it would not be a new condition because the patient told the physician that the problem had never gone away. Moreover, Dr. Gardner testified that, in such a case, it is important that that information be written down in the chart. (Tr. at 1199-1200)

Dr. Gardner testified that, in the foot pain situation noted above, it would be important for the physician to know and to record in the patient record whether the problem had been an ongoing, continuous problem from the previous visit. Dr. Gardner further testified that that information would be significant for future purposes concerning whether it had been a one-time problem or an ongoing problem. (Tr. at 1240-1241)

53. Dr. Gardner testified that the term, "new condition," is not a medical term. Dr. Gardner testified that it is "a general descriptive term" that is used in everyday language. Dr. Gardner further testified that a new condition can be the same thing as a diagnosis, but not always. Dr. Gardner testified that a condition is a general term, and a diagnosis is more specific. Moreover, Dr. Gardner defined "new" as "[n]ew to the responsible physician." (Tr. at 1163-1166, 1175, 1197)

54. When asked if there was anything in her training or background that enabled her to identify new conditions or recurrent conditions, Dr. Gardner testified, "All my education had actually trained me to identify problems or changes or new conditions." (Tr. at 962)

Dr. Gardner testified that, in analyzing the patient records, she relied upon her medical education and experience, as well as Webster's dictionary, in determining whether something was a new condition. (Tr. at 983-986)

55. Dr. Gardner testified that "condition" can be synonymous with "symptom," "problem," "complaint," or "diagnosis." (Tr. at 1003, 1134-1135, 1163-1167)

Dr. Borg's Definition of "New Condition"

56. Dr. Borg testified that he does not know what the Board's definition of new condition is. Dr. Borg further testified that he had been unable to find any statutory or regulatory definition of the term "new condition." Dr. Borg further testified that the term is not a medical term, and it is not commonly used in the medical profession. (Resp. Ex. P; Tr. at 2124-2126, 2132)

57. Dr. Borg stated as follows in his expert report:

> The following report is based upon my review of Ohio statutory and regulatory law, including Ohio's Medical Practices Act, R.C. Chapter 4731, and the statutory chapter governing the practice of physician assistants in Ohio, R.C. Chapter 4730; and my professional and academic training and experience.
>
> **New Condition**
>
> There is no statutory or regulatory definition of the phrase "new condition," as that term is used in R.C. Chapters 4731 and 4730 and the associated regulations. Nor is there a single definition of the phrase "new condition" used by the medical profession.
>
> My professional opinion of the meaning of the phrase "new condition" is that it refers to the actual physical state of the body as a whole, or as to one of its parts, constituting an abnormality or ailment that has not occurred before. This would exclude all recurrent conditions that may experience exacerbation and new episodes of a condition that has previously resolved. To determine whether a new condition is presented, therefore, a patient history is required. That history may be garnered from discussions with the patient, a review of the patient's medical records, as well as from the practitioner's overall knowledge of and past association with the patient even if relevant information is not set forth in the patient's medical records.
>
> Moreover, whether a patient complaint presents a "new condition" involves a differentiation between the condition itself—which is the underlying ailment or abnormality—and the symptoms of the condition that might be presented, which

> evidences the condition. The symptoms that present, including the complaints made by the patient, are not necessarily the medical condition of the patient.

(Resp. Ex. P) (Emphases in original)

58. Dr. Borg also testified concerning his interpretation of the term "new condition." After noting that the word "new" is a relative term that depends on one's perspective, Dr. Borg testified that a "new condition would be an ailment or a body state that has not occurred before." Dr. Borg further testified that, in his opinion, that definition would "exclude recurrent conditions or new episodes of old conditions or old symptoms or old diagnoses." (Tr. at 2126-2127) Moreover, Dr. Borg testified concerning what would be required to render an opinion whether a patient had a new condition:

> In the practice of family practice * * * it is about a relationship with a patient, so one would need to—if one were looking at trying to assess whether a new condition was present, one could look at a medical report. One would also need to understand if the treating physician has knowledge, or if there are any other practitioners in the office, since we're talking about PA's. Also, one would need to know from the patient themselves what history they bring forward.

(Tr. at 2127-2128)

59. Dr. Borg described Dr. Gardner's definition of new condition as "extreme," and added:

> In a sense, she has made new condition—new condition synonymous or equal to symptom. And as I stated before, that's not always the case. It may be in a few specific examples, but it is not necessarily the case and certainly is a very extreme position. And if one were trying to define an undefined term, one would probably take—or at least I would take a more prudent definition of new condition.

(Tr. at 2130-2131)

Dr. Borg testified that, in his opinion, there is a difference between the terms condition and symptom:

> A symptom could be a condition. A symptom could be a diagnosis. A symptom is generally a subjective complaint or presentation by a patient. So—so in some contexts, it might be a condition. But I would—generally speaking, it's not—condition is probably more of the assessment or the diagnosis than it is a symptom.

(Tr. at 2128-2129)

60. Dr. Borg testified that if a patient had had a condition in the past, then had it again later on, "that would be a recurring diagnosis or a recurring episode, depending on what's going on." Whereupon, the following exchange occurred:

Q. (by Ms. Crawford): So if a patient at age two had otitis media and then came back at age 80 and had it again, but had never had it in between those years, would that, under your definition, be a new condition?

A. (by Dr. Borg): Not in the context of what we're talking, no.

Q. If the patient at one point in time had had a heart attack and then ten years later had another heart attack, would that be a new condition?

A. That's a new event, new diagnosis, but it would not be a new condition, no. The patient's had that before.

Q. If the patient at one point in time had breast cancer and then seven years later there was another—she had breast cancer again, and there wasn't any time in between where they viewed that the breast cancer was there, would that, in your definition, be a new condition?

A. Well, now you're getting into some complexity. Breast cancer can be caused by several different cell types. So could the first breast cancer be totally unrelated to the second breast cancer? Yes. Is it—in most cases, is it a reoccurrence and it's the same cancer that is now growing again? That would not be a new condition.

Q. Okay.

A. Or you could have a malignancy that's a cancer from somewhere else that has gone to the breast. That would be new. But not necessarily.

(Tr. at 2173-2174)

<u>Dr. Adamson's and Ms. Adamson's Definition of "New Condition"</u>

61. Dr. Adamson testified as follows concerning his instructions to his staff with regard to the term, "new condition":

> I told them that it was a term in the new PA law and that we were waiting for the definition from the State Medical Board on what a new condition was.

* * *

> I [further] told them, in my mind, a new condition was an ailment or a disease, you could also call it a diagnosis, that was a multisystem disease that would have a major impact on a patient's long-term health. So these were things like hypertension, asthma, [and] diabetes. I also told them that minor self-limiting complaints or complaints that would get better with minor treatment were not considered new conditions.

(Tr. at 631-632) Dr. Adamson defined the term, "self limiting complaint," as "a complaint that [is] not medically necessary to treat that will get better on its own or a, again, minor complaint that would get better with a very simple course of treatment that most people would recognize." Dr. Adamson further testified that such complaints would include "[a]n upper respiratory infection or a cold. Bronchitis in a patient that doesn't smoke. Low back pain." (Tr. at 632-634)

With regard to whether a particular condition was "new," Dr. Adamson testified that he had instructed his staff that if a patient had been treated for a condition in the past, then that condition was not new. Dr. Adamson was then asked by Ms. Crawford, "[I]f a patient had had an ear infection when he was two years old and then he came into your office and was 80 years old and had an ear infection, would that be considered a new condition?" Dr. Adamson replied:

> No, I would not consider that a new condition for two reasons. One, they have had it before. So by my definition of the word 'new,' it's not new. They have had it before. Secondly, an ear infection is an example of a minor, self-limiting problem that will get better with—and does not necessarily require treatment or requires a minor, straightforward treatment that most patients would recognize.

(Tr. at 635-636) Dr. Adamson defined his term "treatment that most patients would recognize":

> I think most people in this room would know that you take penicillin for a strep throat. I think most people would recognize that you take antibiotic for a urinary tract infection, or if you watch television, you know that you can take Zantac or Tagamet for heartburn.

(Tr. at 636)

62. Dr. Adamson testified that the PA Advisory Committee, of which he had been a member from 1993 through 1995, had had discussions concerning the term "new condition." Dr. Adamson further testified,

> I don't recall any type of consensus or vote or anything to that effect. It was—it was less of an issue at that point because it was just a term, you know,

> in the regulation that people were trying to understand, but it didn't sort of have this overbearing shadow on how physicians and PAs practiced.

(Tr. at 1956-1957) Moreover, Dr. Adamson testified that he does not recall from any of the PA Advisory Committee meetings that Dr. Gardner had articulated the definition of "new condition" that she had used in this case. (Tr. at 1957-1958)

63. Dr. Adamson described how he had arrived at his definition of "new condition":

> I arrived at that definition over time. I—going back to the PA advisory discussions. I looked up 'condition' in Stedman's Medical Dictionary at one point. I saw that it was defined there as an ailment or disease. It was also defined by further discussions that Robin had with her involvement with the [PAPC]. She would debrief me in depth about the discussions that she had at the PA policy meetings. And I really felt we had a definition that was in sync with what was proposed by the Ohio Academy of Physician Assistants.

(Tr. at 1983-1984) Dr. Adamson further testified that he excluded minor, self-limiting problems from his definition based upon his discussions with a Board investigator. Dr. Adamson testified that he discussed the issue with the investigator during a PA utilization site visit at his office. Dr. Adamson testified that the investigator told him "that it was the position of the Board that minor self-limiting conditions were not part of a new condition, that included things like upper respiratory infections, sprains, strains, rashes, anything that was self-limiting that would go away in a short period of time." (Tr. at 1984-1987)

64. Ms. Adamson testified that when the Board investigator performed the site visit at Dr. Adamson's office:

> he and I looked at a chart of a patient that I had seen, and I saw them on a day when they had bronchitis. And there was no note in the chart that Dr. Adamson had examined the patient. I saw them. There was a verbal order from him and a prescription.
>
> And the patient had previously been seen for sinusitis, and I asked him, you know, I said, 'I don't think Dr. Adamson saw the patient on that day. Is that a problem?'
>
> And he said, 'Oh, no, he's been seen before for an upper respiratory infection.' And I said, 'Well,' you know, 'what about new condition?' And he said, 'The Medical Board, they are not worried about new condition. Upper respiratory infection is upper respiratory infection.'

(Tr. at 1740-1743)

65. Ms. Adamson testified that her understanding is that "new condition meant a new multisystem disorder" that was new to the patient. Ms. Adamson testified that she got that definition over time, through working with Dr. Adamson, through discussions with the Board investigator, and through her association with the PAPC. Ms. Adamson testified that, by "multisystem disorder," she was "referring to the fact that it's not something that's self-limiting. It's not a cold, a cough, a URI, a sprain, a strain, a contusion. It's a disease process that is chronic." Moreover, Ms. Adamson testified that she developed the "multisystem disorder" element of her definition a "[c]ouple ways":

> The first way is when you are practicing, it's kind of what makes sense because it just—it just does make sense. The physician wants to know and needs to be involved if there's a new multisystem disorder, if there's a new diabetes, new hypertension, new something. That's good medicine.

(Tr. at 1738-1740)

66. Ms. Adamson testified that she had not been aware that there was controversy concerning Dr. Adamson's definition of "new condition" until she received the Board's May 9, 2001, notice of opportunity for hearing. Ms. Adamson further testified:

> Prior to that I felt that Dr. Adamson's definition of new condition was, as a PA under his supervision agreement, that was the one I worked under. When I worked for a different doctor, I worked under their definition of new condition. Because the Board didn't write it down, I have to follow what my supervising physician says, and that changes from physician to physician.

(Tr. at 1905-1906)

Ms. Adamson testified that, after Dr. Adamson left practice she went to work for a different practice where there were four physicians. Ms. Adamson testified that each of the physicians had a different idea of what a new condition was. (Tr. at 1790-1791)

67. Ms. Adamson testified that she is not aware of any statutory or regulatory definition of the term, "new condition." Ms. Adamson further testified that she is not aware of any definition of that term that has been adopted by the Board. Moreover, Ms. Adamson testified that, if the Board had adopted a definition of that term, she would have followed it. (Tr. at 1737-1738, 1863)

68. During the course of the hearing, Ms. Adamson was questioned whether the term "condition" was the same as a patient's diagnosis. Ms. Adamson was directed to the bottom of the medical record for Patient 46, at page 23, in the row labeled "DIAGNOSIS," where it

states "Viral gastroenteritis." The following exchange occurred concerning that entry:

Q. (by Ms. Crawford): Okay. So on Page 23, where it says "Viral gastroenteritis"—

A. (by Ms. Adamson): Yes.

Q. —that is the condition, correct, under the definition that Dr. Adamson has in that term "new condition"?

A. I guess I would say that's his assessment of what's going on.

Q. So where on this form would the condition be?

A. Well, I don't think anybody's ever really defined condition very well.

Q. Well, then how do you know whether or not you could see a patient if Dr. Adamson isn't in the office if you don't know what [the patient's] condition is?

A. Well, you have to use your best judgment.

Q. Well, but if you don't even know what you're looking for, if you don't know what you're looking for, which what—whether the condition is the diagnosis or the condition is the symptom or the condition is the complaint or the condition is whatever you want to call it, what are you looking for?

A. Well, that's something that we wrestled with in the PA Policy Committee for four years.

Q. So what is Dr. Adamson's definition—what did he instruct you with respect to that?

A. If a patient had a new multisystem disease, that was a new condition.

Q. Okay. So a disease is that—what would be the diagnosis?

A. No.

Q. No? Well, or is the disease the symptom?

A. Like—disease is the diagnosis.

Q. Okay. So the condition, then, is the diagnosis?

A. I guess.

(St. Ex. 46 at 23; Tr. at 160-163)

Ms. Adamson's Participation in the PAPC

Discussions Concerning "New Condition" and "Immediate Attention"

69. Ms. Adamson testified that the PAPC was formed in 1996 and, among its duties, it was to develop rules that would govern the practice of physician assistants. Ms. Adamson further testified that she had been a member of that committee from summer 1996 until April 2000. Ms. Adamson testified that the committee met once each month. Membership of the PAPC was comprised of three physician assistants, a Board physician, a Board consumer member, and two physicians who supervise physician assistants. (Tr. at 1745-1750)

    Ms. Adamson testified that the Ohio Association of Physician Assistants had believed that the term "new condition" needed to be defined. Moreover, Ms. Adamson testified that "[e]verybody [on the PAPC and within the OAPA] had a different idea of what new condition was." Ms. Adamson testified that the PAPC had many discussions concerning definitions for the terms "new condition" and "immediate attention." (Tr. at 1752-1756)

70. Ms. Adamson referred to the minutes of the July 10, 1997, meeting of the PAPC. Those minutes indicate that "Mr. Dilling stated that clarification is needed regarding the medical orders provision in Section 4730.21(D). Rules defining 'immediate attention' and 'new conditions' will be drafted for consideration. * * *" Ms. Adamson testified that the substance of that conversation had been "[t]hat we needed to write rules about this bill and we needed to define immediate attention and new condition, had to write it down." (Resp. Ex. K at 2; Tr. at 1780-1782)

71. Ms. Adamson referred to the minutes of the May 14, 1998, meeting of the PAPC. During a discussion of proposed draft rules and a March 28, 1998, letter from the OAPA that included proposed definitions for the term "new condition," the minutes state, "Dr. O'Day said we needed to define condition. Condition should not include self limiting disorders." (Resp. Ex. H at 7; Tr. at 1751-1752)

    Ms. Adamson testified that the PAPC discussed the OAPA's letter, which included a proposed definition of "new condition" that had excluded "self-limiting conditions." Ms. Adamson further testified :

    > Dr. O'Day, Dr. Buchan, and, I think, Ray Albert liked that definition. The PAs liked it. We were the ones that brought the letter from the Ohio Association of Physician Assistants. So we were finally coming to some kind of agreement on what new condition was. New condition was a new multisystem disorder. It was not something that was self-limiting.

(Tr. at 1754) [Note that the OAPA letter that was referenced in the PAPC minutes was not presented as an exhibit. Ms. Adamson could not recall at hearing the exact wording of that letter or the proposed definition. (Tr. at 1890-1891)]

72. Ms. Adamson testified that the PAPC never produced a draft of definitions for immediate attention or new condition. Ms. Adamson further testified that the closest that the committee came to a definition was reflected in the May 1998 minutes, when "there was a consensus that it wasn't a self-limiting condition[.]" Moreover, Ms. Adamson testified that she continued to bring the matter up at meetings, and did so on three occasions. Ms. Adamson testified that, the third time, Mr. Dilling told her that the Board was not going to define new condition, "and if the Ohio Association of Physician Assistants didn't like it, they could go back to the legislators." Ms. Adamson testified that she replied, "'If you don't write it down, you're setting people up to fail.'" (Tr. at 1783-1785)

73. Ms. Adamson testified that she does not recall anyone on the PAPC proposing the definition of "new condition" that Dr. Gardner used in this matter:

> not even close, because her definition somehow got into recurrent; that if something recurred, it was then again new. And we never talked about a time line or a condition recurring. If you had it, you had it, and if it was a self-limiting thing, then it was self-limiting, and you'd had it before. * * * That whole time line and recurrent thing just wasn't an issue.

(Tr. at 1785)

<u>Discussion Concerning Orally Communicated (versus Written) Orders</u>

74. Ms. Adamson testified concerning a discussion she had had during a PAPC meeting concerning Dr. Adamson's orally communicated orders:

> We talked at the PA Policy Committee about verbal orders, and I—I asked Dr. Buchan specifically one day about verbal orders on a patient that I was going to see that afternoon when I left the PA Policy Committee meeting. Dr. Adamson had told me to go see a patient in the hospital that had pneumonia, and I had orders from him 'If the chest x-ray says this, do this. If this happens, do this. If her pulmonary function is this, do this. If she as a fever, do this.' I had a list of tasks to look at.
>
> And I said to [Dr. Buchan], you know, * * *
>
> * * *

> 'After I see a patient, I don't always go back to Dr. Adamson and say, 'Now, is this the verbal order that you want me to carry out that you told me to do before?'' * * *
>
> * * *
>
> Dr. Buchan said, 'Oh, no, no, no, as long as'—
>
> * * *
>
> —'as long as the care is physician directed, then that's what you're doing, you're carrying out his verbal order.'

(Tr. at 1821-1822)

Dr. Adamson's Testimony Concerning Maladies Alleged to be New Conditions in the Board's May 9, 2001, Notice Letter

75. Dr. Adamson testified as follows concerning various maladies that were alleged to be new conditions in the Board's May 9, 2001, notice letter:

    a. Dr. Adamson testified that the following maladies are symptoms, and not new conditions:

    - "rash"
    - "anxiety"
    - "pharyngitis"
    - "cough and runny nose for five days"
    - "sore throat and earache for three weeks"
    - "head congestion"
    - "pain in the right ear"
    - "blurry vision"
    - "headache" without any context or qualifier
    - "profuse sweating and fatigue"
    - "[r]ed spot on temple"
    - "lungs hurt"
    - "dizzy spells"
    - "diarrhea"
    - "diarrhea, vomiting, and cramps"
    - "headache, nausea, shaky"
    - "burning with urination"

    (St. Ex. 60a at 2-3; Tr. at 650-652, 655, 660, 669, 672, 674-676, 679-681)

b. Dr. Adamson testified that he does not consider the following maladies to be new conditions because they are "self-limiting conditions" that will either resolve on their own, or "that will get better with a minor, straightforward treatment that most patients would recognize":

- "acute viral pharyngitis"
- "strep"
- "viral URI"
- "bronchitis" in the absence of chronic obstructive pulmonary disease
- "viral meningitis" if the patient had not had it before and "had not been seen elsewhere or diagnosed with that condition by another physician"
- "otitis media"
- "URI"

(St. Ex. 60a at 2; Tr. at 652-655, 660-661, 665-667, 669-670, 680)

c. Dr. Adamson testified that the following occurrences do not constitute new conditions:

- Dr. Adamson testified that he does not consider "skin tags" to be a new condition. Dr. Adamson further testified that "a condition is an ailment or a disease. Skin tags are not an ailment or disease. Skin tags are a localized collection of skin that we all have, much like a freckle." (St. Ex. 60a at 3; Tr. at 672-673)

- Dr. Adamson testified that he does not consider "pregnancy" to be a new condition:

> Because, as I've said before, a condition is an ailment or a disease. When I was a resident, I was taught most emphatically, particularly by the lady gynecologists, that pregnancy is not a disease. Pregnancy is a state of a normal woman's reproductive cycle, and so for that reason, they did not consider it an ailment or a disease, and I would not consider pregnancy a new condition.

(St. Ex. 60a at 3; Tr. at 675)

d. Dr. Adamson testified that the following could possibly constitute new conditions:

- Dr. Adamson testified that "[a]trophic vulvitis is a symptom of menopause. If the patient was known to be menopausal, I would not consider it a new condition. If the patient came in and was not known to be menopausal before, then it could be a new condition for that patient, depending on their individual history." (St. Ex. 60a at 2; Tr. at 657)

- Dr. Adamson testified that he would not consider "menstrual bleeding" to be a new condition unless it was a woman's menarche. (St. Ex. 60a at 2; Tr. at 671-672)

- Dr. Adamson testified that "right [ear] canal with green exudate, that is a physical exam finding, and it may or may not be a new condition, based on whatever the diagnosis is." (St. Ex. 60a at 2; Tr. at 652-653)

- Dr. Adamson testified as follows concerning whether "fibromyalgia" should be considered a new condition:

  > There are a lot of related conditions to fibromyalgia. Patients with fibromyalgia have multiple different musculoskeletal complaints. So it's very common that before they get the diagnosis of fibromyalgia, they have been in one time because their shoulder hurts, and they have been in another time because their leg hurts, and they have been in another time because their back hurts, and then you put it all together that, aha, that's fibromyalgia. It's not a new condition when you're seeing it that day because it's been going on for two or three or four previous visits where you sort of aren't able to put it all together because it's a—it's what we call a diagnosis of exclusion. Once you have eliminated everything else, then you are left with a diagnosis of fibromyalgia. Some people also refer to it as a wastebasket diagnosis.

  (St. Ex. 60a at 2; Tr. at 655-656)

- Dr. Adamson testified that "C-strain" could be a new condition, and that that determination would require a review of the facts of a particular case. (St. Ex. 60a at 2; Tr. at 656-657)

- Dr. Adamson testified that he would consider "C-sprain" to be a new condition "[i]f there was a new trauma associated with it" or if the patient had never been seen or evaluated for an old injury. (St. Ex. 60a at 2; Tr. at 667-669)

- Dr. Adamson testified that he could not definitively state whether "plantar fasciitis" would be a new condition because it depends on the individual patient. (St. Ex. 60a at 2; Tr. at 657-658)

- Dr. Adamson testified as follows concerning whether "conjunctivitis" is a new condition:

  > Conjunctivitis is a little bit difficult. You'd have to look at the individual case. There are two types of conjunctivitis. There's

> viral conjunctivitis, which will get better on its own without treatment. There's bacterial conjunctivitis, which would get better with eyedrops, which is an example, potentially, of a minor problem that will get better with a treatment that most people know. But if you don't treat conjunctivitis, you can sort of have more problems over the long run.
>
> So, you know, it may be a situation that is a new condition but might require immediate attention, based on the patient's history.

(St. Ex. 60a at 2; Tr. at 658-659)

- Dr. Adamson testified that "otitis externa" may or may not be a new condition depending on the patient's history and situation. Dr. Adamson stated that otitis externa could include problems as simple as swimmer's ear or problems as serious as a ruptured eardrum. Dr. Adamson further testified that if the patient "had never been seen or treated anywhere or been told they had that diagnosis, then I would consider it a new condition." Dr. Adamson further testified that if the patient had been seen in an emergency room, and if Dr. Adamson either spoke to someone at the emergency room or was presented with the patient's instruction sheet from the ER, and if it's a "simple, straightforward diagnosis to make," he would rely on the other physician's diagnosis and not consider it to be a new condition. (St. Ex. 60a at 2; Tr. at 662-663)

  Dr. Adamson was asked if he would consider otitis externa to be a new condition if the patient had only been seen years ago for that problem by someone that Dr. Adamson had not communicated with, and Dr. Adamson had no documentation of the previous occurrence. Dr. Adamson replied:

  > If the patient told me they had it, and I was comfortable with their description—you know, again, for example, the patient comes in and says, you know, 'When I was a teenager, I used to get swimmer's ear all the time, and I remember my mom and dad taking me to the emergency room or taking me to the doctor for swimmer's ear,' and they came in and had otitis externa, I would say, no, that's not a new condition. Two reasons: One, they have had it before; and, two, it's a minor, self-limiting problem that would get better with a straightforward treatment that most patients would recognize.

  (St. Ex. 60a at 2; Tr. at 663-664)

- Dr. Adamson testified, with regard to "ankle sprain," that the determination of whether it is a new condition depends on the individual patient's situation.

Dr. Adamson further testified that if the patient had previously had ankle strain, treated or untreated, he would not consider it to be a new condition,

> because after you've had an ankle sprain, there's a weakening of the ligaments of the ankle that predispose you to ankle sprains on a recurrent basis. So, really, the condition is your first ankle sprain that's left your ankle weak. So when you turn it again, it's not because of what you did the second time; it's because of what happened the first time.

(St. Ex. 60a at 2; Tr. at 664-665)

- Dr. Adamson testified with regard to "acute sinusitis" that "[i]f a patient had never had symptoms before related to their sinuses or their ears or even symptoms related to their nose, potentially, an acute sinusitis could be a new condition." Dr. Adamson further testified that acute sinusitis could also be a new condition if it were serious enough to warrant concern that it was a multisystem disease, such as a bloodstream infection. (St. Ex. 60a at 2; Tr. at 670-671)

- Dr. Adamson testified as follows concerning "warts" and whether he would consider warts to be a new condition:

> Warts are—again, depends on the context of the individual patient. Warts are caused by a virus that frequently are very long-standing for a patient, and a wart is something that an individual can diagnose themselves and treat over the counter. So if it's an absolute new thing that the patient doesn't know what it is and nobody's ever looked at it before, it could be considered a new condition, but you'd have to look at the context. But because of the viral nature of warts, most warts that are seen are not new conditions. Most warts are old, chronic, bothersome conditions.

(St. Ex. 60a at 3; Tr. at 673-674)

- Dr. Adamson testified as follows concerning whether he would consider "acute gastroenteritis" to be a new condition:

> Acute gastroenteritis is a fairly generic term. There are different types of gastroenteritis. Most acute gastroenteritises are viral gastroenteritis. A lot of people would refer to that as a stomach flu. That will get away on its own—get away—that will go away on its own with only minor treatment or no treatment as long as you drink enough fluids.

> There are infectious types of gastroenteritis, and you hear about Salmonella outbreaks or E. coli outbreaks. Those are a type of acute gastroenteritis. Those would be a new condition.

(St. Ex. 60a at 3; Tr. at 676-677)

- Dr. Adamson testified that "acute gastritis" differs from acute gastroenteritis. Dr. Adamson further testified as follows concerning whether he would consider acute gastritis to be a new condition:

> Gastritis is an inflammation of the lining of the stomach, and I would consider acute gastritis a new condition, again, within the context of the individual patient.
>
> * * *
>
> If they had never had the symptoms of acute gastritis before, when that term is used, you're usually inferring that it's something beyond the typical upset stomach that we all might take some Tums for or antacid. Unfortunately, acute gastritis is a very difficult diagnosis to make because there are so many things that are close, it's very hard to tell, is it gastritis, is it an ulcer, is it an inflammation somewhere else. So you really can't confirm a diagnosis of acute gastritis until somebody goes in there with a scope or a light and looks at the stomach and says, 'That's acute gastritis.'

(Tr. at 677-678)

- With regard to "severe left hip pain, lift fell on a patient," Dr. Adamson testified:

> Pain is a symptom. And I would not consider a symptom a new condition. 'Lift fell on patient' is a historical reference that there's no way to determine what happened. You might have a condition as a result of something falling on you, or you might not. You could—you know, you could have a broken leg, or you could have nothing.

(St. Ex. 60a at 3; Tr. at 680)

- Dr. Adamson testified as follows concerning whether he would consider "anxiety disorder" to be a new condition:

  > Anxiety disorder, if that's being used as a diagnosis, that's, again, potentially a new condition, but anxiety disorder is a diagnosis of exclusion. You have to exclude depression. You have to look for medical causes of anxiety.
  >
  > So, again, I can't—couldn't categorically say on anxiety disorder unless you looked at the context of the individual patient.

  (St. Ex. 60a at 2; Tr. at 682)

- Dr. Adamson testified that he would consider a "leg laceration" to be a new condition. Dr. Adamson further testified:

  > [I]f your skin was intact before and you had a cut, then that cut is new. Now, you know, we can have a chicken-or-the-egg kind of discussion on—let's say that person doesn't get stitches, all right, and they come in six days later, and they have an open wound on their leg. Is that still a laceration, or is that an open wound on their leg?
  >
  > So when I use the term 'laceration,' I'm thinking of something that happens acutely that most of us would say, 'Oh, my gosh, I cut myself,' you know, and you would either look at it and make an individual determination, 'Gosh, I need to go to the emergency room,' or, 'Gosh, I need to call somebody,' or 'Oh, that's not that bad; I think it will heal.'
  >
  > So when I say I think it's a new condition, I'm sort of referring to a laceration that, boom, you've got a cut.

  (St. Ex. 60a at 2; Tr. at 658-660)

- Dr. Adamson testified that "Trich" is short for Trichomonas. Dr. Adamson further testified that Trichomonas would be a new condition if the patient had not had it before. (St. Ex. 60a at 3; Tr. at 681)

- Dr. Adamson testified as follows concerning whether he would consider "costochondritis" to be a new condition:

  > Costochondritis is another one of those wastebasket diagnoses that is used frequently in a family practice setting. There is a specific

> condition of costochondritis that could be new or old, depending on the context. Patients who smoke frequently have long-standing costochondritis. They complain of pain and tightness in their chest, and that's due from the smoker's cough and the irritation and inflammation that that has.
>
> On the other hand, it is a potentially self-limiting condition that will get better on its own that you do not have to treat. You only treat if the patient wants something for the symptoms.

(St. Ex. 60a at 3; Tr. at 674)

- Dr. Adamson testified as follows concerning whether he would believe "tinea" to be a new condition:

> Tinea is a very generic term. That's actually a family of funguses. There are multiple types of tinea. There's tinea versicolor, tinea corporis, tinea capitis, jock itch, a whole bunch. So, again, with it being that generic a term, if they have never had any type of fungal skin infection, you might think it's a new condition, but, again, it's something that gets better either on its own or will get better with a minor, straightforward treatment that most patients would recognize. So if the tinea is ringworm, most moms know what ringworm looks like, and they go to Meijer's and get the medication for ringworm, so I don't consider that a new condition.

(St. Ex. 60a at 2; Tr. at 681-682)

e. Dr. Adamson testified that the following constitutes a new condition:

- "cellulitis" (St. Ex. 60a at 2; Tr. at 682)

<u>Dr. Adamson's Standard Care Plans</u>

76. Ms. Adamson testified that Dr. Adamson's practice did not have written protocols, but had approximately nine standard care plans for various conditions such as hypertension, diabetes, and upper respiratory infections. Each plan included pre-printed progress note forms that were used to evaluate patients. Ms. Adamson testified that both the physicians and the physician assistants in the practice used those forms to evaluate patients. (Tr. at 73-75)

77. Dr. Adamson testified concerning the development of his standard care plans. Dr. Adamson testified that he began developing them when he hired Ms. Adamson to help her understand how he wanted her to practice. Dr. Adamson further testified that they evolved into specific sets of orders. Moreover, Dr. Adamson stated that, in the case of a

diabetic patient, he follows the guidelines of the American Diabetes Association, and stated that the patient should have hemoglobin A_{1C} checked every three months, a "micrology buterol" test each year, and a dilated retinal exam each year. Finally, Dr. Adamson testified. "This is a standard care plan that I want to follow. I mean, standard care plans weren't just for PA; standard care plans were for me. I wanted to follow those, too, because they were—because they were good medicine." (Tr. at 1987-1988)

Dr. Adamson testified that, in addition to plans for chronic conditions such as diabetes, "we also did standard care plans for common complaints." Dr. Adamson equated "common complaints" to minor self-limiting conditions. Dr. Adamson testified that they developed standard care plans for common complaints such as upper respiratory infections, coughs, earaches, vaginal discharge, and red eye. (Tr. at 1989-1990)

78. Dr. Adamson described his standard care plans for common complaints as follows:

a. With regard to his standard care plan for headaches, Dr. Adamson testified that the evaluation consisted of a history and physical examination, and a review of any old records or "other pertinent information that we could find." Dr. Adamson further testified that the medication for headache was ibuprofen, either by prescription or over-the-counter. Dr. Adamson stated that any medication beyond ibuprofen "would require a specific order for the individual treatment plan for that particular patient's headaches." Dr. Adamson also testified that imaging was not routinely ordered for headaches, and would have required his specific recommendation. (Tr. at 2074-2075)

b. With regard to his standard care plan for red eye, Dr. Adamson testified that the evaluation included a history and physical examination. Dr. Adamson further testified that if there were any findings of acute glaucoma in the patient, the patient was immediately referred to an ophthalmologist. If there was evidence or complaint of a foreign body or scratching, a fluorescein stain was done. Dr. Adamson testified that if all of those things are negative and the patient appears to have conjunctivitis, then Sodium Sulamyd could be prescribed. Dr. Adamson further testified that that prescription was part of the standard care plan. (Tr. at 2076-2077)

c. With regard to his standard care plan for cough, Dr. Adamson testified that a history and physical examination would be performed. Dr. Adamson further testified:

> If the patient was found to have a self-limiting upper respiratory infection, first order of treatment are over-the-counter medications of the patient's choice. We would recommend they take whatever they have at home, was always our first recommendation. If they had tried over-the-counter medications and had failed, they could be prescribed Humibid for cough. And that was basically the extent of the standard care plan.

(Tr. at 2078) Dr. Adamson testified that a prescription for Amoxil was not part of his standard care plan for an upper respiratory infection. (Tr. at 2095)

d. With regard to his standard care plan for sinusitis, Dr. Adamson testified:

> Patients were seen and a history and physical performed. If they gave us a history of sinusitis or there was a history in the chart of sinusitis, they were to be treated with Amoxicillin as a first line antibiotic, unless they were allergic to it, or if it was a patient that we had seen previously for sinusitis, we would use the last antibiotic that they were treated with that was effective.

(Tr. at 2078-2079)

e. With regard to his standard care plan for earaches, Dr. Adamson testified that a history and physical examination was performed. Dr. Adamson further testified:

> If a—first line antibiotic, if they were found to have a red ear, was Amoxicillin, unless they were allergic to it, or the last effective antibiotic that they were treated with. The problem with those sinus infections and ear infections is Amoxil will work for a certain period of time. And then when it stops working, you usually don't go back to it. You may in some instances if you documented strep or there was an unusual situation, but usually if you go to the second line antibiotics, that's the antibiotic you would use, and that order would be reflected in the chart from their previous visits.

(Tr. at 2079-2080)

79. Dr. Adamson testified that the standard care plan would not be followed for every patient who exhibited the disease processes for which he had a standard plan:

> You know, you hear people talk about distinction between medicine is art and medicine is a science. The science isn't always there. Ninety-nine percent of the patients who came to our office with a cough had some type of upper respiratory infection. But when that patient came in and said they were from Haiti and they were having sweats at night and they lost forty pounds, we immediately went off the standard care plan and got out of the room, because the patient had tuberculosis.

* * *

> So you fall off those fairly quickly once you see you're sort of out of that self-defining range. But it's the one percent of patients. And those are once-in-a-practice-history sort of stories, but they happen.

(Tr. at 1990-1991)

80. Dr. Adamson testified that, aside from the pre-printed progress notes, he did not record his standard care plans in writing:

> Well, first of all, they're good medicine, and so you don't—if you know the right thing to do, you don't have to think twice or you don't have to go look it up; you just go ahead and do it. And because they're—again, like the cough example, I can, you can cover 99 percent of people, but that 1 percent, that fall out can go so many different ways, you can't cover all those alternatives. So it's just really impossible to do, and it's—that—it would have been so time consuming, but in the context of a solo practitioner trying to do that on top of all the other quality efforts they're undergoing, I wouldn't have any time left to see patients.

(Tr. at 1992-1993)

Issuing of Prescriptions Pursuant to Treatment Plans

81. Dr. Adamson testified that, under his standard care plans, his physician assistants were authorized to do specific things, based on findings developed from the history and physical examination. Dr. Adamson further testified that, within the parameters he set forth in the standard care plan, the physician assistants made the determination of what to do. Moreover, Dr. Adamson testified that physician assistants also made the determination of whether to call in the prescriptions for the medications that Dr. Adamson had ordered for the standard care plan. (Tr. at 2080)

The following exchange occurred with regard to physician assistants having prescriptions called in under Dr. Adamson's standard care plans:

Q. (by Ms. Crawford): Can the physician assistant write a prescription for Amoxil for a patient who came in with otitis media and, in your view, fell under the standard care plan?

A. (by Dr. Adamson): No.

Q. Why is that?

A. Because physician assistants are not permitted to write prescriptions.

Q. But the—it's your view that the physician assistant could call in that prescription under the standard care plan?

A. She can follow my order for amoxicillin in that circumstance.

Q. Under the standard care plan?

A. That's correct.

Q. So what's the difference between the physician assistant calling it in under your standard care plan or writing the prescription?

A. If she's—if the physician assistant is writing a prescription, they're acting on their own. If they're following the standard care plan, they're executing my orders.

Q. Even if the Amoxil is under—the reason that the Amoxil is being prescribed is under your standard care plan, you're saying that they can't write that under your standard care plan, but they can call it in under your standard care plan, correct?

A. They can't write it. They could call in my verbal order for Amoxil for that clinical circumstance. They could not initiate the Amoxil independent of my order.

Q. Well, what's the difference between calling it in under your standard care plan and writing it under your standard care plan?

A. The difference is whether or not the physician assistant is following my direction. That's the only difference. It doesn't matter if it's written or called. It's who is ordering it. I mean, a physician assistant cannot write prescriptions, period.

Q. So is that the only difference, is that the physician—the patient is getting prescription for Amoxil under your standard care plan. That's the scenario we're doing, okay?

A. Okay.

Q. So what's the difference if the patient gets the prescription under your standard care plan, whether it be by a call-in prescription or written prescription? The end result is the same, right?

A. If they were both ordered by me, there would be no difference.

Q. And if it was under the standard care plan, wouldn't they both be ordered by you?

A. That's correct.

Q. Okay. So that if it was under the standard care plan, the physician assistant could give the—could call in Amoxil—

A. She could.

Q. —for that patient?

A. She could—a physician assistant could execute my order, based on the standard care plan that I had laid out.

Q. Right.

And that would be to have the patient have Amoxil, right?

A. Correct.

Q. Okay. So could the physician assistant then also write the prescription out under your standard care plan, being that that would be under your order?

A. She could write down the word Amoxicillin and they could write down the dosage. She couldn't sign the prescription. I would then sign the prescription. And once I sign that prescription, then that's obviously my order.

Q. Okay. So if you were out of town, under the standard care plan, the physician assistant can ensure that the patient gets a prescription of Amoxicillin, correct, if it's under your standard care plan?

A. She—he or she can follow my order for what's to be done in that circumstance.

Q. Right.

And if the physician assistant says, okay, according to the standard care plan, this patient meets the requirements that Dr. Adamson has said and I'm going to make sure that this patient gets amoxicillin, that would be okay, right?

A. Correct, they would be executing my order for that standard care plan.

Q. Okay. So the patient can get a prescription either by a written prescription or calling it in, right?

A. Are you speaking in general?

Q. In general.

A. Yes.

Q. Okay. But since you're not in town, the physician assistant calls it in rather than has a written prescription?

A. They—he or she could. If they were functioning outside the standard care plan, they should contact the supervising physician.

Q. But I'm just talking about your standard care plan.

A. Correct.

Q. Okay. So the end result is that the patient's getting the prescription but just having it called in as opposed to having a written prescription, but the end result is the same?

A. Correct, they're getting a called-in prescription from my order. The end result is the same.

(Tr. at 2095-2101)

82. Dr. Adamson testified concerning the authority he gave to Ms. Adamson with respect to medication orders:

> For long-term medications, I gave specific orders that these were the medicines that that patient was to be on until I changed it. For sort of recurring self-limiting problems, such as ear infections, we would give her a specific order that this is the medicine that's to be used in this patient until it fails. And then at that point, she would talk to me about what's the next antibiotic.
>
> Again, you talk about all these medicines and antibiotics, but there are no hundred percents in medicine. Not all strep responds to penicillin. Not all antibiotics X respond—not all bug X respond to antibiotic Y, so we frequently—especially with sinus infections. If Y doesn't work, then I want you to do Z. And, again, it was a logical progression that we would follow over and over again. You didn't need to write it down, because that's just the way we practiced. That's the—that's just the next thing that was done. We would write it down if it was an exception or something odd or peculiar to that particular patient.

(Tr. at 1996-1997)

83. Ms. Adamson testified concerning what Dr. Adamson had authorized her to do with regard to prescription medication:

> Well, we had specific treatment plans for patients that had chronic diseases that were on long-term medicine, and in those cases, we would discuss—he would tell me, 'These patients need to be on this medication forever, make sure they have this lab annually or quarterly' or whatever it was, and then there was a specific plan.

(Tr. at 168) Ms. Adamson further testified concerning long-term medications that "if they came in and they had done the prescribed plan, done all that we asked them to do, get your labs drawn or whatever it was, then we could refill it until they needed to be seen again." Ms. Adamson further testified that she could have a prescription called in for a patient without discussing the patient with Dr. Adamson on that day. Moreover, Ms. Adamson testified that that was true for long-term medications for diabetes, hypertension, asthma, or "whatever [Dr. Adamson] had ordered for that patient." Ms. Adamson testified that that was Dr. Adamson's policy throughout the period 1995 through 2000. (Tr. at 169)

84. Ms. Adamson testified that she had also been authorized by Dr. Adamson to have prescriptions called in for patients with certain types of conditions based upon Dr. Adamson's standard care plans. Ms. Adamson testified that such prescriptions had been issued based upon her own assessments of the patients, and "pending other lab results." (Tr. at 170-176)

85. Ms. Adamson testified that there were occasions when she gave patients samples of prescription medication. Ms. Adamson further testified that she would write "sample" in the patient chart to reflect that. Moreover, Ms. Adamson testified that when Dr. Adamson was out of the office, she relied on Dr. Adamson's "specific order about samples," namely, "[i]f a patient was on a long-term medication that he had prescribed, we could sample if we had it." (Tr. at 184-185)

<u>The "VOWCA/RRH" Notation</u>

86. Ms. Adamson testified that the handwritten notation "VOWCA/RRH" that appears in the charts stood for "verbal order Wallace C. Adamson/Robin Rae Hawn." Ms. Adamson testified that that notation "meant that I had been given a direct verbal order from him that day or previously a verbal order about that patient, what to do sometime in the past, or that we had a standard care plan about what to do in that situation." Ms. Adamson further testified, however, that her initials do not necessarily mean that she had seen the patient. (Tr. at 155-159, 1803-1805)

87. Ms. Adamson testified that "VOWCA/RRH" could identify her supervising physician, but did not always. Ms. Adamson testified that, with regard to Patient 53's visit on June 11, 1997, Dr. Ghiloni had been her supervising physician. Nevertheless, she had written

"VOWCA/RRH" on the progress note. Ms. Adamson testified that, in this example, "VOWCA/RRH" did not signify who her supervising physician had been. (St. Ex. 53 at 124a; Tr. at 1818-1821)

88. Concerning testimony by Ms. Adamson that the use of "VOWCA/RRH" could mean either a specific order or general standing order, Dr. Adamson testified that "[t]he use of VO has to be interpreted within the context of the individual patient and the individual visit. In the context of a day when I was in the office, it means that I was there and gave a specific verbal order." (Tr. at 728-729)

The "REVIEWED" Stamp

89. On the left side of page 21 of the medical records for Patient 46 is a stamp that says:

REVIEWED
JAN 28 1999
WCA

This stamp, with different dates, appears in all of the patient charts. Dr. Adamson testified that the "REVIEWED" stamp had been an effort to comply with the then-recently updated statutes and regulations governing the practice of physician assistants. Dr. Adamson further testified that he was aware that there were time requirements concerning how soon his signature had to go into a chart. Moreover, Dr. Adamson testified that it saved him the time of having to write the date on all of the charts. (St. Exs. 1-59; Tr. at 2000-2001)

Dr. Adamson testified that he was the only person authorized to use the "REVIEWED" stamp unless he gave another person "instructions to specifically stamp a specific entry in a specific chart." Dr. Adamson testified that those instructions could have been given in person or over the telephone. (Tr. at 2002-2003)

90. Dr. Adamson testified that his "REVIEWED" stamp was intended to show his "ongoing involvement with these patients on an ongoing basis to monitor the quality of the care that they received and the physician input into ongoing care being provided by a physician assistant." Dr. Adamson further testified that the stamp would indicate his approval of treatment rendered if he had authorized that treatment. If, however, the treatment had been authorized by another physician, such as times when Dr. Adamson was out of town and another physician was supervising the physician assistant, "then the stamp would indicate that [Dr. Adamson] had reviewed what was going on and was aware of it and was stamping it as part of [his] continuity of care of knowing what's going on with these patients." (Tr. at 758-760)

91. Ms. Adamson indicated that she also had used the "REVIEWED" stamp "on occasion * * * when he authorized [her] to use it." Ms. Adamson testified that such authorization would

have been specific to a particular page in a patient's chart. (St. Ex. 46 at 21; Tr. at 149-151, 1333, 1824-1825)

Contrary to Dr. Adamson's testimony, Ms. Adamson testified that every time the "REVIEWED" stamp appears in the chart it indicates that Dr. Adamson had been her supervising physician for the order that she wrote. (Tr. at 224)

92. Ms. Adamson testified that she did not use the "REVIEWED" stamp when Dr. Adamson was out of town. (Tr. at 167)

93. Patient 52, who had worked as a front office employee at Apple Health, testified that one problem that had occurred at Dr. Adamson's office concerned charts piling up for Dr. Adamson's review. Patient 52 further testified that, to address this problem,

> they had stamps made up so that he could just, instead of taking the time to go through the whole chart and sign off on it, he could use his stamper on mail or on charts and then Robin could stamp off on her charts as well.
>
> And it would help, because then the charts could get filed back and it didn't take so much time to track everybody down.

(Tr. at 1393-1395) With regard to that testimony, the following exchange occurred:

Q. (by Ms. Crawford): And I believe you testified, if I'm paraphrasing your testimony right, that he had the stamp made up so he could use the stamp to stamp his chart and then Robin could use it to stamp her charts, is that what you said?

A. (by Patient 52): Right, it was made because—once it was made, he used it as convenience himself too, but she would use it so that his charts looked like he got his work done, but she did it to help keep him caught up.

Q. And this was the stamp that had his initials?

A. It just—yeah.

Q. Or the date on it?

A. His signature.

Q. The stamp—did you ever see Robin use the one—the stamp with the lab on it, the lines that said lab results and so forth?

A. I don't—I just seen her using stamps.

Q. But you saw her using the one with his signature and the date on it?

A. Uh-huh.

Q. So after—when you say stamping on the charts, would that be on a progress note or where on the chart?

A. The last time they were seen stamped off, if it was her patient so that he did his thing, you know, he signed off that it was done, it could be filed back away. Because he always wanted to see—he wanted to see her things, you know, the patients that she had seen. But like I said, it would just get to be too many because she seen a lot of patients in a day. So for him to have the chance to read through all of those—

Q. How many patients would [Ms. Adamson] see in a day, average?

A. I don't know, maybe 30.

Q. So after they got this stamp, is it your testimony that Ms. Hawn stamped this and then Dr. Adamson didn't review those charts?

A. I can't say for sure that he didn't. I know that she would stamp them so that they could get filed back into the file system within a timely manner.

Q. After she stamped the charts, where were they put?

A. They'd get stamped off and then they'd just bring piles of them up to the front or they would go in a basket that we knew were charts that had already been reviewed and we could haul them up to the front and then they could be filed.

(Tr. at 1395-1398)

94. Ms. McCale testified that she had been the staff member of Dr. Adamson's office who was primarily responsible for calling in prescriptions, although Ms. Adamson did so on occasion. After Ms. McCale had called in a prescription, Ms. McCale wrote "done" in the patient record. (Tr. at 1674-1678)

Ms. McCale testified that, if Ms. Adamson had seen a patient and Dr. Adamson was not in the office that day, the chart would be placed in her basket if a prescription needed to be called in. Ms. McCale further testified that the progress note for that day's visit would "[s]ometimes" have already been stamped with the "REVIEWED" stamp. Moreover, Ms. McCale testified that, on those occasions, Ms. Adamson had usually placed the chart in Ms. McCale's basket immediately after having seen the patient. (Tr. at 1678-1679)

Ms. McCale testified that she had seen Ms. Adamson using the "REVIEWED" stamp on a daily basis. (Tr. at 1680)

Dr. Adamson's Review of Physician Assistant Charts; Countersigning Orders

95. Dr. Adamson testified that he regularly reviewed the orders that he had given to the physician assistants in his practice. Dr. Adamson further testified that he had reviewed the clinical findings and notes of his physician assistants with regard to their examinations of patients, and that his goal had been to review all of them. Dr. Adamson testified that he did so because it was good medicine, and because he set very high standards for himself and for those under his supervision. Finally, Dr. Adamson testified that he would memorialize his review of the charts by either initialing the chart or stamping it. (Tr. at 1999-2000)

96. Dr. Adamson testified that he evaluated one hundred percent of his charts, However, Dr. Adamson further testified that he did not evaluate one hundred percent of the occasions where Ms. Adamson initialed something in the chart. Dr. Adamson explained:

> If you look at a chart and I've signed it at least once, then I have reviewed that chart at some point. So I would say that you—I have not seen any charts presented here that did not contain my signature or reviewed notation somewhere in the chart. So I would say that I reviewed 100 percent of the charts.

(Tr. at 2102-2103)

Dr. Adamson's Office Schedule; Absence From Office

97. Dr. Adamson testified that his office schedule varied. Dr. Adamson testified that "the office was generally open from 8:00 in the morning until 5:00 at night. That didn't necessarily mean a provider was seeing patients during those hours, but phones were answered and staff was there." Dr. Adamson further testified that the office was, "[i]n general," open Monday through Friday. Dr. Adamson testified that there were no Saturday or Sunday hours. Finally, Dr. Adamson testified that patients were scheduled starting at either 8:00 or 9:00 a.m. depending on the day of the week and the provider. (Tr. at 1311-1312)

98. Dr. Adamson was out of the office on the following dates:

    a. March 1 through 3, 1998. Dr. Adamson had gone to Winter Haven, Florida. Dr. Adamson testified that he returned to his office the morning of March 3, 1998.

    b. March 27, 1998, through April 1, 1998. Dr. Adamson had gone to Las Vegas, Nevada. Dr. Adamson testified at hearing that he could not recall if he had been in his office on March 27, 1998. At his October 26, 2000, deposition, however,

Dr. Adamson had testified that on March 27, 1998, the telephone was being answered at his office, but that there had been no providers on site.

c. June 12, 1998. Dr. Adamson had gone to Mammoth Cave in Kentucky. Dr. Adamson testified at hearing that he had been in his office in the morning and left around 1:00 p.m. At his October 26, 2000, deposition, however, Dr. Adamson had testified that he had left in the morning, and did not believe that he had gone to his office that day.

d. August 7 through 16, 1998. Dr. Adamson and Ms. Adamson were wed in St. Petersburg, Florida.

e. November 26 through 30, 1998. Dr. Adamson and Ms. Adamson had gone to Toronto, Ontario. Dr. Adamson testified that he returned to Columbus the morning of November 30, and went to his office that day.

f. January 15 through 18, 1999. Dr. Adamson had gone to Chicago, Illinois. Dr. Adamson testified that he returned to Columbus the morning of January 18, and went to his office that day.

g. May 25 through 29, 1999. Dr. Adamson and Ms. Adamson had gone to the Virgin Islands.

Dr. Adamson testified that, when both he and Ms. Adamson had been away on a trip to the Virgin Islands, Dr. Tweel had covered for Dr. Adamson, and Jamie Price, P.A., saw patients at Dr. Adamson's office under Dr. Tweel's supervision.

h. July 26 through 27, 1999. Dr. Adamson had gone to New York City. Dr. Adamson testified that he returned to his office sometime during the day on July 27, 1999, and worked for the rest of the day, although he did not see patients.

i. July 29 through August 3, 1999. Dr. Adamson had gone to Myrtle Beach, South Carolina.

j. February 22, 2000. Dr. Adamson had been in Worthington, Ohio, but was out of the office that day.

(St. Ex. 83B; Tr. at 1298-1310, 1977-1979, 2022-2025)

Supervision of Dr. Adamson's Physician Assistants when Dr. Adamson was Out of Town

Testimony of Dr. Adamson

99. Dr. Adamson testified that he made arrangements for another physician to supervise Ms. Adamson when he was absent from the office:

> I would call the physician and ask them to cover. They were all physicians who employed PAs themselves and were signed on to the American Health Network supervising plan. I informed them that Robin would be in the office seeing patients and that she would be contacting them if anything went outside of our—outside of the orders that I had given her previously.

(Tr. at 1320) Dr. Adamson testified that the orders could have included "an individual specific treatment plan that I'd given for a patient * * * or any of the standard care plans for minor self-limiting problems." (Tr. at 1321)

Dr. Adamson testified that the only time that Ms. Adamson would have contacted the supervising physician would have been if she had encountered a situation that was outside of the orders that Dr. Adamson had previously given her, or if the patient had had something that Ms. Adamson had believed to have been a new condition. (Tr. at 1322)

Dr. Adamson testified that he does not know if he had given Ms. Adamson specific instructions concerning new conditions when he was out of town. However, Dr. Adamson testified that Ms. Adamson knew that "she needed sign-off from the supervising physician prior to initiating any treatment plan that she would develop" for the patient with a new condition. Dr. Adamson explained that, by the term "sign-off," he meant "either a verbal okay and then followed by a signature or whatever type of personal evaluation the supervising physician would like to do." When asked if he had expected that the supervising physician would come to his office to look at the patients, Dr. Adamson replied, "I didn't supervise the supervising physicians. That's up to their professional discretion on how they would handle that situation." (1322-1323)

Testimony of Ms. Adamson

100. Ms. Adamson testified that, during the time period of 1995 through 2000, she had been under the supervision of Dr. Tweel for one day; Ms. Adamson could not recall the day or the year. Ms. Adamson further testified that, for the same time period, she had been under the supervision of Dr. Buddie from July 26 through August 3, 1999. Ms. Adamson testified that there may have been other times for which Dr. Buddie was her supervising physician, but she could not recall at hearing. Finally, Ms. Adamson testified that Dr. Ghiloni had supervised her during the time period 1995 until Dr. Ghiloni left the practice in 1997. (Tr. at 587-591)

101. Ms. Adamson testified that, when Dr. Adamson had gone out of town, another physician supervised her. Ms. Adamson further testified that different physicians covered for Dr. Adamson on different occasions, and that Dr. Adamson informed the office who the covering supervising physician would be. (Tr. at 137-138)

     Ms. Adamson testified that, on those occasions when Dr. Adamson was out of town and another physician had supervised her, no physician called the office on a regular basis to check with her, and no physician came to Dr. Adamson's office while Ms. Adamson was seeing patients. Ms. Adamson further testified that she never had any conversations with the covering supervising physician concerning how that physician wanted Ms. Adamson to handle patients, or how that physician wanted her to handle the patient charts. Finally, Ms. Adamson further testified that she had not had any conversations with the covering supervising physician concerning Ms. Adamson's work as a physician assistant. (Tr. at 137-140)

     Nevertheless, a few moments later, Ms. Adamson testified that, when Dr. Adamson was out of town, she had contacted her covering supervising physician "a couple times" regarding patient matters. Ms. Adamson testified that she had made notations in the patient chart concerning those issues. (Tr. at 140-141)

Testimony of Mark Alan Buddie, M.D.

102. Mark Alan Buddie, M.D., testified that he practices family medicine in Westerville, Ohio. Dr. Buddie further testified that he was licensed to practice medicine in Ohio in 1996, and that he joined American Health Network, Inc., that same year. (Tr. at 1583-1584)

     Dr. Buddie testified that he had known Dr. Adamson since Dr. Buddie was a resident at Grant Medical Center. Dr. Buddie further testified that Dr. Adamson was one of the physicians who had recruited him into the American Health Network. (Tr. at 1586-1587)

     Dr. Buddie testified that, when he joined American Health Network, he had signed a supervision agreement that listed the names of several physician assistants, including Ms. Adamson. Dr. Buddie testified that it had been his understanding that, by entering into that agreement, "if a physician assistant needed supervisory coverage and plans were made to do so, that [Dr. Buddie] could supervise a physician assistant within the practice." (Tr. at 1584-1585)

     Dr. Buddie testified that he never worked at Apple Health. (Tr. at 1586)

103. Dr. Buddie was asked if he had ever had an agreement with Dr. Adamson to supervise Dr. Adamson's physician assistant when Dr. Adamson was out of town. Dr. Buddie replied, "Well that's, I guess, the whole debate. What I recollect is Dr. Adamson asked me to cover his practice or cover him on a number of occasions." Dr. Buddie further testified that, initially, he had a call arrangement with Dr. Adamson and some other physicians to

share call for 24-hour emergency availability. Dr. Buddie testified that, later, he and Dr. Adamson entered into a less formal arrangement to share evening and weekend hours. Moreover, Dr. Buddie testified that, "probably three or four times, Dr. Adamson asked me if I would cover him during the week as well." (Tr. at 1587-1588)

Dr. Buddie testified that, when Dr. Adamson had asked Dr. Buddie to cover for him during the week, "one of the questions I was asked [was] if Robin has any questions, could she call. So essentially I interpreted that to be would I be available for emergency calls, question calls, weekend, evening calls." However, Dr. Buddie further testified that it had not been his understanding that he would act as Ms. Adamson's supervising physician. Dr. Buddie testified:

> As a supervising physician, I would assume that as medical overseer, the physician of record, on any patient seen, I would need to have at least brief knowledge of the interaction, what the assessment and plan of treatment was going to be, have some discussion of, if medications were to be prescribed, how that was going to be taken care of. And then typically some form of signing off a chart or co-signing a record, a document.

(Tr. at 1588-1590) Dr. Buddie further testified that that sort of an arrangement had not been made when he agreed to cover for Dr. Adamson. Moreover, Dr. Buddie testified that he had not been asked to have interaction with Ms. Adamson on a day-to-day basis, to come to Dr. Adamson's office to see patients, or to come to Dr. Adamson's office to sign off on patient charts. Concerning whether he had been asked to authorize medications, Dr. Buddie testified, "I wasn't asked specifically to do that, although I do believe on at least one or two occasions, I was called and contacted about medications that I did give a little background and approve." Finally, Dr. Buddie testified that he could not recall having a conversation with Dr. Adamson in which Dr. Adamson talked about his standing orders. (Tr. at 1590-1593)

Dr. Buddie testified that, on those occasions when he had covered for Dr. Adamson when Dr. Adamson went out of town, he conferred with Dr. Adamson by telephone concerning what had taken place. Dr. Buddie later clarified that these were not matters that had occurred in Dr. Adamson's office during regular office hours. Rather, they were matters "that happened off hours that I didn't think he had otherwise known about or heard about," such as calls from emergency rooms concerning Dr. Adamson's patients. Moreover, Dr. Buddie testified that he did not know what had been going on in Dr. Adamson's office during regular office hours. (Tr. at 1596-1599)

Examples of Dr. Adamson's Medical Records

104.

PROGRESS NOTE Cough/URI						
PATIENT		AGE 28	HT	WT 194½	SMOKER	NON-SMOKER
CHIEF COMPLAINT (L) ear pain		TEMP 98.6	B/P 116/84	HR 66	RR	
DURATION OF SYMPTOMS	<1 1	2 3	4 5	6 7	1 - 2 weeks	> 2 weeks
OTC RX	Advil	Robitussin	Tylenol	Sudafed	TheraFlu	
Cough	productive	nonproductive	yellow sputum	wheezing	PND	
Nose & Sinus symptoms	clear rhinorrhea	yellow snot	nasal congestion	facial pain	headache	
Throat symptoms	sore throat	hard to swallow	swollen glands	PND	hoarseness	lost voice
Other symptoms	fever > 101	myalgias	fatigue	chills	earache L R	nausea & vomiting
Past History	sinusitis	bronchitis	strep throat	pneumonia	mono	otitis media
PHYSICAL EXAM General	NAD	febrile	appears ill	labored resp.	appears dry	
Skin	no rash	sandpaper rash	rash			
Ears	normal TM's	effusion L R	red L R	bulging L R	wax L R	canal tender
Nose	normal	red mucosa	purulent rhinorhea	clear rhinorhea	enlarged turbinates	pale mucosa
Throat	normal	injected	enlarged tonsils	exudates	ulceration	yellow PND
Neck	normal	AC nodes	PC nodes	tender	sinus tenderness	
Lungs	clear	decreased BS	rhonchi anteriorly	wheezing	rales LUL LLL	rales RUL RML RLL
ASSESSMENT	Viral URI	Bronchitis	Otitis Media	Sinusitis	Strep Pharyngitis	Viral Pharyngitis
	Pneumonia	Influenza	Allergies	Mono	Asthma	COPD
PLAN	Throat Culture	CXR	Sinus XR	Sputum Culture	CBC	Monospot
OTC Rx	tylenol	advil	alleve	robitussin DM	sudafed	benadryl
Rx meds	amoxil 250	amoxil 500	Z pak	entex	humibid DM	humibid LA
	codiclear DH	bactrim DS	cechlor	cefzil	ceftin	claritin
	albuterol MDI	albuterol aerosol	allegra	augmentin	cipro	claritin D
	Amoxicillin 500 tid *30					
DIAGNOSIS				DATE		

REVIEWED JAN 28 1999 WCA

called to Ron

RRH

OM r/o early cellulitis 1-28-99

(St. Ex. 46 at 21) (Note: Blank areas and the page number were cropped for space considerations, and patient identifying information was redacted.)

Referring to page 21 of the patient record for Patient 46, which is reproduced above, Ms. Adamson testified that that is the type of progress note used in Dr. Adamson's office for a patient suffering from "Cough/URI." In the upper left corner a chief complaint of "[left] ear pain" was recorded. Ms. Adamson testified that that information would usually have been written in the chart by the person who had brought the patient back to the examination room. The row labeled "Duration of Symptoms" is divided into columns of "<1 1", "2 3", "4 5", "6 7", "1-2 weeks", and ">2 weeks"; "> 2 weeks" is circled. In the row labeled "Nose & Sinus Symptoms," a different symptom is printed in each column; clear rhinorrhea is printed in the first column, and is circled. Ms. Adamson testified that the person who took the history had recorded this information. (St. Ex. 46 at 21; Tr. at 143-147)

Ms. Adamson testified that the initials "RRH" that appear at the bottom right of the form are her initials, and indicate that she had "had something to do with the chart." Ms. Adamson further testified that the notations "called to Ron," the number "30," and "0 refills" are written in her handwriting. (St. Ex. 46 at 21; Tr. at 147-149)

105.

Progress Note Generic
Patient
Chief Complaint
Age 24 HT WT Smoker Nonsmoker
Temp 98.4 BP 118/72 HR 80 RR 16

ROS	PE	HPI (location, quality, severity, duration, timing, context, modifying factors)
gen WNL	gen WNL	
eyes WNL	eyes WNL	
NT WNL	ENT WNL	
COR WNL	COR WNL	
Resp WNL	Resp WNL	
GI WNL	GI WNL	PMHx, Fam Hx & Social Hx updated on chart form
GU WNL	GU WNL	Positive ROS responses and Abnormal Physical findings
MS WNL	MS WNL	
Skin WNL	Skin WNL	
Neur WNL	Neur WNL	
Psych WNL	Psych WNL	
Endo WNL	Endo WNL	
eme WNL	Heme WNL	
Aller WNL	Aller WNL	Assessment
Injection Documentation		Plan:

REVIEWED AUG 25 1998 WCA

DIAGNOSIS DATE

(St. Ex. 46 at 22) (Note: Blank areas and the page number were cropped for space considerations, and patient identifying information was redacted.)

Referring to page 22 of the patient record for Patient 46, reproduced above, Ms. Adamson testified that that is the generic form of progress note used in Dr. Adamson's office. Ms. Adamson testified that this form was used for something for which "we didn't have a specific treatment plan established." There are two columns on the left side of the page labeled "ROS" [review of symptoms], for recording the patient's history; and PE, for recording the physical examination. Ms. Adamson testified that the ROS and PE information was usually recorded by the provider who saw the patient. Ms. Adamson testified that the handwriting in the bottom left of the page was that of Anna Ray, Dr. Adamson's referral specialist. Ms. Adamson testified that the bulk of the writing in the column labeled "HPI [history of present illness] (location quality, severity, duration, timing, context, modifying factors)" was hers. (St. Ex. 46 at 22; Tr. at 152-155)

106.

sick again

PROGRESS NOTE Cough/URI						
PATIENT		GE 8	HT	WT	SMOKER	NON-SMOKER
CHIEF COMPLAINT URI	1 x 2 w	TEMP 99	B/P	HR	RR	
DURATION OF SYMPTOMS	<1 1	2 3	4 5	6 7	1 - 2 weeks	> 2 weeks
OTC RX	Advil	Robitussin	Tylenol	Sudafed	TheraFlu	Sx upset Chills
Cough	productive	nonproductive	yellow sputum	wheezing	PND	
Nose & Sinus symptoms	clear rhinorrhea	yellow snot	nasal congestion	facial pain	headache	
Throat symptoms	sore throat	hard to swallow	swollen glands	PND	hoarseness	lost voice
Other symptoms	fever > 101	myalgias	fatigue	chills	earache L R	nausea & vomiting
Past History	sinusitis	bronchitis	strep throat	pneumonia	mono	otitis media
PHYSICAL EXAM General	NAD	febrile	appears ill	labored resp.	appears dry	
Skin	no rash	sandpaper rash	rash			
Ears	normal TM's	effusion L R	red L R	bulging L R	wax L R	
Nose	normal	red mucosa	purulent rhinorrhea	clear rhinorrhea	enlarged turbinates	pale mucosa
Throat	normal	injected	enlarged tonsils	exudates	ulceration	yellow PND
Neck	normal	AC nodes	PC nodes	tender	sinus tenderness	
Lungs	clear	decreased BS	rhonchi anteriorly	wheezing	rales LUL LLL	rales RUL RML RLL
ASSESSMENT	Viral URI	Bronchitis	Otitis Media	Sinusitis	Strep Pharyngitis	Viral Pharyngitis
	Pneumonia	Influenza	Allergies	Mono	Asthma	COPD
PLAN	Throat Culture	CXR	Sinus XR	Sputum Culture	CBC	Monospot
OTC Rx	tylenol	advil	aleve	robitussin DM	sudafed	benadryl
Rx meds	amoxil 250	amoxil 500	Z pak	entex LA	humibid DM	humibid LA
	codiclear DH	bactrim DS	cechlor	cefzil	ceftin	claritin
	albuterol MDI	albuterol aerosol	allegra	augmentin	cipro	claritin D
DIAGNOSIS		URI		DATE	2-24-99	

(St. Ex. 46 at 20) (Note: Blank areas and the page number were cropped for space considerations, and patient identifying information was redacted.)

On page 20 of the patient record for Patient 46, in the area where medications are listed, the pre-printed word "Entex" is circled along with a handwritten "LA." Ms. Adamson testified that that was the prescription that was issued to the patient. (St. Ex. 46 at 20; Tr. at 163-165)

107.

Patient:		Phone #	URGENT	PLEASE CALL	FYI
Caller:					
MESSAGE FOR	WCA RRH	MW KT	DG AR		
	All: NLA				
medication question					
? If needs seen					
		Need decongestant, already			
billing question		taking antibiotic			
referral question					
medication refill request					
medication					
dosage		Entex LA #20		1 BID	
pharmacy					
pharmacy #			VOW CA/RRH		
Rx: called written	Drug Emp Macland			Message taken	
Pharmacist				By	
By				Date	
date time	888-0240			Time	
TELEPHONE MESSAGE					

(St. Ex. 46 at 16) (Note: Blank areas and the page number were cropped for space considerations, and patient identifying information was redacted.)

Ms. Adamson testified that page 16 of the patient record for Patient 46 is a telephone message form. In the bottom left of that page is a check mark and the handwritten word "done." Ms. Adamson testified that that indicates that a prescription for Entex LA #20 had been called in to a pharmacy. (St. Ex. 46 at 16; Tr. at 165-167)

108.

fatigue - diarrhea & N&V x1d - myalgias

Progress Note Generic								
Patient				Age 23	HT 6'0"	WT 181	Smoker	Nonsmoker
Chief Complaint sick 3 days				Temp 97.5	BP 120/74	HR 76	RR 16	
ROS	PE	HPI (location, quality, severity, duration, timing, context, modifying factors)						
gen WNL	gen WNL	onset	saturday,	fatigue,	nausea	V/D on	Sunday.	
eyes WNL	eyes WNL	fever to (?).	fluids	improv.	better c̄ lyte		dam.	
NT WNL	ENT WNL	lose hair in day.	work	4-hrs				
COR WNL	COR WNL							
Resp WNL	Resp WNL							
GI WNL	GI WNL	PMHx, Fam Hx & Social Hx updated on chart form						
GU WNL	GU WNL	Positive ROS responses and Abnormal Physical findings						
MS WNL	MS WNL							
Skin WNL	Skin WNL							
Neur WNL	Neur WNL							
Psych WNL	Psych WNL							
Endo WNL	Endo WNL							
eme WNL	Heme WNL							
Aller WNL	Aller WNL	Assessment	VIRAL GASTROENTERITIS					
			NO RED FLAGS FOR FOOD BORNE ILLNESS					
Injection Documentation		Plan:	Flu i blood, Pur, etc					
			Hydrate					
DIAGNOSIS		VIRAL	GASTROENTERITIS			DATE		

(St. Ex. 46 at 23) (Note: Blank areas and the page number were cropped for space considerations, and patient identifying information was redacted.)

Referring to page 23 of the patient record for Patient 46, Ms. Adamson testified that the handwriting in the column labeled "HPI (location quality, severity, duration, timing, context, modifying factors)" was Dr. Adamson's. Ms. Adamson further testified that the mark above the date at the bottom right of the page is Dr. Adamson's initial "A." Ms. Adamson testified that that initial signifies "[t]hat [Dr. Adamson] wrote this, that he saw this patient." Conversely, Ms. Adamson testified that the initial "A" on a chart has the same significance as the "REVIEWED" stamp. Ms. Adamson testified that there is no date with the "A," so the "A" gives no indication when the chart was reviewed. (St. Ex. 46 at 23; Tr. at 159-160)

Ms. Adamson later testified that Dr. Adamson's initial "A" being written on an entry does not necessarily mean that Dr. Adamson saw the patient for that visit, nor does it necessarily mean that Ms. Adamson spoke to Dr. Adamson and showed him the chart prior to initiating treatment for the patient. (Tr. at 505)

109. Dr. Adamson testified that he developed most of the progress notes that were used in his office, but that some of them were developed by Dr. Ghiloni. Dr. Adamson further testified that he had intended them to be used by all of the providers, including the physician assistants. However, Dr. Adamson acknowledged that no provision had been made on those forms for recording the date and time of treatment or for the supervising physician's initials. (Tr. at 1348-1350)

Individual Patient Records

Note: Evidence adduced at hearing identified patients based on Master Patient Key numbers. These numbers are identical to the Patient Key used for Dr. Adamson's notice letter with the exception of Patients 1 and 2, which were reversed on Dr. Adamson's Patient Key. The numbers on the Master Patient Key differ substantially from the Patient Key used for Ms. Adamson's notice. Therefore, Patients are identified below first by the Master Patient Key Number, which is underlined, then by Dr. Adamson's Patient Key for Patients 1 and 2 only, in parentheses, followed by Ms. Adamson's Patient Key, in parentheses, if the patient is relevant to Ms. Adamson's notice.

Patient 1 (Dr. Adamson Patient 2)

July 30, 1999

110. On July 30, 1999, Patient 1 was seen for a well-woman examination. The initials "RRH" are circled at the top of the progress note for that visit. The diagnosis indicates, among other things, "infertility." The plan indicates that Patient 1 was referred to a fertility specialist. No time was recorded for that referral. Aside from a "REVIEWED" stamp dated July 30, 1999, there is no indication that Dr. Adamson, or any other physician, signed or initialed the order for the referral. (St. Ex. 1 at 33)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1306-1309)

Patient 2 (Dr. Adamson Patient 1)

March 6, 2000

111. On March 6, 2000, a telephone message from the patient's mother was taken. The message indicates that the child had been suspended from school on two occasions, and that the mother wanted Patient 2's medication increased. The form states, "Ritalin SR 1½ BID." It further states that, if the patient does not improve, he will be switched to Adderall. In addition, counseling was recommended. The initials "VOWCA/RRH" appear on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 2 at 49)

Patient 3

January 20, 1998

112. On January 20, 1998, Patient 3 was seen for a diagnosis of uncontrolled hypertension. A prescription for Norvasc 5 mg #30 with refills for one year was written or called in for Patient 3. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 3 at 301a)

February 24, 1998

113. A telephone message form dated February 24, 1998, indicates that a prescription for Trazodone 100 mg #30 with refills for one year was called in for Patient 3. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 3 at 299)

March 23, 1998

114. On March 23, 1998, Patient 3 was seen for hypothyroid and elevated lipids. The plan states that Patient 3 was to return in one month, "fasting for TSH, LFTs, lipid profile." Synthroid was increased and prescriptions were written or called in for Synthroid 0.125 mg #30 with refills for one year, and Pravachol 20 mg with refills for one year. "VOWCA/RRH" is written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 3 at 298)

January 15, 1999

115. On January 15, 1999, a pharmacist called Dr. Adamson's office concerning Patient 3. A prescription for Accupril 40 mg #60 with refills for one year was called in. The initials "NK" are written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 3 at 283a)

    Dr. Adamson was out of the state on January 15, 1999. (St. Ex. 83B; Tr. at 1306)

March 10, 1999

116. On March 10, 1999, Patient 3 was seen for a chief complaint of dehydration and morning vomiting. The plan states, "CBC, Basic Met[,] UGI, RUQ US." "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated March 25, 1999, is present. There is no physician signature. (St. Ex. 3 at 280)

March 15, 1999

117. On March 15, 1999, a message was left for Ms. Adamson that indicated that Patient 3 had been vomiting every day. The telephone message form indicates that Patient 3's x-ray needed to be moved from April 9 to "ASAP," or referred to a gastroenterologist. "VOWCA/RRH" is written on the note. A "REVIEWED" stamp dated March 23, 1999, is present. There is no physician signature. (St. Ex. 3 at 276)

March 23, 1999

118. On March 23, 1999, a message was left for Ms. Adamson that Patient 3 keeps vomiting and not eating. The telephone message form indicates that an appointment with a

gastroenterologist had been scheduled for Thursday afternoon, and that Patient 3 was "advised ok to go to ER." "VOWCA/RRH" is written on the form. A "REVIEWED" stamp dated March 25, 1999, is present. There is no physician signature. (St. Ex. 3 at 275a)

July 30, 1999

119. On July 30, 1999, Patient 3 was seen for a diagnosis of dehydration. The plan indicates that her potassium supplement was changed to twice per day. The initials "MB-PAS" are written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 3 at 252)

Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

August 27, 1999

120. On August 27, 1999, prescriptions were called in for Synthroid 0.15 #30, and Peri-Colace #30, both with refills for one year. In addition, a note indicates "needs TSH." The initials "RRH" are written on the form. Two "REVIEWED" stamps, one dated August 31, 1999, and the other dated September 8, 1999, are present. There is no physician signature on the note. (St. Ex. 3 at 246)

November 23, 1999

121. On November 23, 1999, a telephone message was left by or on behalf of Patient 3. The message form indicates that a prescription for Garamycin ointment 3.5 gm was called in for the patient. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 3 at 231)

April 24, 2000

122. On April 24, 2000, a telephone message was left by or on behalf of Patient 3, requesting an order for home physical therapy. A note stating "OK PT" followed by the initials "RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 3 at 212)

<u>Patient 4</u>

February 16, 1999

123. On February 16, 1999, Patient 4 was seen for flu symptoms of two months duration. The plan called for "CBC, mono spot, LFTs, GGT, Basic Met, H. Pylori, chol, U/A, [and] Throat culture." "VOWCA/RRH" is written on the progress note. A reviewed stamp dated February 18, 1999, is present. There is no physician signature. (St. Ex. 4 at 42a)

May 27, 1999

124. On May 27, 1999, Patient 4 was seen for stomach pain. A diagnosis of GERD was indicated on the progress note. A prescription for Axid 150 mg was called in. Further, the plan states that Patient 4 should be re-checked in two weeks if not better, and "consider h2 blocker or adding Propulsid." The name, "Jamie Price PA-C" is written on the progress note. No time is recorded. A "REVIEWED" stamp dated June 2, 1999, is present. There is no physician signature. Further, there is no indication that any physician other than Dr. Adamson had been the supervising physician. (St. Ex. 4 at 39)

    Both Dr. Adamson and Ms. Adamson were out of state on May 27, 1999. (St. Ex. 83B; Tr. at 1306)

125. Dr. Adamson testified that, when both he and Ms. Adamson had been away on a trip to the Virgin Islands, Dr. Tweel had covered for Dr. Adamson, and Jamie Price, P.A., saw patients at Dr. Adamson's office under Dr. Tweel's supervision. (Tr. at 1977-1979)

<u>Patient 5</u> (Ms. Adamson Patient 1)

July 30, 1999

126. Patient 5 was seen on July 30, 1999, for a chief complaint of "Rash on arms & face." Ms. Adamson testified that she had seen the patient that day. On the progress note for that visit, Ms. Adamson noted "Tinea versicolor" in the diagnosis section. Further, a prescription for "Ketoconazole 200 mg #7 qd 0 ref" was called in to a pharmacy on that day. The time of this order is not recorded on the progress note. "VOWCA/RRH," is written on the note. A "REVIEWED" stamp dated July 30, 1999, appears on the note. There is no physician signature. (St. Ex. 5 at 27 and 46; Tr. at 195-199)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

127. Ms. Adamson testified that she had not considered Patient 5's tinea versicolor to be a new condition on July 30, 1999. Ms. Adamson testified that, after taking the patient's history and examining her rash, Ms. Adamson had "flipped back through her chart and saw that she had been treated for the same rash on 5-18-98" with Nizoral (ketoconazole). Ms. Adamson testified that she had also seen the patient on May 15, 1998. Finally, Ms. Adamson testified that she repeated Patient 5's medication per "Dr. Adamson's order on 5-18-98." (St. Ex. 5 at 27 and 36; Tr. at 195-199, 1850-1852)

    Ms. Adamson testified that tinea versicolor is a fungal skin infection that can sometimes last "a lifetime." Moreover, Ms. Adamson testified that, on July 30, 1999, she did not consider Patient 5's rash to be a new condition, "[b]ecause tinea versicolor is a chronic condition that you often see early in the summer when people tan, and you treat them to

help alleviate their symptoms, but it's very difficult to eradicate." Ms. Adamson further testified that a Caucasian patient generally becomes aware that he or she has tinea versicolor because the areas of infection do not tan where there is enough of the fungus in the skin. Ms. Adamson testified that, accordingly, in Ohio, it tends to be seasonal. Moreover, Ms. Adamson testified that a person can have tinea versicolor without being aware of it. (St. Ex. 5 at 27 and 36; Tr. at 195-199, 1850-1852)

Ms. Adamson testified that she did not believe tinea versicolor to be a new condition for Patient 5 on July 30, 1999, even though there is no record of Patient 5 having been treated for tinea versicolor at anytime during the preceding fourteen months. Moreover, Ms. Adamson testified that she would not have considered tinea versicolor to be a new condition for Patient 5 if Patient 5 had had that condition at any time during Patient 5's life. (Tr. at 197-198)

128. Ms. Adamson testified that the prescription called in for Patient 5 on July 30, 1999, had been authorized by Dr. Adamson's "specific order on this patient." Ms. Adamson further testified that, during Patient 5's previous visit on May 18, 1998, Dr. Adamson and Ms. Adamson would have had a discussion concerning how to treat Patient 5. Accordingly, Ms. Adamson testified that the "VOWCA/RRH" notation on the July 30, 1999, progress note had referenced her May 18, 1998, discussion with Dr. Adamson. (St. Ex. 5 at 27; Tr. at 199-201)

129. With regard to the "REVIEWED" stamp, dated July 30, 1999, Ms. Adamson testified that Dr. Adamson did not review that record on that day. (St. Ex. 5 at 27; Tr. at 201-202)

130. Dr. Adamson testified that he does not believe that Patient 5 had needed to be seen by a physician prior to the commencement of treatment on July 30, 1999. Dr. Adamson testified that Patient 5 had been previously diagnosed with tinea versicolor on May 18, 1998, "and this is a follow-up visit for a chronic benign condition." Dr. Adamson further testified that tinea versicolor is difficult to eradicate, and that he has seen patients return three or four years after an initial treatment for a relapse of the problem. (St. Ex. 5 at 27 and 36; Tr. at 691-696)

Moreover, Dr. Adamson testified that the prescription for ketoconazole that was called in for the patient on July 30, 1999, had been issued "pursuant to a specific authorization on the treatment plan that I had ordered for this patient on [May 18, 1998]." Dr. Adamson further testified that, on May 18, 1998, he had told Ms. Adamson to treat the patient with Nizoral on that date "and repeat it as many times as necessary" until there was no evidence of the disease. Finally, Dr. Adamson testified that that order had not been recorded in the patient chart, but was given verbally to Ms. Adamson. (St. Ex. 5 at 27 and 36; Tr. at 691-696)

Dr. Adamson acknowledged that Patient 5 had not been seen by his office for tinea versicolor between May 18, 1998, and July 30, 1999. (St. Ex. 5; Tr. at 696)

131. The medical record indicates that on May 18, 1998, Patient 5 was diagnosed with laryngitis and tinea versicolor. At that time, she was treated with "Nizoral 200 mg #2 [ii] po stat." The progress note indicates that the patient's chief complaint had been "sore throat." There is no indication on that note concerning where the tinea versicolor had manifested. In fact, the physical examination section of the note indicates "no rash" on the skin. However, the diagnoses listed were laryngitis and tinea versicolor. (St. Ex. 5 at 36)

132. Dr. Gardner testified that, in her opinion, Patient 5 presented with a new condition on July 30, 1999. Moreover, Dr. Gardner testified that treatment with the prescription medication ketoconazole was initiated. Dr. Gardner testified that, previous to that date, a rash had not been mentioned in the patient record. (Tr. at 991-992)

133. Dr. Borg offered no testimony or opinion concerning Patient 5 or any other patient. (Resp. Ex. P; Tr. at 2119-2178)

<u>Patient 6</u> (Ms. Adamson Patient 2)

July 30, 1999

134. Patient 6 visited Dr. Adamson's office on July 30, 1999, for a physical examination. In the "Synopsis" section of the page, it states, among other things, "scored moderate for anxiety disorder"; "Zoloft 50 mg x 1 month samples"; and "return one month for re-eval anxiety." The initials "MB-PAS" are written on the physical examination form. There is no "REVIEWED" stamp or physician signature present. (St. Ex. 6 at 21a-b)

    Ms. Adamson testified that "MB-PAS" stands for "Marsha Bendle, PA Student." Ms. Adamson further testified she was with Ms. Bendle during this visit, and that Ms. Bendle "was learning under" Ms. Adamson. Ms. Adamson testified that Patient 6 was not seen by Dr. Adamson that day. (St. Ex. 6 at 21a; Tr. at 204, 207-209)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

135. Patient 6 was seen again on August 31, 1999, and received a prescription for Zoloft 50 mg #30 with five refills. The diagnosis states, among other things, "anxiety." (St. Ex. 6 at 17)

136. Ms. Adamson testified that Patient 6 had been scheduled for an adult well check on July 30, 1999. During the visit, he had complained of anxiety, indicated that he and his wife were going through marriage counseling, and stated that his wife was being treated for depression. Ms. Adamson testified that she had given Patient 6 "a patient self-evaluation form for anxiety disorder, which Dr. Adamson ordered us to do if patients had anxiety symptoms. And if they scored moderate or above, then they were to be started on an SSRI [selective serotonin reuptake inhibitor] and referred for counseling." [Note, however, that

there is no indication on the progress note for July 30, 1999, that Ms. Adamson referred Patient 6 to counseling] (St. Ex. 21a-22; Tr. at 204-206)

Ms. Adamson testified that she had reviewed the completed self-evaluation and, based on the result, gave Patient 6 a sample "starter pack" of medication. Moreover, Ms. Adamson testified she based this action on Dr. Adamson's general authorization concerning patients who suffered from anxiety. Ms. Adamson acknowledged that there had been no specific authorization from Dr. Adamson on July 30, 1999, to give Patient 6 a starter pack of Zoloft. (St. Ex. 6 at 21a and 21b; Tr. at 207-208)

137. Ms. Adamson testified concerning the issue of whether anxiety had been a new condition for Patient 6 on July 30, 1999. Ms. Adamson testified that "[t]he patient had new symptoms." Ms. Adamson further testified that she had "[m]ade an assessment of anxiety disorder." However, Ms. Adamson testified that the actual diagnosis was not made until Patient 6 returned one month later and had improved on the medication. Ms. Adamson concluded that, on July 30, 1999, the patient did not have a new condition, but "had symptoms of something. * * * Anxiety is a symptom." (Tr. at 209-210)

138. Dr. Adamson testified concerning the treatment of Patient 6 on July 30, 1999. Dr. Adamson testified that Patient 6 had not been personally evaluated by a physician prior to treatment being rendered on that date. However, Dr. Adamson further testified that he does not believe that the patient had presented with a new condition. Accordingly, Dr. Adamson testified that he does not believe that the patient needed to be personally evaluated by a physician prior to treatment being rendered. (St. Ex. 6 at 21a; Tr. at 697)

Dr. Adamson further testified as follows:

> The patient presented to the office on that date for a physical examination. He had called in earlier and arrangements were made for this exam. Within the course of the physical exam, he brought up his symptoms of anxiety.
>
> These were symptoms that we were very aware of. From his first visit with me, he noted his history of drug and alcohol use[.] * * *
>
> This patient's spouse was an employee at Focus Healthcare and she and I spoke about his care many times. She was also a patient in the office. And he had ongoing problems with anxiety, problems with marital counseling, and there are references to that in the chart of his wife.
>
> So I was aware—I was aware of his symptoms, but we did not have a diagnosis, so the patient completed a self-assessment questionnaire. It's not a diagnostic questionnaire. It's purely a self-assessment to try to see if the level of symptoms and dysfunction that the patient is having would warrant a trial of treatment to try to confirm what the diagnosis is.

> Frequently, you may hear people talk about medicine being an art as well as a science, that you make an assessment and you go with a trial treatment to see if it works and that's your confirmation if you are on the right track or not.
>
> So when we instituted these patient self-evaluation forms in the office, it's something that Robin and I talked about and decided to use just because it's good quality patient care to get this patient to document what their symptoms are.
>
> For patients who scored moderate or above for anxiety disorder, they would be given a trial of medication and then followed-up to see if we can make a firm diagnosis on what the condition might be at that point, or if it doesn't work, refer them on or consider whatever other evaluation might be necessary.

(St. Ex. 6 at 21a-22; Tr. at 697-699)

139. Dr. Adamson testified that Ms. Adamson had given Patient 6 a one-month trial sample of Zoloft based upon Dr. Adamson's "specific authorization related to" the self-assessment form completed by Patient 6. Dr. Adamson further testified that this authorization is not reflected in the medical record. (St. Ex. 6 at 22; Tr. at 700-701)

140. Dr. Adamson testified that there is no indication on the progress note for July 30, 1999, that he had reviewed that record. (St. Ex. 6 at 21a; Tr. at 701)

141. Dr. Gardner testified that, in her opinion, Patient 6 presented with a new condition on July 30, 1999. Dr. Gardner further testified that the patient was treated for anxiety on that date with Zoloft, a prescription medication. (Tr. at 993-996)

<u>Patient 7</u> (Ms. Adamson Patient 3)

October 30, 1998

142. Ms. Adamson testified that she saw Patient 7 on October 30, 1998. Two progress notes were generated for that visit. The first progress note for that visit, which is labeled "Generic," indicates the patient's chief complaint had been "(1) [Left] heel painful in a.m. (2) fluid on knee." Diagnoses of onychomycosis and left plantar fasciitis were recorded. Prescriptions were issued for Lamisil 250 mg #30 with one refill, and Naprosyn 500 mg #60. "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 7 at 40 and 41; Tr. at 210-212)

    The second progress note for that visit is labeled "Cough/URI," and indicates for the patient's chief complaint, "onset 1 week." The diagnosis states "Bronchitis[.]" Moreover, "Amoxil 500" is circled, and the handwritten note, "TID #30" appears next to it.

Ms. Adamson acknowledged that amoxicillin was prescribed for the patient. No "REVIEWED" stamp or physician signature is present. (St. Ex. 7 at 41; Tr. at 210-212)

Ms. Adamson testified that the patient had presented with "[l]eft heel pain in the morning, fluid on the knee, and cough and nasal congestion." Ms. Adamson further testified that there is no indication that Dr. Adamson had reviewed the chart, but stated that she "probably called him on this patient because there were multiple issues." Ms. Adamson further stated that she would have discussed the prescriptions for Lamisil and Naprosyn with Dr. Adamson. Finally, Ms. Adamson testified that she believed that Dr. Adamson had been in the office that day. (St. Ex. 7 at 40 and 41; Tr. at 212-214)

Ms. Adamson testified that "VOWCA/RRH" appears on the chart for that day and indicates that Dr. Adamson had been the physician supervising her. (St. Ex. 7 at 40 and 41; Tr. at 215-216)

143. Dr. Adamson testified that, prior to treatment being rendered on October 30, 1998, it had not been necessary that Patient 7 be personally evaluated by a physician. Dr. Adamson testified that Patient 7 had presented with bronchitis, which is "a self-limiting upper respiratory infection that will resolve without treatment or with a straightforward treatment that most patients would recognize, so I don't consider that to be a new condition or require physician involvement." (St. Ex. 7 at 41; Tr. at 722-723)

Dr. Adamson testified that Patient 7 had previously been seen for episodes of bronchitis and upper respiratory infections. Dr. Adamson referred to an April 23, 1997, diagnosis of "viral syndrome." The chief complaint for that visit had been "stomach ache, myalgias, headache, tinnitus, no vomiting, no diarrhea, no sore throat." The physical examination indicates that the head, eyes, ears, nose, throat, and lungs were all clear at that time. Dr. Adamson testified that, nevertheless, viruses are very nonspecific and can cause a variety of maladies, and affect different people different ways. (St. Ex. 7 at 42a; Tr. at 723-724)

Dr. Adamson testified that Patient 7 had also had bronchitis when he was seen on July 9, 1996. The chief complaint for that visit was cough, head congestion, clogged sinuses. The progress notes state that the patient had a cough. The patient's oral temperature was 98.4 degrees. The diagnosis was "sinusitis." The term, "bronchitis" is not charted on the progress note. However, Dr. Adamson testified:

> [T]he treatment plan is my writing at the bottom and with his complaints and the cough being his predominant symptom, cough is not the main symptom of sinus infections. You can have a secondary cough to a sinus infection, but it's usually not the number one reason that a patient comes in, and that was the very first thing that he mentioned on his chief complaint.

> In addition, the antibiotic I chose for him on 7/9/96 on that page was Biaxin, and while Biaxin can be used to treat both sinusitis and bronchitis, in my practice I choose to use Biaxin primarily to treat bronchitis.
>
> And the second medication that he was given on that date is Duratuss, which is a cough medicine. So the diagnosis at the bottom is sinusitis, which is correct, but he also had bronchitis as well, which is not charted.

(St. Ex. 7 at 46a; Tr. at 723-725) Dr. Adamson was asked why, if he had prescribed Biaxin in the past for this patient's bronchitis, it would still be within his authorization to have Amoxil called in for the patient's bronchitis on October 30, 1998. Dr. Adamson replied that he had been in the office all that day and had personally authorized the prescription for Amoxil. Dr. Adamson further testified that another prescription that the patient had received that day, Lamisil tablets, was a medication that he and Ms. Adamson would have discussed prior to prescribing it for a non-diabetic patient. Moreover, Dr. Adamson testified that "VOWCA/RRH" appears on the first page of the progress note for that visit. Therefore, Dr. Adamson testified that he had given "a specific verbal order for these medications on that date." (St. Ex. 7 at 40-41; Tr. at 726-728)

144. Dr. Adamson testified that he could not recall if he had personally seen and evaluated the patient on October 30, 1998. Dr. Adamson further testified that there is no notation in the medical record to indicate that he had. (St. Ex. 7 at 40-41; Tr. at 728-731)

145. Dr. Gardner testified that, in her opinion, Patient 7 presented with a new condition on October 30, 1998. Dr. Gardner testified that the patient was treated with amoxicillin for bronchitis. Moreover, Dr. Gardner testified that bronchitis had not been documented previously in the medical record for Patient 7. (St. Ex. 7; Tr. at 999-1000)

146. Patient 7 testified that he had been a patient at Apple Health, and that Dr. Adamson had been his physician. Patient 7 further testified that he had been a patient there for approximately three or four years. Patient 7 testified that, on one occasion, he had seen Ms. Adamson for a complaint of water on the knee and a sinus infection or flu symptoms. Patient 7 further testified that he received a sample of antibiotics that day and a written prescription for an anti-inflammatory. Finally, Patient 7 testified that he does not believe that Dr. Adamson came into the room during that visit. (Tr. at 1527-1530)

    Ms. Adamson testified that Amoxil does not come in samples. (Tr. at 1854-1855)

October 5, 1999

147. On October 5, 1999, Patient 7 was seen for a chief complaint of history of depression. The diagnosis indicates, "depression." Patient 7 was given a five-week supply of samples of Zoloft 50 mg, and told to follow up in one month. The initials "MB-PA" are written on the

progress note. A "REVIEWED" stamp dated October 7, 1999, appears on the progress note for that visit. No physician signature is present. (St. Ex. 7 at 28)

Patient 8 (Ms. Adamson Patient 4)

November 20, 1998

148. Patient 8 visited Dr. Adamson's office on November 20, 1998. The chief complaint was, "Yesterday went to Fairfield Medical Center—diagnosed viral meningitis." In the diagnosis section of the note, Ms. Adamson wrote "viral meningitis" and "C-strain." The plan included "flexeril #15" and over-the-counter Excedrin. The initials "RRH" are written on the progress note. A "REVIEWED" stamp dated November 20, 1998, is present. (St. Ex. 8 at 30a; Tr. at 217-220)

149. Ms. Adamson testified that she specifically recalls speaking to Dr. Adamson about this patient. Ms. Adamson testified that she and a student went to Dr. Adamson's office "and had a powwow about what to do with her, because this is not something that you see every day in family practice." Ms. Adamson testified that she could not recall if Dr. Adamson went in to see the patient. (Tr. at 219-221)

    Ms. Adamson testified that she did not believe viral meningitis and C-strain to have been new conditions for Patient 8 because Patient 8 "had been evaluated [for viral meningitis] at the emergency room at Fairfield Medical Center." Ms. Adamson further testified that the C-strain had been secondary to viral meningitis. Moreover, Ms. Adamson testified that the emergency room had contacted Dr. Adamson and Dr. Adamson had been made aware of the patient's condition. (Tr. at 221-222)

    Ms. Adamson acknowledged that there was nothing in the medical record indicating that the patient had been seen previously for that condition. Ms. Adamson further testified that she had viewed Dr. Adamson's verbal order and signing of the prescription for Flexeril to have been Dr. Adamson's authorization for what she had done with the patient. Finally, Ms. Adamson testified that the "REVIEWED" stamp identified the physician under whose authorization she had written the order. (St. Ex. 8 at 30a and 30b; Tr. at 222-223)

150. Dr. Adamson testified that he does not believe that Patient 8 had presented with a new condition on November 20, 1998. Dr. Adamson further testified that he does not believe that Patient 8 needed to be personally evaluated by a physician prior to being treated on that date, because the patient had come into Dr. Adamson's office as a follow up for an emergency room visit at Fairfield Medical Center. (St. Ex. 8 at 30a; Tr. at 737-738)

    Dr. Adamson testified that he "specifically recall[s] speaking to the emergency room physician" although he acknowledged that that conversation was not charted in the medical record. Dr. Adamson further testified that he recalls having been told by the emergency

room physician of Patient 8's diagnosis and that the diagnosis had been based upon results from a spinal tap. (Tr. at 738-739)

Dr. Adamson testified that the findings of the emergency room physician are documented on the progress note for the November 20, 1998, visit, where it states, "'FMC spinal tap WBC 15,000.'" Dr. Adamson testified that that the information included on the progress note concerning Patient 8's emergency room visit had probably been a combination of information obtained from the patient during that visit and information obtained by Dr. Adamson from his conversation with the emergency room physician. (St. Ex. 8 at 30a; Tr. at 740-743)

Dr. Adamson testified that he did not perform a physical examination of Patient 8 on November 20, 1998, although he "personally evaluated all the patient's information and their care in the emergency room the night before." Dr. Adamson further testified that no other physician in his office evaluated Patient 8 on November 20, 1998. (Tr. at 743-745)

151. Dr. Gardner testified that, in her opinion, Patient 8 presented with and was treated for a new condition of viral meningitis on November 20, 1998. Moreover, Dr. Gardner testified that nothing in the medical record for Patient 8 indicated that she had had that condition previously. (St. Ex. 8; Tr. at 1003-1006)

September 10, 1999

152. On September 10, 1999, Patient 8 was seen for a chief complaint of injury and pain in her right ankle. The patient history indicated that Patient 8 had "turned [right] ankle over while walking—lateral aspect." The physical examination was positive for "swelling & tenderness lateral maleolus [sic]." The diagnosis stated "ankle injury." The plan indicates that Patient 8 was pregnant and should take Tylenol for pain. It further states "ice, elevation, [and] exercises to strengthen ankle." Moreover, the patient was referred for x-rays. The initials "MB-PA" are written on the progress note. A "REVIEWED" stamp dated September 10, 1998, is present. (St. Ex. 8 at 25)

153. Dr. Adamson testified that he does not believe that Patient 8 had needed to be personally evaluated by a physician prior to treatment on September 10, 1999. Dr. Adamson further testified that that is because he had previously seen Patient 8 for an injury to her right ankle on November 6, 1996. Moreover, Dr. Adamson testified that, in September 1999, the patient had turned her ankle while simply walking. Dr. Adamson testified that this is indicative of a weakened ankle from her previous injury. Therefore, Dr. Adamson stated that he does not consider the September 10, 1999, injury to be a new condition, or one that required a physical examination. (St. Ex. 8 at 25 and 34a; Tr. at 645-747, 2025-2026)

Dr. Adamson testified that he had been in the office on September 10, 1999, but could not recall if he had personally examined Patient 8 at that time. Dr. Adamson further testified that he had reviewed the chart with Ms. Bendle, and determined that Patient 8 needed to be

x-rayed. Dr. Adamson further testified that his standard care plan for musculoskeletal injuries had been RICE. Dr. Adamson also testified that, since this patient was pregnant, she had been told that if she felt like she needed to take something, she could take Tylenol. (Tr. at 747-753)

154. Dr. Gardner testified that, in her opinion, Patient 8 presented with a new condition of right ankle injury on September 10, 1999. Dr. Gardner noted that Patient 8 had had a previous right ankle injury on November 6, 1996, but that there had been no further mention in the medical record of right ankle injury or pain between November 6, 1996, and September 10, 1999. Accordingly, Dr. Gardner testified that, in her opinion, the earlier ankle injury had resolved, and the September 10, 1999, injury was a new condition. Finally, Dr. Gardner testified that treatment was rendered to Patient 8 on September 10, 1999, in that over-the-counter Tylenol was recommended and an x-ray was ordered. (St. Ex. 8; Tr. at 1008-1010)

December 16, 1999

155. Patient 8 visited Dr. Adamson's office on December 16, 1999. The chief complaint was "pain [right] ear x 1 wk" and "URI [symptoms] x 2 mo." The progress note indicates that the diagnosis was "[right] OM." Ms. Adamson testified that "OM" was an abbreviation for otitis media. Prescriptions for Entex-LA and Ceftin were called in to a pharmacy that day. (St. Ex. 8 at 24 and 37; Tr. at 227)

156. Ms. Adamson testified that she had seen Patient 8 on December 16, 1999. Ms. Adamson further testified that she did not believe that the upper respiratory infection had been a new condition, "because she's had symptoms for two months, and she was 19, and you can't have a cold for two months. Chances are you've had a cold before that. She had just been treated [for] viral meningitis. That's a virus. That's what colds are." Ms. Adamson further testified that the ear infection had not been a new condition "[b]ecause otitis media is what happens to people when they get viral infections. Their Eustachian tube swells up, and they get fluid in there, and their ear gets infected. It's one of the things that's a normal progression from a cold." (Tr. at 225-228)

    Ms. Adamson acknowledged, however, that there was nothing in the medical record that indicated that Patient 8 had previously been treated for an upper respiratory infection. Ms. Adamson further acknowledged that there was nothing in the medical record that indicated that Patient 8 had previously been treated for an ear infection. (St. Ex. 8; Tr. at 225-227)

157. With regard to Patient 8's December 16, 1999, visit, Dr. Adamson testified that he does not believe that Patient 8 had required physician evaluation prior to treatment. Dr. Adamson further testified that "[t]he patient presented with ear pain, which in general reflects a minor self-limiting condition that would get better with a straightforward treatment that most patients would recognize." Moreover, Dr. Adamson testified that, although there was

nothing in the chart indicating that he had seen Patient 8 for an ear infection, "[i]n 15 years of practice, I don't ever recall meeting an adult who had an ear infection who did not have one before." (Tr. at 754-757)

158. Dr. Gardner testified that, in her opinion, Patient 8 presented with a new condition on December 16, 1999, and was treated with prescriptions for Entex and Ceftin on that date. Dr. Gardner further testified that the patient had not previously presented with an ear infection prior to that date. (St. Ex. 8; Tr. at 1010-1012)

Testimony of Patient 8

159. Patient 8 testified that she had been a patient at Apple Health for two or three years. Patient 8 further testified that she had visited that office about four or five times during that period. Moreover, Patient 8 testified that she had never seen Dr. Adamson on any of these occasions. Finally, Patient 8 further testified that she would sometimes see Ms. Adamson; other times she saw "a foreign man and a lady with blonde hair." [Note that, at hearing, Patient 8 was unable to identify either Ms. Adamson or Dr. Adamson as being in the hearing room, although both were present.] (Tr. at 1629-1632)

    Patient 8 testified that when she saw someone other than Dr. Adamson, she was given prescriptions, rather than having prescriptions called in for her. Patient 8 further testified that she could not recall being given samples of medication. (Tr. at 1631)

    Patient 8 testified that, on one occasion, she had been asked by "the lady with blonde hair" if she would like to see Dr. Adamson, because of questions that Patient 8 had about treatment she was receiving. Patient 8 testified that she said yes, "and the nurse went back to get him. She came back into the room and said that he was too busy with other patients and he couldn't come into the room." (Tr. at 1633-1634)

<u>Patient 9</u> (Ms. Adamson Patient 5)

November 9, 1998

160. On November 9, 1998, Patient 9 was seen by Nancy Keeler, P.A., for a chief complaint of laryngitis. The diagnosis indicates "acute sinusitis." The pre-printed names of the medications Sudafed, Robitussin DM, and Amoxil 500 mg are circled on the progress note. The name "N. Keeler PA-C" is written on the note. A "REVIEWED" stamp dated November 9, 1998, is present. (St. Ex. 9 at 52; Tr. at 768-769)

161. Ms. Adamson did not see Patient 9 on November 9, 1998. (St. Ex. 9 at 52; Tr. at 240)

162. Dr. Adamson testified that he does not believe that Patient 9 needed to be personally evaluated by a physician prior to her treatment on November 9, 1998. Dr. Adamson testified that laryngitis is "a self-limiting complaint that will get better with minor or no

treatment." Dr. Adamson further testified that this had been Ms. Keeler's second week in the office, and that Dr. Adamson had been supervising her closely. Dr. Adamson testified that "before she could do anything, she had to come to me for specific orders on what to do for that patient based on her assessment of that patient." (Tr. at 768-769)

Dr. Adamson testified that Patient 9 had not previously been seen for acute sinusitis in his office, but that a past history of sinusitis and bronchitis had been reported by the patient on November 9, 1998. (St. Ex. 9 at 52; Tr. at 770-771)

163. Dr. Adamson testified that he had stamped the progress note, but does not recall if he had seen the patient on November 9, 1998. (Tr. at 769)

May 4, 1999

164. On May 4, 1999, Patient 9 was seen in Dr. Adamson's office for a well woman visit. There is no indication on the progress note which provider had seen the patient, although Ms. Adamson testified that she had seen Patient 9 that day. The plan states that Ortho Cyclin would be prescribed, and that the patient would be re-checked in two weeks. A "REVIEWED" stamp dated May 11, 1999, appears on the chart. There is no physician signature present. (St. Ex. 9 at 46; Tr. at 240-242)

May 18, 1999

165. On May 9, 1999, Patient 9 called Dr. Adamson's office and left a message with the answering service complaining of "severe bleeding and stomach cramping." (St. Ex. 9 at 47)

A telephone message form indicates that Patient 9 called again on May 10, 1999, and left a message that she was "[f]eeling better—not bleeding as bad," and asked, "Do you want me to stay on current med (Birth control)." (St. Ex. 9 at 49)

Ms. Adamson testified that she saw Patient 9 on May 18, 1999, for a well woman exam. The progress note states that Patient 9's last menstrual period had begun April 24, 1999, and that she had bled for 17 days. The diagnosis states "yeast vulvitis." A prescription for Diflucan 150 mg #1 was called in to a pharmacy that day. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated May 18, 1999, is present. (St. Ex. 9 at 45, 46, and 56; Tr. at 240-242)

166. Ms. Adamson testified that the May 18, 1999, visit had been a follow-up to Patient 9's May 4, 1999, visit. Ms. Adamson further testified that the May 4 visit had been a well woman visit that could not be completed because Patient 9 had been on her menses. (St. Ex. 9 at 45, 46, and 56; Tr. at 240-242)

Ms. Adamson further testified that she had discussed Patient 9 with Dr. Adamson on May 4, 1999, who had advised that Patient 9 just needed "'to get adjusted to her birth control pills." (Tr. at 248-249)

Ms. Adamson testified that her assessment of Patient 9's condition on May 18, 1999, had been yeast vulvitis. Ms. Adamson testified that she does not believe yeast vulvitis to have been a new condition for Patient 9. Ms. Adamson testified that Patient 9's yeast vulvitis had resulted from the moisture cause by excessive bleeding, which had been addressed during Patient 9's previous visit on May 4, 1999. (St. Ex. 9 at 45-46; Tr. at 253-254, 256-257)

167. With regard to Patient 9's May 18, 1999, visit, Dr. Adamson testified that he does not believe that the patient had needed to be personally evaluated by a physician prior to treatment. Dr. Adamson testified that, first, the patient had been seen as a follow up to a previous visit in order to have a Pap smear completed; second, the patient had been "found to have a yeast infection, which is an example of a minor self-limiting condition that would get better with simple—with no treatment or simple and straightforward treatment." (St. Ex. 9 at 45; Tr. at 771-773)

    Concerning the prescription called in that day, Dr. Adamson testified that he recalls specifically authorizing that prescription. Dr. Adamson further testified that he recalls personally evaluating the patient's lab specimen. However, Dr. Adamson could not recall if he saw the patient that day. (Tr. at 773-779)

168. Dr. Gardner testified that, in her opinion, Patient 9 had presented with a new condition of yeast vulvitis on May 18, 1999. Dr. Gardner testified that yeast vulvitis had not been mentioned in the medical record previous to that date. Dr. Gardner further testified that treatment by the prescription medication Diflucan was rendered. (St. Ex. 9; Tr. at 1017-1020)

August 18, 1999

169. Patient 9 was seen on August 18, 1999, for a chief complaint of headache. Among other things, it was noted in the patient history that the patient's vision blurs when the headache starts. It was further was noted in the physical examination that Patient 9 had "very edematous turbinates" and a possible polyp on the right side. In the plan section there is a check next to "Headache handout." In the diagnosis section, "allergies" and "chronic multiple HA" were noted. The chart further indicated that samples of Zyrtec and Flonase had been given to the patient, and that she was to be re-checked in two weeks. "VOWCA/RRH" is written on the note, and the "REVIEWED" stamp is dated August 18, 1999. (St. Ex. 9 at 39)

170. Ms. Adamson testified that she had seen Patient 9 on August 18, 1999. Ms. Adamson testified that the patient's history indicated that Patient 9 had been having headaches for four years. Further, Ms. Adamson testified that, on an updated history completed on May 17, 1999, the patient indicated that she had suffered from allergies since 1989.

Accordingly, Ms. Adamson testified that she did not believe Patient 9's headaches had been a new condition on August 18, 1999. Nevertheless, Ms. Adamson acknowledged that Patient 9 had not been treated for headaches in Dr. Adamson's office prior to August 18, 1999. (St. Ex. 9 at 4b, 39, 44; Tr. at 258-263)

Ms. Adamson further testified that she did not believe that Patient 9's blurred vision had been a new condition on August 18, 1999. Ms. Adamson testified that Patient 9 had reported having headaches for four years, and that that her headaches were accompanied by burred vision. Ms. Adamson acknowledged, however, that the first time that "blurred vision" appeared in Patient 9's chart had been August 18, 1999. (Tr. at 261-262)

Ms. Adamson testified that on August 18, 1999, Patient 9 had been given Zyrtec and Flonase "by Dr. Adamson's order." Ms. Adamson testified that she would have discussed the patient's situation with Dr. Adamson because of Ms. Adamson's question whether Patient 9 had a polyp. (Tr. at 263)

171. Dr. Adamson testified with regard to the August 18, 1999, visit, that he does not believe that Patient 9 had needed to be personally evaluated by a physician prior to treatment. Dr. Adamson testified that, on the date of that visit, the patient had reported a four-year history of headaches. Dr. Adamson further testified that she had reported vision disturbances as an associated symptom of those headaches. Dr. Adamson also testified that the patient had a longstanding history of allergies that were causing her headaches. (St. Ex. 9 at 39; Tr. at 775-777)

    Dr. Adamson testified that he could not recall if he had evaluated Patient 9 on August 18, 1999, but that he had stamped the progress note on that date. (Tr. at 776)

172. Dr. Gardner testified that, in her opinion, Patient 9 presented with new conditions of headache and allergies on August 18, 1999. Dr. Gardner further testified that treatment was initiated consisting of Zyrtec and Flonase. (St. Ex. 9; Tr. at 1014-1017)

November 29, 1999

173. On November 29, 1999, Patient 9 was seen for a diagnosis of "BTB." The pre-printed initials "RRH" are circled on the progress note. The plan states, "Start Depo Provera IM Rx x 1 yr." There is no "REVIEWED" stamp or physician signature on the progress note. (St. Ex. 9 at 33a)

Testimony of Patient 9

174. Patient 9 testified that she had been a patient of Dr. Adamson's at Apple Health. Patient 9 further testified that there were occasions when she had seen Ms. Adamson, rather than Dr. Adamson. Moreover, Patient 9 testified that she believes one of these occasions had been in November 1998 when she was suffering from sinusitis. Patient 9 further testified

that Ms. Adamson wrote out a prescription, excused herself and left the room for a moment, then returned and gave Patient 9 the prescription. Finally, Patient 9 testified that Dr. Adamson had not come in and examined her prior to her receiving that prescription. (Tr. at 2180-2182)

Patient 9 testified that on another occasion she had gone to Dr. Adamson's office and told Ms. Adamson that her current birth control medication was causing her to bleed too much. Patient 9 further testified that Ms. Adamson had written her a prescription for a different medication that was supposed to reduce the bleeding. Moreover, Patient 9 testified that Dr. Adamson had not come into the room to examine her. (Tr. at 2183)

Patient 9 testified that, on one occasion, Ms. Adamson had given her samples of birth control medication. (Tr. at 2184)

Patient 9 testified that on one occasion she had gone to Dr. Adamson's office for a headache. Patient 9 stated that Ms. Adamson was the only person she saw that day, and that she had received a prescription for the headache. (Tr. at 2184)

Patient 10

July 30, 1999

175. On July 30, 1999, Patient 10 was seen for epigastric discomfort. A diagnosis of GERD was recorded. The plan states, "CBC, H. pylori, LFTs, Tagamet (has)." "VOWCA/RRH" is written on the form. A "REVIEWED" stamp dated July 30, 1999, appears on the form. No physician signature is present. (St. Ex. 10 at 76a)

Patient 11 (Ms. Adamson Patient 6)

December 9, 1998

176. On December 9, 1998, Patient 11 was seen for a cough and upper respiratory complaints. The progress note indicates that the patient was advised to use over-the-counter Robitussin DM. Further, prescriptions were given for Zestoretic 10/125 #30 with five refills, and Entex LA #20 with one refill. The name "N. Keeler PA-C" is written on the progress note. A "REVIEWED" stamp dated December 11, 1998, is present. No physician signature is present. (St. Ex. 11 at 181)

August 3, 1999

177. Patient 11 was seen by Ms. Adamson on August 3, 1999, for a chief complaint of "[follow up] elbow." The diagnosis was "tenosynovitis." The plan consisted of physical therapy, "note off work x 6 wks[.]" In addition, a prescription for Celebrex 200 mg #60

with one refill was called in, and a sample of Flonase was given to the patient. Finally, the "REVIEWED" stamp is dated August 3, 1999. (St. Ex. 11 at 172b)

Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

178. Ms. Adamson testified that Dr. Adamson had previously seen Patient 11 for tenosynovitis on July 19, 1999, and prescribed Celebrex 200 mg #28. (St. Ex. 11 at 172b and 174; Tr. at 265-266) Whereupon, the following exchange occurred:

Q. (by Ms. Crawford): And referring you to the date of 8-3-99, when this patient was in your office when Dr. Adamson was out of state, is there any indication that on that date he authorized you to give this patient samples of Flonase and to call in a prescription for Celebrex?

A. (By Ms. Adamson): The—the authorization would have been discussed on 7-19-99.

Q. And how do you know that?

A. Because he saw the patient with Marsha and told the patient to follow up because she had tenosynovitis in her elbow.

Q. And what does follow up mean?

A. To come back in.

Q. Is there any indication [on the progress note for July 19, 1999,] that Dr. Adamson said 'Give this patient Celebrex and Flonase when she comes for her follow-up visit'?

A. No.

(Tr. at 266-267)

179. Dr. Adamson testified that, on July 19, 1999, when the patient was seen for arm pain, he had given the patient Celebrex and Allegra. Dr. Adamson further testified that he notified the patient and gave orders to Ms. Adamson that if the Allegra did not work, Patient 11 would be started on Flonase. Dr. Adamson testified that he also informed Patient 11 that if the Celebrex was effective, the prescription would be renewed. (St. Ex. 11 at 174; Tr. at 1473-1475)

Dr. Adamson acknowledged that the progress note for July 19, 1999, does not contain any indication that Ms. Adamson had been involved with the patient that day. (St. Ex. 11 at 174; Tr. at 1475)

October 4, 1999

180. On October 4, 1999, Patient 11 left a message with Dr. Adamson's office that she was on antibiotics but that her ears were still bothering her. A prescription for Augmentin 875 mg was issued. The initials "MB-PA" are written on the message form. A "REVIEWED" stamp dated October 7, 1999, appears on the form. There is no physician signature. (St. Ex. 11 at 170)

Testimony of Patient 11

181. Patient 11 testified that she had been a long-time patient of Dr. Adamson's. Patient 11 testified that she suffers from an uncommon malady called Wallenberg's Syndrome, caused by a lesion on the left side of her brain, that affects her in many ways. Patient 11 testified enthusiastically that she had received excellent medical care from Dr. Adamson and Ms. Adamson. (Tr. at 2186-2203)

    Patient 11 testified that she recalls having received two prescription medications in July 1999. Patient 11 further testified that one was a pain medication for her right arm, and the other was "a real tiny little bottle of Flonase" for her sinus problems. Patient 11 testified that she had seen Ms. Adamson, but not Dr. Adamson, on that occasion. Finally, Patient 11 testified that this had been a follow-up to a visit in which she had seen Dr. Adamson for her right arm pain and her sinuses. (Tr. at 2193-2195, 2201-2203)

    Patient 11 testified that, when she visited Dr. Adamson's office, she had received written prescriptions if Dr. Adamson was there. Patient 11 further testified that, if Dr. Adamson was not there, "they would call it in." (Tr. at 2196-2197)

<u>Patient 12</u> (Ms. Adamson Patient 7)

October 15, 1997

182. On October 15, 1997, Patient 12 was seen for chief complaints of sinuses and flu. The diagnoses listed were nasal congestion and hypertension. The treatment listed is "Zestril 10[.]" An illegible name followed by "RN, NP student" is written on the progress note. There is no indication that a physician assistant had seen the patient. No physician signature or "REVIEWED" stamp is present. (St. Ex. 12 at 57a)

183. Dr. Adamson testified that he had seen Patient 12 on October 15, 1997, along with a nurse practitioner student. Dr. Adamson further testified that he did not believe that he had needed to countersign that entry, because "[t]here's no statute that I'm aware of that requires me to sign my own chart entries." (Tr. at 2014-2015)

July 26, 1999

184. Patient 12 saw Ms. Adamson on July 26, 1999, for a chief complaint of "scraped back." The progress note indicates that Patient 12 was 61 years old, weighed 258 pounds, and had a temperature of 99.6 degrees. The patient history indicated that the patient "fell down [about] 6 steps 8 days ago abrasing back" and "steps were carpeted[.]" The note also indicates that the patient had an eight centimeter by six centimeter infected sebaceous cyst on his left scapula. The diagnosis states, "cellulitis[.]" (St. Ex. 12 at 50; Tr. at 268-273)

    Ms. Adamson performed an incision and drainage of the cyst and took a culture. Following drainage she packed the cyst with one-quarter-inch Iodoform. A prescription for Keflex 500 mg #28 with one refill was called in to a pharmacy that day. "VOWCA/RRH" was written on the progress note. A "REVIEWED" stamp dated July 26, 1999, is present. (St. Ex. 12 at 50; Tr. at 268-273)

    Ms. Adamson testified that Dr. Adamson had been out of town on July 26, 1999, but returned that evening. (Tr. at 268) Nevertheless, Dr. Adamson's testimony at hearing and in his October 26, 2000, deposition indicates that had been in New York City on July 26, 1999, and returned to Columbus the following day. (St. Ex. 83B; Tr. at 1306-1309)

185. Ms. Adamson testified that she had told Dr. Adamson's staff at the front desk that she did not want to see Patient 12 that day, "[b]ut he was adamant, he wanted to be seen. He just wanted somebody to look at his back. He lived by himself, and he was a diabetic, and he felt like his back was irritated, and he wanted someone to see it." Ms. Adamson testified that Patient 12 had called Dr. Adamson's office several times that day. She acknowledged that there is nothing in the patient chart recording such calls, but testified, "I remember it." (Tr. at 268-269)

    Ms. Adamson testified that when she had seen Patient 12's cyst, she believed that he had had it for some time. Ms. Adamson further testified that she did not know at the time whether it was infected, but that Dr. Adamson had instructed her to assume that such a cyst is infected "because you don't want someone having an infected sebaceous cyst. So the idea is you have to get a culture from the inside of the cyst to see if it's really infected." Moreover, Ms. Adamson testified that Patient 12 was diabetic and, as a result, it would have been dangerous to allow an infection to go untreated. Ms. Adamson testified that she did not know at the time if it was infected, and that she needed to obtain a culture to have that determination made. Ms. Adamson testified that she performed an incision and drainage on the cyst by "taking a little blade and nicking it, getting the sebaceous material out of it." Ms. Adamson testified that she took a culture, and that a report concerning that culture was received from a laboratory on July 28, 1999. (St. Ex. 12 at 15 and 50; Tr. at 270-273, 277-278)

    Ms. Adamson testified that, on July 26, 1999, she had not been certain that Patient 12 had cellulitis, but acknowledged that the diagnosis section of the progress note for July 26, 1999,

states "cellulitis[.]" However, Ms. Adamson testified that "[t]hat's my assessment. That's not the diagnosis." Ms. Adamson further testified that the diagnosis section of the progress note served several purposes: "One, you have to come up with some kind of working assessment just to help with chart flow and charting, but it's also a way to bill. You have to bill something. You can't just bill an I and D." Ms. Adamson further testified that "you don't do an incision and drainage on a sebaceous cyst. It doesn't work. They come back." Moreover, Ms. Adamson testified that the incision and drainage had been performed "[t]o obtain the culture to see if it was infected." Finally, Ms. Adamson testified that the patient ultimately did not have an infection. (St. Ex. 12 at 50; Tr. at 273, 277-278, 1848-1850)

186. Ms. Adamson testified that she did not believe that the sebaceous cyst had been a new condition. Ms. Adamson acknowledged that there was nothing in the medical record indicating that Patient 12 had been treated for, or had had, a sebaceous cyst prior to July 26, 1999. (Tr. at 273-274)

187. Ms. Adamson testified that she had had a prescription called in for Patient 12 "per [Dr. Adamson's] standing order, if you have someone with a soft tissue infection, start them with Keflex." Ms. Adamson further testified that this was a global order applicable to any patient with a soft tissue infection. Moreover, Ms. Adamson testified that she had not spoken to Dr. Adamson prior to having the prescription called in, and instead had relied on the standing order. However, Ms. Adamson testified that she talked to Dr. Adamson that night when he returned. (Tr. at 272-273)

188. Patient 12 was seen by Ms. Adamson several times thereafter—on July 27, 29, and 30, and August 2, 4, and 6, 1999—for cleaning and repacking of his wound. The diagnosis on each of the progress notes for these dates states, "cellulitis[.]" On August 9, 1999, Patient 12 was again seen by Ms. Adamson for cleaning and repacking, and the diagnosis section of the progress note states, "healing cellulitis[.]" Subsequently, on August 11, 1999, the patient was seen again by Ms. Adamson, a fistula was found, and he was referred to a surgeon. The patient continued to be seen by Ms. Adamson for wound care on August 13 and 17, 1999. (St. Ex. 40-49; Tr. at 280)

189. Dr. Adamson testified concerning the treatment of Patient 12 on July 26, 1999. Dr. Adamson testified that, prior to treatment being rendered on that date, Patient 12 had not been personally evaluated by a physician. However, Dr. Adamson further testified that he does not believe that the patient had presented with a new condition. Accordingly, Dr. Adamson testified that he does not believe that the patient needed to be personally evaluated by a physician prior to treatment being rendered. (St. Ex. 12 at 50; Tr. at 702-703)

190. Dr. Adamson testified that Ms. Adamson had been authorized to have the prescription for Keflex called in on July 26, 1999, based upon their "standard care plan for patients with reddened sebaceous cysts[.]" Dr. Adamson testified that that standard care plan was to obtain a culture and start the patient on antibiotics pending the results of the culture. Dr. Adamson further testified that Patient 12 was diabetic, which made it particularly

important to start him on antibiotics without delay to prevent the spreading of infection. (Tr. at 703-704)

Dr. Adamson testified that the standard care plan had not been in writing:

> When I say standard care plan, I mean, there are things that you do in the—family practice is the type of practice where you do the same things over and over and over again. And so when I say standard care plan, that's automatically what I would do in that situation and what Robin has been instructed to initiate in that situation.

(Tr. at 704-705)

191. A lab report dated July 28, 1999, indicates that that a light growth of diphtheroids were present in the specimen, and that no sensitivity was performed. Dr. Adamson testified that the wound culture report for the specimen taken on July 26, 1999, had indicated that the cyst was not infected. Dr. Adamson further testified:

> [Y]ou base whether or not infection is present based on your culture results. And a lot of things can grow from culture results. You can grow normal organisms. If we were to culture everyone's skin here, we would find certain types of bacteria that normally inhabit the skin, and you can also find pathogens, which are bugs that cause disease.
>
> So when we do a culture, we're looking for pathogens. We're looking for bacteria that cause disease. And then when we find those, we do further testing, called sensitivity, so we can treat that particular type of infection.
>
> [This test result indicates that] this patient grew diphtheroids from their culture. And that is not a pathogen in the skin; it's normal skin flora. And that's the reason for the lab not—where it says no sensitivity performed, there's no sensitivity, because this is not a pathological organism in that setting. It's not indicative of any disease or any infection.

(St. Ex. 12 at 15; Tr. at 2026-2028) Dr. Adamson testified that he would conclude that the lab report shows that the cyst was not infected. (Tr. at 2028-2029)

192. Dr. Gardner testified that, in her opinion, Patient 12 had presented with a new condition on July 26, 1999. Dr. Gardner further testified that the patient's condition that day had not been previously mentioned in the medical record. Moreover, Dr. Gardner testified that the patient was treated by "incision and drainage of the cellulitis cyst" and with a prescription medication, Keflex. (Tr. at 1020-1023)

Dr. Gardner testified that the new conditions that Patient 12 presented with on July 26, 1999, were cellulitis and an infected cyst. Dr. Gardner further testified that, in making the determination that the cyst was infected, she had relied on the progress note. (St. Ex. 12 at 50; Tr. at 1207)

193. Dr. Gardner testified that the lab report concerning the culture, which states, "'Diphtheroids, light growth, no sensitivity,'" indicates that an infection had been present. (St. Ex. 12 at 15; Tr. at 1209-1210)

July 30, 1999

194. On July 30, 1999, Patient 12 was for a chief complaint of "recheck abscess." Ms. Adamson testified that she had seen the patient that day. The diagnosis states "cellulitis." The area was cleaned and repacked. The initials "MB-PAS" are written on the progress note. A "REVIEWED" stamp dated July 30, 1999, appears on the note. There is no physician signature. (St. Ex. 12 at 47; Tr. at 280)

Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

August 6, 1999

195. On August 6, 1999, Patient 12 was seen for a chief complaint of "recheck abscess." Ms. Adamson testified that she had seen the patient that day. The diagnosis states "cellulitis." The area was cleaned and repacked. The initials "MB-PAS" are written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 12 at 44; Tr. at 280)

August 9, 1999

196. On August 9, 1999, Patient 12 was seen for a chief complaint of "follow up abscess." The diagnosis states "healing cellulitis." The area was cleaned and repacked. The initials "RRH" are written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 12 at 43; Tr. at 280)

August 13, 1999

197. On August 13, 1999, Patient 12 was seen by Ms. Adamson for a chief complaint of "follow up cyst." The diagnosis states "[sebaceous] cyst—healing." The area was cleaned, irrigated, and repacked. The initials "RRH" are written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 12 at 41; Tr. at 280)

Patient 13 (Ms. Adamson Patient 8)

August 15, 1998

198. A telephone message form states that a telephone message had been taken concerning Patient 13 on August 15, 1998. On August 17, 1998, a prescription for Augmentin 500 mg #20 was called in for Patient 13. "VOWCA/RRH" is written on the message form. A "REVIEWED" stamp dated August 18, 1998, is present. There is no physician signature. (St. Ex. 13 at 29)

November 30, 1998

199. A telephone message form dated November 30, 1998, indicates that Patient 13 needed medication for ringworm. A prescription for Lamisil 1% cream was issued. The initials "NK" are written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 13 at 25)

August 3, 1999

200. On August 3, 1999, Patient 13 was seen by Ms. Adamson for a chief complaint of "rash on back and legs x 3 wks." A diagnosis of ringworm is noted. Further, a prescription for 30 grams of Oxistat 1% was called in to a pharmacy. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated August 3, 1999, is present. (St. Ex. 13 at 17 and 40)

    Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

201. Ms. Adamson testified that, on August 3, 1999, she had not believed that Patient 13 had presented with a new condition because Patient 13 had been treated for ringworm previously, and because Patient 13 had been treated for a fungal scalp infection on May 8, 1998. Ms. Adamson testified that Patient 13 had recurrent fungal infections. (St. Ex. 13 at 32; Tr. at 286-288)

    Ms. Adamson further testified that the August 3, 1999, prescription "was called in based on the fact that the patient had been treated for ringworm before," on November 30, 1998. (St. Ex. 13 at 17 and 25; Tr. at 282-284)

    Ms. Adamson testified that Dr. Adamson had ordered Lamisil for Patient 13 on November 30, 1998. When asked how Lamisil being called in for Patient 13 on November 30, 1998, authorized Ms. Adamson to call in Oxistat for the patient nine months later, Ms. Adamson replied:

    > Well, 11-30-98, his drug of choice was Lamisil, first line. But if it recurred—which ringworm does in children, it can be very hard to eradicate—his second

> choice per standing order would be a once-a-day medicine instead of a twice-a-day medicine. He thought, you know, if they had a hard time getting it on twice a day, that's why it didn't go away, change to a once-a-day medicine.

(Tr. at 284-286)

202. Dr. Adamson testified that, prior to treatment being rendered on August 3, 1999, Patient 13 had not been personally evaluated by a physician. However, Dr. Adamson testified that he does not believe that the patient had needed to be personally evaluated by a physician prior to treatment being rendered. Dr. Adamson testified that Patient 13 had "had a minor self-limiting condition and had, I believe, been treated previously for this condition." Dr. Adamson testified that, even if the patient had not been previously seen for that condition, it would not change his opinion, "because this would fall under the guise of a minor self-limiting condition or a condition that would get better with treatment that most patients would recognize." (St. Ex. 13 at 17; Tr. at 705-706)

203. Dr. Gardner testified that, in her opinion, Patient 13 presented with a new condition, ringworm, on August 3, 1999. Dr. Gardner testified that the patient had received treatment for ringworm previously, as evidenced by a telephone message form dated November 30, 1999, but that that does not alter her opinion because the new complaint was nearly one year later. Dr. Gardner further testified, "The assumption there is that the previous rash would have completely cleared. This would have to be a new case. It's a reoccurring thing." Moreover, Dr. Gardner testified that Patient 13 had not actually been seen for ringworm prior to August 3, 1999. (Tr. at 1023-1027)

<u>Patient 14</u> (Ms. Adamson Patient 9)

December 9, 1998

204. On December 9, 1998, Patient 14 was seen for a chief complaint of having been hit in the head while playing football. A history was taken and physical examination performed. Patient 14 was told to follow up as needed, take Tylenol as needed for headache, and put ice to his head. There are no initials or any other indication as to who saw Patient 14 on this visit. A "REVIEWED" stamp dated December 11, 1998, is present. There is no physician signature. (St. Ex. 14 at 25)

August 2, 1999

205. On August 2, 1999, a pharmacy called Dr. Adamson's office and informed the office that no refills were available on a prescription for Patient 14. A prescription for Claritin 10 mg #30 with refills for one year was called back in to the pharmacy that day. "VOWCA/RRH" appears on the note. Further, a "REVIEWED" stamp dated July 30, 1999—three days earlier—is stamped on the message form. (St. Ex. 14 at 21 and 39)

Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

206. Ms. Adamson testified that the prescription called in for Patient 14 on August 2, 1999, had been a refill of a prescription ordered by Dr. Adamson on May 22, 1998. Ms. Adamson further testified that it had been authorized by a standing order "based on the fact that this is a long-term medicine for [the patient]." Moreover, Ms. Adamson testified that the patient had "fulfilled his obligations as a patient" by appearing for a physical examination on April 9, 1999, "therefore, Dr. Adamson ordered the Claritin for him for as long as he needed it." Note, however, that there is nothing on the April 9, 1999, physical examination form concerning prescriptions for Claritin. (St. Ex. 14 at 28 and 31; Tr. at 289-292)

    Ms. Adamson testified that she and Dr. Adamson had also discussed Patient 14's allergies on June 15, 1999, when Ms. Adamson completed the patient's camp physical examination form. The form indicates, under "Prescription Medications," that Patient 14 had been taking Claritin for allergies. In addition, Ms. Adamson testified that she had based the August 2, 1999, prescription on Dr. Adamson's verbal order and discussion that she had had with Dr. Adamson on May 22, 1998, at which time Dr. Adamson had authorized Claritin for Patient 14 for as long as he needed it. Note, however, that the medical record makes no mention of such discussions, or of an order by Dr. Adamson that Patient 14 could have prescriptions for Claritin for "as long as he needed it." (St. Ex. 14; Tr. at 292-299)

207. Dr. Adamson testified that Claritin had been "the specific treatment plan" for this patient's allergies. Dr. Adamson further testified that that plan was noted on a camp physical examination form dated June 15, 1999, on which it was stated that Patient 14 was to take Claritin 10 mg for allergies for a "duration of treatment [of] one year." Moreover, Dr. Adamson testified that he had ordered Ms. Adamson to call in a prescription for Claritin for Patient 14 on May 22, 1998, and on that date gave Ms. Adamson "an order that this patient, Patient 14, needs to be on Claritin for his allergies as long as it works for his allergies." (St. Ex. 14 at 31; Tr. at 1475-1477)

208. A telephone message form dated May 22, 1998, states, with regard to Claritin, "Claritin 10 mg #30 qd ref x 1 yr." It further states "VOWCA/RRH" and bears Dr. Adamson's initial "A." No further order concerning Claritin is indicated. (St. Ex. 14 at 31)

<u>Patient 15</u> (Ms. Adamson Patient 10)

August 3, 1999

209. On August 3, 1999, Patient 15 was seen by Ms. Adamson and Marsha Bendle, who was at that time a physician assistant student, for chief complaints of "consult menopause" and "flu." The diagnoses were "heel spur" and "sinusitis/bronchitis." Prescriptions for Piroxicam 20 mg #30 and Z-Pak were called in to a pharmacy on that date. On the generic progress note, the initials "RRH" and "MB PAS" are written. On the Cough/URI progress

note, the initials "MB-PAS" are written. No "REVIEWED" stamp or physician signature appears on either progress note. (St. Ex. 15 at 149-150a, 233)

Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

210. Ms. Adamson testified that there is nothing in the medical records indicating that she had received authorization from Dr. Adamson to issue these prescriptions on August 3, 1999. Moreover, Ms. Adamson testified that there is no indication in the medical record identifying the physician under whose authorization she had written the orders. Finally, Ms. Adamson testified that there is no indication in the medical record indicating the time that the orders were written. (St. Ex. 15 at 149-150a; Tr. at 301-303)

211. Dr. Adamson testified that the authorization for calling in prescriptions for Piroxicam and Z-Pak had been given when the patient was seen on July 22, 1999. Dr. Adamson testified that, on that date,

> the patient was seen for sinuses and heel pain. Robin and I discussed the case on that day. She was initially prescribed Amoxicillin and I gave Robin a specific order that the patient was to have a Z-pak if the Amoxicillin did not work.
>
> As far as her foot was concerned, I ordered an x-ray, ordered her to be wearing her walking shoes and to see a podiatrist and that if she did not improve with that, that she could be treated with Piroxicam for an anti-inflammatory medication.

(St. Ex. 15 at 1480-1481)

Dr. Adamson acknowledged that his orders for prescriptions for Piroxicam and Z pak are not recorded in the medical record for Patient 15. Dr. Adamson further acknowledged that he did not sign the progress note for August 3, 1999. (Tr. at 1481-1482)

[Note that there is nothing on the progress notes for August 3, 1999, indicating that Patient 15 had seen a podiatrist, as per Dr. Adamson's order. (St. Ex. 15 at 149-150b)]

<u>Patient 16</u> (Ms. Adamson Patient 11)

August 25, 1995

212. On August 25, 1995, a telephone message form indicates that a prescription was issued for Patient 16 for Midrin #20, with one refill. "VOWCA" is written on the form, as are the initials "RRH." No "REVIEWED" stamp or physician signature is present. (St. Ex. 16 at 161)

September 19, 1995

213. On September 19, 1995, a telephone message from indicates that a prescription was issued for Patient 16 for Midrin #20, with one refill. "VOWCA" is written on the form, as are the initials "RRH." No "REVIEWED" stamp or physician signature is present. (St. Ex. 16 at 160)

June 5, 1998

214. A telephone message form dated June 5 [no year] states, "rash—not able to see but skin feels itchy all over—told her to try Benadryl—Call Monday if worsens." A "REVIEWED" stamp dated June 12, 1998, is present. There are no initials or any other indication of physician assistant involvement. (St. Ex. 16 at 120)

215. Dr. Adamson testified that this entry represents "a discussion between a patient and the medical assistant. I had—the medical assistant had asked me about the patient and I recommended they try Benadryl, so it was my recommendation the medical assistant was relaying to the patient. And that does not require my signature." (Tr. at 2013-2014) Nevertheless, Dr. Adamson acknowledged that the medical assistant did not chart such a discussion. Subsequently, the following exchange occurred:

    Q. (by Ms. Crawford): Do you remember this conversation?

    A. (by Dr. Adamson): No, but that—it was—that's a standard response to a question. If someone's feeling itchy, we gave them Benadryl. The medical assistants, in most cases, would ask. And I don't have a specific recollection if Molly asked me on this case or not. Molly was, in general, a pretty good medical assistant and she would ask.

    Q. Okay. I thought your testimony had been that you had discussions with her and that's why I was confused how you got that from the chart.

    A. I think I testified that I told her to tell the patient to try Benadryl, but I was saying that from sort of the general practice of what I would have said in this type of conversation, not that I have a specific recollection of this conversation.

    (Tr. at 2082-2083)

July 15, 1998

216. On July 15, 1998, Patient 16 was seen for diagnoses of depression and urticaria. Prescriptions were issued for Wellbutrin 75 mg #180 with five refills, and Hismanal 10 mg #30 with five refills. "VOWCA/RRH" is written on the progress note for that date. No "REVIEWED" stamp or physician signature is present. (St. Ex. 16 at 118)

On July 15 [no year] Patient 16 called and left a message for Ms. Adamson that Wellbutrin and Hismanal are not on her formulary. A note indicates "[change] to Zyrtec 10 mg qd #30 5 refills." The telephone message form further indicates that Wellbutrin and Claritin were approved following a call to PruCare. The preprinted initials "RRH" were circled. No "REVIEWED" stamp or physician signature is present. (St. Ex. 16 at 117a)

217. Dr. Adamson acknowledged that he had not signed the progress note and telephone message form dated July 15, 1998. (St. Ex. 16 at 117a-118; Tr. at 1484-1486)

July 30, 1999

218. On July 30, 1999, Ms. Adamson saw Patient 16 for a chief complaint of "med refill." The diagnosis section of the progress note states "bunion." Ms. Adamson had a prescription called in for Wellbutrin 75 mg #180 with five refills. The notation "VOWCA/RRH" appears on the progress note, as does a "REVIEWED" stamp dated July 30, 1999. There is no physician signature. (St. Ex. 16 at 109 and 207; Tr. at 304-305)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

219. Ms. Adamson testified that the notation "VOWCA/RRH" indicates "[t]hat Dr. Adamson had told me on this patient specifically that she was to continue her Wellbutrin forever, basically. She could not go without it." Ms. Adamson acknowledged, however, that she had not spoken to Dr. Adamson or received specific authorization for the prescription on July 30, 1999. (Tr. at 304-306)

220. Dr. Adamson testified that the prescription for Wellbutrin issued on July 30, 1999, had been authorized by him during a discussion with Ms. Adamson on July 15, 1998, concerning the patient's depression. Dr. Adamson testified that it had been necessary to contact Patient 16's insurance company for a non-formulary request, and that he and Ms. Adamson discussed all non-formulary requests. (St. Ex. 16 at 65 and 117a; Tr. at 1482-1484)

<u>Patient 17</u> (Ms. Adamson Patient 12)

March 2, 1998

221. A telephone message form dated March 2, 1998, indicates that a prescription for Prozac 20 mg #30 was called in for Patient 17. A note on the form indicates that the patient was to follow up in one month. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 17 at 23 and 36)

    Dr. Adamson was out of the state on March 2, 1998. (St. Ex. 83B; Tr. at 1298-1299, 1304-1305, 1486)

222. Ms. Adamson testified concerning her authorization to have a prescription for Prozac called in for Patient 17:

> [Dr. Adamson] ordered me that specifically on this patient—who is another one who could not go without her serotonin reuptake inhibitors, she had trouble with severe depression, and he did not want her going off her medicine—that if she called in for a refill, she needed to be seen, but that she could have enough medication to get her to her next visit, which is what I told her.
>
> The message is 'Please call.' So I called her and said, 'You can have medication for a month, but you have to be seen.'

(Tr. at 308-310)

Ms. Adamson acknowledged that there is no indication in the March 2, 1998, message form that Dr. Adamson had reviewed the chart, nor is there anything that clearly identifies the physician under whose supervision she had been authorized to write the order. (St. Ex. 17 at 23; Tr. at 310-311)

223. Dr. Adamson testified that he had given Patient 17 a 21-day supply of Prozac samples on February 9, 1998. Dr. Adamson further testified that he had told the patient that, if she kept her follow-up appointment and was improving, "we would renew her Prozac." Dr. Adamson testified with regard to the notation on the bottom right of the note that states:

"Prozac 20 [mg] qd
"#21 samples"

that the first line is his order, and the second line is "just a documentation of the samples, that's not really the order." Moreover, Dr. Adamson testified that there was no time limit on the order, and that the indication that she had received 21 samples merely documented how much medication she had been given. Further, Dr. Adamson testified that he expected his orders "to be carried out on an ongoing basis" until he changed the order. (St. Ex. 17 at 24a; Tr. at 1486-1488) Whereupon the following exchange occurred:

Q. (by Ms. Crawford): So then does that mean that anytime we see a notation in the record for a medication that that is your order to give that medication continuously anytime?

A. (by Dr. Adamson): Unless there's a time limit or a quantity limit or there are certain types of medication that aren't continuous. We've seen prescriptions for Z-Paks. Z-Pak is a certain number of days worth of a medication, but for a patient with a chronic medical problem such as depression, such as hypertension, such as asthma, an

order like that I would consider to be my order until I specifically change it, or it's changed by another physician.

Q. Now, this does have a limited number in it, the number 21, meaning she was given 21 samples, so that doesn't count for—I think you said that there's a limit, then that's a limit.

A. That's not the order. That's me documenting how many samples we gave her.

Q. So anytime we see a medication being given, then that is your order to continue giving it, this particular medication to this patient forever until there's a notation in the record that says stop giving this medication?

A. Yeah, you have to look at—

Q. Is that the answer?

A. You have to look at the context of the individual visit. In general, I would say that's correct. On an antibiotic order, for example, it will usually say, Amoxil 500 times 10 days, or there's a quantity limit on the specific prescription.

(Tr. at 1488-1490)

Dr. Adamson testified that February 9, 1998, had been the first time that he had given Patient 17 Prozac. Dr. Adamson further testified that Patient 17 had a long history of depression and had in the past received Paxil, Zoloft, and Effexor. (Tr. at 1490-1491)

224. Dr. Adamson acknowledged that there was no stamp or signature on the telephone message form dated March 2, 1998, indicating that he had reviewed the form. (Tr. at 1491)

<u>Patient 18</u>

May 27, 1999

225. On May 27, 1999, Patient 18 was seen for acne vulgaris. The patient was given recommendations for skin care, and a prescription for A/T/S liquid was called in. The name "Jamie Price, PA-C" is written on the progress note, followed by a slash and a notation that could be Dr. Adamson's initials, "WA." No times are recorded for the order or for physician review. A "REVIEWED" stamp dated June 2, 1999, is present. There is no indication that any physician other than Dr. Adamson had been the supervising physician. (St. Ex. 18 at 26)

Dr. Adamson and Ms. Adamson were out of state on May 27, 1999. (St. Ex. 83B; Tr. at 1306)

226. Dr. Adamson testified that, when both he and Ms. Adamson had been away on a trip to the Virgin Islands, Dr. Tweel had covered for Dr. Adamson, and Jamie Price, P.A., saw patients at Dr. Adamson's office under Dr. Tweel's supervision. (Tr. at 1977-1979)

Patient 19 (Ms. Adamson Patient 13)

August 2, 1999

227. On August 2, 1999, Patient 19 was seen by Ms. Adamson for a chief complaint of "follow up abdominal discomfort." Ms. Adamson gave Patient 19 samples of Prevacid, a prescription medication, during that visit. The initials "RRH" are written on the progress note, and a "REVIEWED" stamp dated July 30, 1999, is present. Ms. Adamson testified that where her initials appear on the progress note she should have indicated that it had been a verbal order from Dr. Adamson. (St. Ex. 19 at 29; Tr. at 312-313)

    Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

228. Ms. Adamson testified that she and Dr. Adamson "had talked about this patient specifically on 5-11-99, a treatment plan, a plan of action for her stomach—her abdominal discomfort." A progress note dated May 11, 1999, indicates that the patient was seen that day for a chief complaint of "flu." A note in the history of present illness section stated "feels better on Prevacid." The diagnosis section of the note indicates that Patient 19 had elevated cholesterol and tested positive for H. pylori. Ms. Adamson testified that "Dr. Adamson and I talked about how to treat her. Treatment plan was [to] give her a Prevpac, which is Prevacid, which she got on the 29th, plus an antibiotic for 14 days." Patient 19 was also given a prescription for Tagamet. Finally, Ms. Adamson testified that the notation "VOWCA/RRH" on the progress note for May 11, 1999, further indicates that she had spoken to Dr. Adamson about this patient. (St. Ex. 19 at 30; Tr. at 313-315)

    Ms. Adamson was questioned at hearing concerning how one could know from the "VOWCA/RRH" notation that Ms. Adamson had actually spoken to Dr. Adamson on May 11, 1999, about that patient's situation. Ms. Adamson testified that she "can be certain on this patient" that she had done so. Ms. Adamson testified that one of the "clues" that she had done so was that the prescriptions that were given to Patient 19 on May 11, 1999, were written, and not called in. Ms. Adamson testified that another clue, not present in this instance, would have been if Dr. Adamson had written something in the chart. (St. Ex. 19 at 30; Tr. at 314-319)

    Ms. Adamson testified that there is nothing in the medical record prior to August 2, 1999, to indicate that Patient 19 was to remain on Prevacid. Further, Ms. Adamson testified that there was nothing in the medical record that identifies the physician under whose supervision she had been authorized to write the order on August 2, 1999. Finally,

Ms. Adamson testified that there was no indication in the medical record concerning the time that the order was written. (St. Ex. 19 at 29; Tr. at 320-321)

229. Ms. Adamson testified that she had been working under the supervision of Dr. Buddie on August 2, 1999, because Dr. Adamson had been out of town. Nevertheless, Ms. Adamson testified that she had been "working off [Dr. Adamson's] specific order on this specific patient." Concerning the "REVIEWED" stamp dated July 30, 1999, Ms. Adamson testified,

> I was actually working under Dr. Buddie's supervision, but it was Dr. Adamson—it was my understanding that I was to treat Dr. Adamson's patients according to his orders, even though Dr. Buddie was supervising. The date on that stamp is just [Dr. Adamson] being disoriented when he got back from vacation.

(St. Ex. 19 at 29; Tr. at 321-322) Ms. Adamson further testified that Dr. Adamson had stamped some charts with the wrong date when he returned from vacation. (Tr. at 322)

230. Dr. Adamson testified that on May 4, 1999, Patient 19 had been seen in his office for a number of problems, and was given Prevacid samples based upon his verbal order that date. Dr. Adamson further testified that Patient 19 was seen again on May 11, 1999, and given a Prevpac. Dr. Adamson testified that Prevpac is a package that contains three or four different medicines, including Prevacid, and is used to treat H. pylori, the bacterium that causes ulcers. Dr. Adamson testified that, once a patient has finished the Prevpac, the patient might need to continue taking Prevacid. (St. Ex. 19 at 30-31a; Tr. at 1492)

Accordingly, Dr. Adamson testified that, on May 11, 1999, he had ordered Ms. Adamson to "give her the Prevpac and go ahead and try her on Tagamet." Dr. Adamson noted that Tagamet is similar to Prevacid but is considerably less expensive. Dr. Adamson further testified that he gave additional orders to Ms. Adamson that, if the Tagamet did not work, to go back to giving the patient Prevacid. Moreover, Dr. Adamson testified that, when the patient returned on August 2, 1999, she was having more symptoms on the Tagamet, so Ms. Adamson followed his order and put Patient 19 back on Prevacid. (Tr. at 1492-1493)

Dr. Adamson acknowledged that his May 11, 1999, order had not been written in the patient record. Dr. Adamson further testified, "We would not write the secondary orders down because it could—it potentially gets very confusing on what they had and what they didn't have, so we would only write the secondary orders down when they were actually executed." (Tr. at 1494)

Patient 20 (Ms. Adamson Patient 14)

August 2, 1999

231. Ms. Adamson testified that she saw Patient 20 on August 2, 1999, for a chief complaint of "sore throat x 1 wk." The progress note indicates that a monospot was performed, and a throat culture was taken. The diagnosis indicates "pharyngitis." The note further indicates that over-the-counter Tylenol was recommended. The initials "MB-PAS" appear on the chart, as do two "REVIEWED" stamps; one dated August 3, 1999, and the other dated August 9, 1999. (St. Ex. 20 at 17a; Tr. at 327)

    Dr. Adamson was out of state from July 29 through August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

232. Ms. Adamson testified that she had not believed that Patient 19 had had a new condition on August 2, 1999, because the patient had been seen for "viral syndrome" on September 23, 1998. Ms. Adamson testified that "Dr. Adamson used 'viral syndrome' as a way to describe a constellation of symptoms that could be caused by a virus because there are many, many viruses." These symptoms include "headache, fever, nausea, low back pain, stiff neck/shoulders, sore throat, runny nose, sometimes GI complaints, body aches. There's probably a list of 50. You can get a rash from viral syndrome." Ms. Adamson further testified that no treatment had been provided to Patient 20 on August 2, 1999, and that the visit was primarily a "triage." Finally, Ms. Adamson testified that Patient 20 had been seen in Dr. Adamson's office on December 10, 1997, for cold symptoms, which was later eventually diagnosed as asthma. (St. Ex. 20 at 19 and 24; Tr. at 327-334)

    Concerning the "REVIEWED" stamp, Ms. Adamson testified that the August 3, 1999, stamp had been an error, and that Dr. Adamson had actually reviewed the chart when he returned to the office on August 4, 1999, but had not properly advanced the stamp. (St. Ex. 20 at 17a; Tr. at 330-333)

233. Dr. Adamson acknowledged that Patient 20 had not been personally evaluated by a physician on August 2, 1999. However, Dr. Adamson further testified that Patient 20 had complained of a sore throat, which "in general is a minor self-limiting condition that will get better on its own or with a straightforward treatment that most patients would recognize." Moreover, Dr. Adamson testified that he does not believe that any treatment was rendered to the patient that day; Dr. Adamson testified that the taking of a throat culture or deployment of a mono test do not constitute treatment. (St. Ex. 20 at 17a; Tr. at 708-711)

234. Dr. Gardner testified that, in her opinion, Patient 20 presented with a new condition—sore throat—on August 2, 1999. Dr. Gardner further testified that there had been no previous mention of that condition in the medical record. Dr. Gardner testified that treatment had

been given the patient that day, namely Tylenol, and a throat culture and mono test were performed. (Tr. at 1027-1029)

Patient 21 (Ms. Adamson Patient 15)

August 3, 1999

235. Patient 21 was seen by Ms. Adamson on August 3, 1999, for a chief complaint of heartburn with eating for one week, "worse @ hs." The diagnosis section of the progress note states "GERD"; a section of the progress note labeled for "Assessment" was left blank. A prescription was called in that day for Tagamet 400 mg #60 with five refills. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated August 3, 1999, is present. (St. Ex. 21 at 61; Tr. at 342-342)

    Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

236. Ms. Adamson testified that she had believed that she had been able to see and treat Patient 21 while Dr. Adamson was out of state "[b]ecause [she] had a standing order on what to do for patients with heartburn, and Dr. Buddie had told Dr. Adamson that I was to treat patients like Dr. Adamson wanted." (Tr. at 342-344)

    Ms. Adamson testified that, under Dr. Adamson's standing order concerning the treatment of patients with heartburn, she was to perform a history and physical examination on the patient. If there was no sign of bleeding, then Ms. Adamson was to initiate Tagamet and have the patient return in one or two weeks. Ms. Adamson testified that, in this case, Patient 21 did not return for one month, but that the office had had no control over that. Ms. Adamson acknowledged that there is no indication in the August 3, 1999, progress note that Patient 21 was to return in one or two weeks. (St. Ex. 21 at 61; Tr. at 344-345)

237. Ms. Adamson testified that she had been authorized to treat Patient 21 for two reasons. First, she had a standing order to treat a patient with heartburn that got worse at night. Second, she testified that heartburn "is sometimes more than just heartburn, and this guy needed evaluation under the immediate attention clause." Ms. Adamson testified that it is her understanding that a P.A. can initiate treatment for a patient who has a new condition if that patient requires immediate attention. Ms. Adamson further testified that she ruled out the possibility of myocardial infarction by history, blood pressure and, although not recorded in the chart, by listening to the patient's chest, prior to calling in the prescription for Tagamet. [Note, however, that the progress note for that visit does not indicate that the possibility of a coronary event was considered or ruled out.] (St. Ex. 21 at 61; Tr. at 349-370)

    Ms. Adamson further testified that on August 3, 1999, Patient 21 had "had a new symptom. We don't know what the condition is until much further into the chart." Ms. Adamson stated that "his symptom is heartburn. His working assessment is GERD. But later on we

find out he has duodenitis, which is really the condition." Ms. Adamson testified that Patient 21 was eventually diagnosed on October 15, 1999, as suffering from duodenitis following an upper endoscopy. (St. Ex. 21 at 21; Tr. at 342-343, 359)

Ms. Adamson acknowledged that, under her definition of new condition, she could not determine if Patient 21 had a new condition until two and one-half months after she treated him on August 3, 1999. (Tr. at 359-360)

238. Dr. Adamson testified concerning the treatment of Patient 21 on August 3, 1999. Dr. Adamson acknowledged that, prior to treatment being rendered on that date, Patient 21 had not been personally evaluated by a physician. However, Dr. Adamson testified that he does not believe that the patient had presented with a new condition. Moreover, Dr. Adamson testified that the patient had required immediate attention, because heartburn can be a symptom of a heart attack. Dr. Adamson stated that, after cardiac problems were ruled out, it became "a situation where you have a minor self-limiting complaint that will get better on its own or with a simple straightforward treatment that most people would recognize." Finally, Dr. Adamson testified that heartburn is a symptom and not a condition. Accordingly, Dr. Adamson testified that he does not believe that the patient needed to be personally evaluated by a physician prior to treatment being rendered. (St. Ex. 21 at 61; Tr. at 711-717)

Dr. Adamson testified that Ms. Adamson had been authorized to have a prescription for Tagamet called in for Patient 21 because their standard treatment plan for heartburn was to recommend H2 blockers such as Tagamet and Zantac. Dr. Adamson further testified that, although those medications are available over-the-counter, some patients preferred to get prescriptions if it was cheaper to use prescription drug insurance coverage. Finally, Dr. Adamson acknowledged that this treatment plan had not been written down. (Tr. at 716-717)

Concerning the issue of "immediate attention," Dr. Adamson testified that the decision as to whether a patient requires immediate attention must be made by the individual who is seeing the patient. Dr. Adamson further testified that he had not instructed his staff concerning the meaning of that phrase "other than that there was a clause in the law that allowed for immediate attention and that we were waiting for rules related to the statute and definitions from the Medical Board as to what immediate attention meant." (Tr. at 711-714)

239. Dr. Adamson testified that the notation GERD as it appeared on the progress note dated August 3, 1999, was Ms. Adamson's initial assessment of the patient. Dr. Adamson further testified that the patient subsequently underwent an evaluation by gastroenterologists, which failed to confirm the diagnosis of GERD. (St. Ex. 21 at 21, 25; Tr. at 2031-2034)

Dr. Adamson testified that he believes that the patient had actually been treated for an existing condition of heartburn, rather than a new condition of GERD. Dr. Adamson

testified that GERD had been recorded as a diagnosis for billing purposes, because "many insurance companies would reject the symptom-based codes and only accept disease-based codes. So we were forced to bill based on whatever our initial assessment was, whether or not that was the correct diagnosis[.]" (Tr. at 2084-2088)

240. Dr. Gardner testified that Patient 21 presented with a new condition of gastroesophageal reflux disease on August 3, 1999. Dr. Gardner further testified that that condition had not been previously documented in the chart. Moreover, Dr. Gardner testified that treatment was provided that day in the form of a prescription medication, Tagamet. (Tr. at 1029-1031)

Patient 22 (Ms. Adamson Patient 16)

December 17, 1998

241. On December 17, 1998, Patient 22 was seen for a consult concerning menopause. The diagnosis states "amenorrhea." The plan was "FSH, LH, TSH, chol, Basic Met, mammogram, menopausal info given, [and] bone density." "VOWCA/RRH" is written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 22 at 51)

July 21, 1999

242. On July 21, 1999, Patient 22 was seen for a re-check of sores on her legs. The diagnosis was "cellulitis." The plan indicated "Silvadene dressing" and "continue ATB." The initials "RRH" are written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 22 at 46)

July 26, 1999

243. On July 26, 1999, Ms. Adamson saw Patient 22 for a follow up visit concerning sores on Patient 22's leg. On that date, a prescription for Bactrim DS #20 with one refill was called in to a pharmacy, and Patient 22 was given samples of Augmentin. The progress note indicates that the diagnosis was "cellulitis." "VOWCA/RRH" is written on the progress note, and a "REVIEWED" stamp is dated July 26, 1999. (St. Ex. 22 at 43 and 47; Tr. at 372)

    Dr. Adamson was out of the state on July 26, 1999. (St. Ex. 83B; Tr. at 372, 1306-1309, 1495)

244. Ms. Adamson testified that Patient 22 had presented to Dr. Adamson's office on July 19, 1999, with blisters on her legs, and that Dr. Adamson had ordered Silvadene dressings, Augmentin, and follow-up. The progress note for July 19, 1999, indicates that the diagnosis had been "cellulitis." Among other things, samples of Augmentin 875 mg were given to the patient. Ms. Adamson further testified that a culture was taken. (St. Ex. 22 at 47; Tr. at 372-373)

Ms. Adamson testified that on July 23, 1999, the office received preliminary results from the laboratory concerning the culture. Ms. Adamson testified that Dr. Adamson had told her that Patient 22 was to be followed up a few days later by which time the office would have received the "MIC, which is mean inhibitory concentration." Ms. Adamson further testified that the MIC that was received had indicated that Patient 22 was infected with three organisms, one of which was sensitive to Augmentin, which Dr. Adamson had previously ordered, and another was sensitive to Bactrim. Accordingly, Ms. Adamson testified that, on July 26, 1999, she had followed Dr. Adamson's order to treat the patient according to the MIC report. (St. Ex. 22 at 13-14, 43, 44; Tr. at 373-375)

245. Dr. Adamson testified that the lab results from a culture taken on July 19, 1999, had been received on July 23, 1999, at which time he learned that Patient 22 was infected with proteus and group B strep bacteria. Dr. Adamson further testified that "the combination of antibiotics that would take care of those two bacteria based on the antibiotic sensitivities are Augmentin and Bactrim, and I gave Robin that order on 7/23." Dr. Adamson further testified that he had given Ms. Adamson an order "that the patient needed to continue her Augmentin and we needed to add Bactrim the next time that we saw her if it looked like these weren't healing." Moreover, Dr. Adamson testified that, when Ms. Adamson saw Patient 22 on July 26, 1999, she noted that there had been no change in Patient 22's ulcers, and added Bactrim "based on our discussions and the culture report." Finally, Dr. Adamson acknowledged that his order to continue Augmentin and add Bactrim were not written down. (St. Ex. 22 at 43-47; Tr. at 1496-1498)

[Note that the lab report for the culture taken from Patient 22 on July 19, 1999, is dated July 24, 1999, and bears "REVIEWED" stamps dated July 26, 1999]. When Dr. Adamson was asked if he had reviewed this report on July 23, 1999, he replied:

> There were preliminary reports reviewed on the phone on 7/23. This particular written report is from 7/24. When these reports of these sensitivities come out, you get preliminary reports all the way along, you'll get a report of 24 hours, you get a report at 48, you get a report at 72.
>
> Our practice in the office was to only save the final report, unless there was documentation or writing on one of the—one of the previous reports.

(St. Ex. 22 at 13-14; Tr. at 1498) Further, when Dr. Adamson was asked if he had had the culture and sensitivity report when he gave Ms. Adamson the order on July 23, 1999, he replied:

> No, but we knew that the bug was proteus and proteus is sensitive to Bactrim. I had enough information to make the decision that Bactrim needed to be added if she wasn't getting better.

> Again, if these things were healed, you wouldn't have added anything because she would have been responding, and she wasn't healing and it had almost been a month at that point, this poor lady with swollen legs and weeping and oozing.

(Tr. at 1499)

Patient 23 (Ms. Adamson Patient 17)

July 30, 1999

246. On July 30, 1999, Patient 23 was seen by Ms. Adamson for a chief complaint of earache for two days. Ms. Adamson recorded in the progress note that there was "green exudate" in the patient's right ear canal. The diagnosis section was left blank. The medical records indicate that prescriptions for Amoxil 250 mg #30, and Cipro HC Otic were called in on that date. A "REVIEWED" stamp dated July 30, 1999, is stamped on the progress note. There is no physician signature. (St. Ex. 23 at 13 and 38; Tr. at 375-377)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 375-377, 1307-1310)

247. Ms. Adamson testified that she had had the prescriptions called in for Patient 23 because Patient 23 had been treated multiple times for otitis media, the last previous occurrence having been February 9, 1999. (Tr. at 378-380)

248. Dr. Adamson testified concerning the treatment of Patient 23 on July 30, 1999. Dr. Adamson acknowledged that Patient 23 had not been personally evaluated by a physician prior to treatment being rendered on that date. Dr. Adamson further testified that the patient had previously been seen for complaints related to the ears, and that he does not believe that the patient had presented with a new condition. Accordingly, Dr. Adamson testified that he does not believe that the patient needed to be personally evaluated by a physician prior to treatment being rendered. (St. Ex. 23 at 13; Tr. at 718-719)

    Dr. Adamson testified that Ms. Adamson had been authorized to have prescriptions for Amoxil and Cipro HC Otic called in for Patient 23 because "[t]hat was the specific treatment plan for this patient related to the longstanding history of otitis media." Dr. Adamson referenced previous visits in which Patient 23 had had otitis media and been prescribed amoxicillin. Dr. Adamson acknowledged that Patient 23 had not been treated with Cipro HC Otic prior to July 30, 1999, but testified that Cipro HC Otic had not become available until 1999. (St. Ex. 23 at 12a, 16, 24a, 25a, 26a, and 28a; Tr. at 719-721)

249. Dr. Gardner testified that, in her opinion, Patient 23 presented with a new condition on July 30, 1999. Dr. Gardner further testified that the new condition "is really the patient complaint of a right canal exudate. There was no specific diagnosis listed on the chart."

Dr. Gardner testified that such a complaint would "most likely" indicate an infection of the ear canal. Moreover, Dr. Gardner testified that there was no previous mention of ear canal infection in the medical record, although Patient 23 had been treated for a middle ear infection approximately five months earlier on February 2, 1999, and on other occasions prior to 1999. (Tr. at 1031-1038)

Patient 24 (Ms. Adamson Patient 18)

June 4, 1998

250. On June 4, 1998, a prescription for Depo-Provera 150 mg with refills for one year was issued to Patient 24. "VOWCA/RRH" is written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 24 at 83)

June 19, 1998

251. On June 19, 1998, Patient 24 was seen for a chief complaint of "on Prozac 40 mg, still on edge." The diagnoses recorded were hypertension and "[rule out] CTS." The plan indicates that Patient 24's potassium was to be tested. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated June 23, 1998, is present, but there is no physician signature. (St. Ex. 24 at 80)

June 30, 1998

252. On June 30, 1998, Patient 24 was seen for a diagnosis of "skin tags; warts." The progress note states:

> "Rt neck—mult. skin tags & nevi removed, infiltrated [with] Xylocaine [illegible] removed [with] scalpel
>
> "Lt neck—mult skin tags removed as above.
>
> "Lt wrist & knee—Liquid N applied to area."

(St. Ex. 24 at 78) The name "S.T. Riedlinger, PA-S" is written on the progress note. Further, a "REVIEWED" stamp dated June 30, 1998, is present. (St. Ex. 24 at 78)

253. Ms. Adamson testified that she does not remember if she had been involved in Patient 24's care on June 30, 1998. Ms. Adamson acknowledged that she would have seen the patient along with the physician assistant student if Dr. Adamson was not in the office; however, Ms. Adamson testified that she does not remember Dr. Adamson being out of the office on that day. (Tr. at 381-383)

254. Ms. Adamson testified that she does not believe that Patient 24 had presented with a new condition. Ms. Adamson testified that "skin tags aren't new. They develop over time." Moreover, Ms. Adamson testified that Patient 24 was an employee in Dr. Adamson's office, and that "she pointed out these things almost daily to us in the office. She had complaints daily." Ms. Adamson acknowledged, however, that Patient 24 had not been treated for that condition prior to June 30, 1998. (Tr. at 383-384)

255. Dr. Adamson testified that he does not believe that Patient 24 needed to be personally evaluated by a physician prior to treatment on June 30, 1998. Dr. Adamson testified that, first, he does not consider skin tags to be a new condition. Second, the skin tags were in plain view on the patient's neck, and the patient was an employee of Dr. Adamson's practice. (Tr. at 780-781)

    Dr. Adamson testified that a physician assistant student had performed the procedure, and that he recalls "going in and out of the room several times while she was doing the procedure to make sure it was going okay and she wasn't having any problems." Dr. Adamson further testified that he cannot recall if anyone else had been in the room, although a medical assistant may have been. Finally, Dr. Adamson testified that the physician assistant student may have been in the room alone with the patient for part of the time. (Tr. at 781-782)

256. Dr. Gardner testified that, in her opinion, Patient 24 presented with a new condition of skin tags and nevi on June 30, 1998. Dr. Gardner further testified that these had not been previously mentioned in the patient record. Finally, Dr. Gardner testified that Patient 24 was treated using excision and cryotherapy. (Tr. at 1038-1040)

August 20, 1998

257. On August 20, 1998, Patient 24 was seen by Ms. Adamson for a chief complaint of "onset two months profuse sweating, fatigue." Current medications noted were Hyzaar and Paxil 40 mg. The plan states, "TSH, LFTs, H&H," to "[discontinue] Paxil wean," and to "consider Wellbutrin." The diagnosis indicates fatigue and hyperhidrosis. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated August 20, 1998, is present. (St. Ex. 24 at 74)

258. Ms. Adamson testified that she had talked to Dr. Adamson about the patient on August 20, 1998. Ms. Adamson stated that she knows that she had talked to Dr. Adamson because Dr. Adamson "wanted the Paxil weaned and Wellbutrin considered," and "[b]ecause there's a verbal order there, and we talked about this person a lot." (Tr. at 385-387)

259. Ms. Adamson testified that she does not believe that Patient 24 had presented with a new condition on August 20, 1998, because Patient 24 had been seen previously for profuse sweating on May 6, 1998. (St. Ex. 24 at 86a; Tr. at 386-388)

260. Dr. Adamson testified that he does not believe that Patient 24 needed to be personally evaluated by a physician prior to treatment on August 20, 1998. Dr. Adamson further testified that the patient had complained of "symptoms." Dr. Adamson testified that, "regardless if they were new or not, symptoms can be evaluated by a physician assistant." Moreover, Dr. Adamson stated that symptoms can be evaluated and treatment commenced without a physician personally evaluating the patient "[i]f it's not identified as a new condition." Finally, Dr. Adamson testified:

> The patient had testing ordered to evaluate her symptoms. She had tests done of her thyroid, tests done of her liver, tests done of her blood count, and tests done to check for mono, all of which were negative.
>
> That leaves us with symptoms that we can't really ascribe to a specific diagnosis or a specific condition, which would not be uncommon in the care of this individual patient.
>
> This patient complained frequently, vocally, and was an employee in the office. So it was very evident that—it was very evident when she had a complaint. We all—we all knew about it.
>
> Robin and I discussed this case because she was not authorized to provide medication to employees without talking to me about it first.
>
> As I'm sure you might be able to appreciate, taking care of your employees where they work is a really awkward and really sensitive situation. You have to try to maintain confidentiality for the patient. You know, they may want time off work, but you don't want them off work because you need something done.
>
> So our practice was to talk about any medication changes, and in talking about her symptoms, since we had no other condition that we could ascribe her symptoms to, we felt that it might be due to the Paxil. So I chose to tell Robin to wean her Paxil and consider using Wellbutrin in the future.
>
> So if the Paxil dose was decreased and continued to be effective, then she could be maintained on that lower dose. If she didn't have adequate symptom relief of her depression and the side effects didn't go away on a lower dose, then the medication was to be changed.

(Tr. at 784-786) Dr. Adamson further testified that he was relying on his recollection for that statement, and that there is nothing in the record concerning his discussion with Ms. Adamson except his "REVIEWED" stamp. Dr. Adamson testified that he and Ms. Adamson had been frustrated because they had been unable to find any specific cause

for Patient 24's fatigue and sweating, despite previous attempts to do so. (St. Ex. 24 at 74, 86a, 95a-95b, 104a, 128a, 129a; Tr. at 786-795)

261. Dr. Gardner testified that, in her opinion, Patient 24 presented with a new condition of sweating, decreased libido, and fatigue on August 20, 1998. Dr. Gardner further testified that neither decreased libido or fatigue had been previously documented in the medical record. Finally, Dr. Gardner testified that treatment was initiated on that date. (Tr. at 1040-1041)

September 15, 1998

262. On September 15, 1998, Patient 24 was seen by Ms. Adamson for a chief complaint of a red spot on her right temple, and for a Depo-Provera injection. The initials "RRH" are written on the progress note. A "REVIEWED" stamp dated September 16, 1998, is present. The diagnosis indicates rash and costochondritis. Ms. Adamson testified that Patient 24 received written prescriptions for Elocon cream and Wellbutrin. Ms. Adamson further testified:

> I remember asking Dr. Adamson about this because this patient—because she was also an employee, it was a little frustrating because every day there were different complaints. And I remember saying to him, '[Patient 24] has a red spot behind her glasses,' and he said, 'Yes, I know. I've seen it. Give her some Elocon.'

(St. Ex. 24 at 70; Tr. at 388-390)

263. Ms. Adamson testified that she does not believe that the rash had been a new condition on September 15, 1998, because the patient had had it for four months, and because Dr. Adamson had seen it. (Tr. at 391-395)

264. Dr. Adamson testified that he does not believe that Patient 24 had needed to be personally evaluated by a physician prior to treatment on September 15, 1998. Dr. Adamson testified that the patient had complained of a red spot on her temple, and that that "would mean a rash or skin irritation, which would be an example of a minor self-limiting condition that could go away with no treatment or a minor treatment that most patients would recognize." Further, Dr. Adamson testified that Patient 24 had shown him the spot, and he had known that "it wasn't anything bad or any kind of new condition, so I thought it was perfectly reasonable for the patient to be seen by the physician assistant on that date." (St. Ex. 24 at 70; Tr. at 795-796)

Dr. Adamson testified that he had specifically authorized Ms. Adamson to give Elocon cream to Patient 24. Dr. Adamson further testified that Ms. Adamson had not been authorized to give medication to employees of his office without Dr. Adamson's specific approval. (Tr. at 796-798)

265. Dr. Gardner testified that, in her opinion, Patient 24 presented on September 15, 1999, with a new condition of a red spot on her temple. Dr. Gardner further testified that "red spot on the temple was not previously mentioned anywhere in the medical record." Moreover, Dr. Gardner testified that treatment via Elocon cream was initiated on that date. (Tr. at 1041-1046)

Testimony of Patient 24

266. Patient 24 testified that she had been a patient at Apple Health, and that Dr. Adamson was her physician. (Tr. at 1439)

    Patient 24 testified that there were occasions when she had seen Ms. Adamson rather than Dr. Adamson, and that she had seen Ms. Adamson "often." Patient 24 further testified that, on one of these occasions, she had had some skin tags removed from her neck by a physician assistant student. Patient 24 testified that she had not shown her skin tags to Dr. Adamson. Patient 24 stated that Ms. Adamson examined them, said to Patient 24, "it's no problem, we just burn them off," and that the student performed the procedure. Moreover, Patient 24 testified that Ms. Adamson was not in the room when the student performed the procedure. In addition, Patient 24 testified that Dr. Adamson was not in the office that day. (Tr. at 1440-1441)

    Patient 24 testified that, on another occasion, she had been seen and treated by Ms. Adamson for a complaint of fatigue and perspiration. (Tr. at 1441-1442)

    Patient 24 testified that, on yet another occasion, she had been seen and treated by Ms. Adamson for a skin lesion on the side of her face. Patient 24 further testified that she believes that she had been given a sample of Bactrim cream for that. Moreover, Patient 24 testified that "actually it ended up being caused just by my frames on my glasses." (Tr. at 1442-1443)

<u>Patient 25</u> (Ms. Adamson Patient 19)

January 12, 1998

267. Ms. Adamson saw Patient 25 on January 12, 1998, for a complaint of lung and chest pain. The diagnosis indicates costochondritis. Patient 25 was advised to take over-the-counter medication. The pre-printed initials "RRH" are circled, and Dr. Adamson's initial, "A," is written on the progress note for that date. (St. Ex. 25 at 37 and 38; Tr. at 396)

268. Ms. Adamson testified that on January 12, 1998, Patient 25's physical examination had been normal and "we didn't do anything." Ms. Adamson noted that, by the time that Patient 25 had come in to Dr. Adamson's office on January 12, her symptoms had improved. (Tr. at 396-398)

269. Ms. Adamson testified that Patient 25 had been previously seen by Dr. Adamson on October 21, 1991, for a complaint of tightness in her chest, which had been diagnosed as wheezing bronchitis. (St. Ex. 25 at 54; Tr. at 396-397)

270. Dr. Adamson testified that he does not believe that Patient 25 needed to be personally evaluated by a physician prior to treatment on January 12, 1998. Dr. Adamson testified that "[t]he patient came in with symptoms of chest hurting, but also saying that she was getting better with a normal physical exam, and the other piece of her history is cough. That would be an example of a minor self-limiting condition that would get better on its own." Dr. Adamson further testified that he does not see anything in the record to reflect that any treatment was provided that visit. (St. Ex. 25 at 38; Tr. at 799-800)

271. Dr. Gardner testified that, in her opinion. Patient 25 presented with a new condition of costochondritis on January 12, 1998. Dr. Gardner testified that that condition had not been previously documented in the chart. Moreover, Dr. Gardner testified that treatment was initiated that date when over-the-counter Tylenol was recommended. (Tr. at 1052-1053)

July 1, 1998

272. On July 1, 1998, Ms. Adamson spoke to Patient 25 over the telephone concerning an injury to her ankle. The telephone message form indicates that Patient 25 had reported that she had "stepped into a hole and something on [her] right foot/ankle snapped." Patient 25 also reported that she had been seen in a hospital and that x-ray results were to be faxed to Dr. Adamson's office. The form states that a prescription for Daypro 600 mg #60 was called in. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 25 at 35; Tr. at 398-400)

273. Ms. Adamson testified that she had spoken to Dr. Adamson concerning Patient 25 on July 1, 1998, and that Dr. Adamson had told her to give Patient 25 Daypro and schedule her for an appointment. Ms. Adamson acknowledged, however, that there is nothing in the medical record indicating that Dr. Adamson had authorized that treatment. (St. Ex. 25 at 35; Tr. at 400)

274. Dr. Adamson testified that he does not believe that the patient had needed to be seen by a physician on July 1, 1998, before the prescription was called in. Dr. Adamson testified that the patient had been evaluated at an emergency room, and that an x-ray report from that visit had been faxed to his office. Dr. Adamson further testified that the patient had a history of stomach upset with ibuprofen. Accordingly, Dr. Adamson testified that, when Ms. Adamson asked him what he wanted to do, he ordered Daypro. (St. Ex. 25 at 25 and 35; Tr. at 801-803)

275. Dr. Gardner testified that, in her opinion, Patient 25 had presented with a new condition of right foot pain on July 1, 1998. Dr. Gardner testified that a report that "something

snapped" would constitute a new condition because "[i]t's different from before." Dr. Gardner further testified that the patient had previously been seen for foot pain at Mount Carmel East on June 25, 1998, but had not been seen or evaluated in Dr. Adamson's office for that condition previous to July 1, 1998. Finally, Dr. Gardner testified that the patient was treated with Daypro. (Tr. at 1046-1048, 1214)

November 25, 1998

276. On November 25, 1998, Patient 25 was seen for a well-woman visit. The progress note indicates that a 28-day supply of Triphasil with eleven refills was called in. "Nancy" is handwritten and circled at the top of the note, and "N. Keeler PA-C" is written at the bottom. No "REVIEWED" stamp or physician signature is present. (St. Ex. 25 at 33)

277. Dr. Adamson testified that Ms. Keeler had failed to chart his verbal order that authorized Triphasil. Dr. Adamson testified that "our standard practice was that patients had to have their Pap smears done before things were refilled, so [Ms. Keeler] would have had to request an authorization from me for a specific order for that in order to continue those birth control pills." Dr. Adamson acknowledged that he had not signed the progress note. (St. Ex. 25 at 33; Tr. at 805-807)

March 9, 1999

278. On March 9, 1999, Patient 25 was seen for a well-woman visit. The diagnosis indicates that Patient 25 was found to be pregnant, that she was referred to an ob/gyn, and that pre-natal vitamins were called in to a pharmacy. The initials "NK PA-C" are written on the progress note. Dr. Adamson's "REVIEWED" stamp dated March 10, 1999, is present. (St. Ex. 25 at 32)

279. Ms. Adamson testified that she did not see Patient 25 on March 9, 1999. Further, there is no indication on the progress note for that visit that Ms. Adamson had had contact with the patient at that time. (St. Ex. 25 at 32; Tr. at 400-401)

280. Dr. Adamson could not recall at hearing if he had seen Patient 25 on March 9, 1999. Dr. Adamson further testified that he does not believe that Patient 25 had needed to be evaluated by a physician prior to treatment. Dr. Adamson testified that Patient 25 was pregnant, had probably been in her fourth month of pregnancy, and that he does not believe that pregnancy is a disease. Accordingly, Dr. Adamson testified that there is "no new condition here." (Tr. at 803-805)

    Dr. Adamson testified that it was his standard practice to give pregnant patients prenatal vitamins. Dr. Adamson could not recall if he had given Ms. Keeler specific authorization to do so. Nevertheless, Dr. Adamson stated that such treatment would fall under the definition of a patient requiring "immediate attention," because there is an increased risk of birth defects if prenatal vitamins are not started early in the pregnancy. (Tr. at 804-809)

281. Dr. Gardner testified that, in her opinion, Patient 25 had presented with a new condition of pregnancy on March 9, 1999. Dr. Gardner testified that the pregnancy had not been previously mentioned in the patient record. Dr. Gardner further testified that treatment was initiated with prenatal vitamins and a referral to an ob/gyn. (Tr. at 1051-1052)

    Concerning the issue of pregnancy as a new condition, Dr. Gardner testified that "if a patient has been pregnant six times previously, she has already had those children. Obviously, this is a different child. It's a new pregnancy." (Tr. at 1049-1051)

Patient 26 (Ms. Adamson Patient 20)

July 30, 1999

282. Patient 26, a three-year-old female, was seen by Ms. Adamson on July 30, 1999, for a chief complaint of elevated temperature, nausea, and vomiting. The patient's axillary temperature was recorded as 98 degrees. The progress note indicated that the patient had "enlarged tonsils" and "exudates," among other things. The diagnosis states probable strep. A throat culture was taken, and a prescription for Amoxil was called in that day. A "REVIEWED" stamp dated July 30, 1999, is faintly visible near the bottom of the progress note. There is no physician signature. (St. Ex. 26 at 40 and 51; Tr. at 401-402)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 404-405, 1307-1310)

283. Ms. Adamson testified that she did not believe that Patient 26 had had a new condition on July 30, 1999, because the patient had been seen previously for upper respiratory infections. Ms. Adamson further testified that she had been authorized to have the prescription for Amoxil called in "based on Dr. Adamson's standing order, someone with enlarged tonsils with exudate, with a history of fever—[she] did not have a fever when they were in the office—get a throat culture, give them amoxicillin if they are not allergic—at this age." (Tr. at 403-404)

284. Dr. Adamson testified that Patient 26 had not been personally evaluated by a physician prior to the commencement of treatment on July 30, 1999. Dr. Adamson further testified that he did not believe that Patient 26 had needed to be personally evaluated by a physician. Dr. Adamson testified that Patient 26 had previously been treated for otitis media and strep throat, "so evaluating a three-year-old with a fever, I would not consider a new condition." (St. Ex. 26 at 40; Tr. at 809-810, 818)

    Dr. Adamson testified that "temperature, nausea and vomiting are symptoms and the nausea and vomiting is more than likely secondary to the fever." Dr. Adamson testified that the top three things that cause fever in children are otitis media, strep throat, and viral infections. Dr. Adamson testified that a throat culture taken on July 30, 1999, was negative

for strep. Dr. Adamson further testified that Patient 26 did not have otitis media. Moreover, Dr. Adamson testified that, "[m]ore than likely, by process of elimination, what you're left with is a viral syndrome that will get better on its own. And her next office visit was 1/7/2000, so I have to assume that she recovered uneventfully from that viral infection of 7/30/99." (Tr. at 815-817)

Dr. Adamson testified that Patient 26 had previously been treated for strep throat at Children's Hospital on February 20, 1998. Dr. Adamson further testified that she had been treated for otitis media at his office on May 25, 1998. (St. Ex. 26 at 17-18, 41; Tr. at 810-815)

285. Dr. Adamson testified that a prescription had been called in for amoxicillin based on his standard care plan for patients who have had strep before. Dr. Adamson further testified that the authorization had been a general, verbal authorization that applied to such patients. Moreover, Dr. Adamson testified that the reason for using amoxicillin is not to cure the strep infection but to prevent potential long-term complications involving the heart valves. Finally, Dr. Adamson testified that his authorization had not been recorded in writing. (Tr. at 817-818)

286. Dr. Gardner testified that, in her opinion, Patient 26 had presented with a new condition of increased temperature, nausea, and vomiting on July 30, 1999. Dr. Gardner further testified that there had been no previous mention in the medical record of the patient having been seen for those complaints. Moreover, Dr. Gardner testified that Patient 26 had not been previously treated for strep. Finally, Dr. Gardner testified that treatment was rendered on that date with amoxicillin, and the taking of a throat culture. (Tr. at 1054-1056)

<u>Patient 27</u>

August 2, 1999

287. On August 2, 1999, Patient 27 was seen for a chief complaint of discomfort in his right great toe. A diagnosis of "onchyomycosis/NIDDM" was recorded. A prescription for Lamisil #90 was issued. The initials "MB-PAS" are written on the progress note. No "REVIEWED" stamp or physician signature is recorded. (St. Ex. 27 at 149)

Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

<u>Patient 28</u> (Ms. Adamson Patient 21)

July 30, 1999

288. On July 30, 1999, Patient 28 was seen by a physician assistant student and Ms. Adamson for a chief complaint of cough and runny nose for 5 days. Ms. Adamson testified that Dr. Adamson was out of the office on that date. The diagnosis on the progress note states

bronchitis. A prescription for Humibid DM #40 was called in for the patient. The initials "MB-PAS" are written on the progress note. A "REVIEWED" stamp dated July 30, 1999, is faintly visible on the right side of the progress note. There is no physician signature. (St. Ex. 28 at 30a; Tr. at 405-406)

Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

289. Ms. Adamson testified that she had the prescription for Humibid called in based upon a general standing order for patients who present with a cough and runny nose. Tr. at 406-408)

290. Dr. Adamson testified that he does not believe that Patient 28 had needed to be personally evaluated by a physician prior to treatment on July 30, 1999. Dr. Adamson testified that Patient 28's complaint that day had been cough and runny nose, which are "minor self-limiting complaints in both cases and would fall under the definition of not a new condition as I've spoken to previously." Dr. Adamson further testified that the patient had been diagnosed with sinusitis on June 4, 1999, and that the cough could have resulted from continuing sinus infection and drainage. (St. Ex. 28 at 30a, 31, 32; Tr. at 818-819)

Dr. Adamson testified that the prescription for Humibid had been called in based upon a diagnosis of bronchitis. The following exchange occurred concerning his approval for that prescription:

A. (by Dr. Adamson): That was part of our standard care plan for treatment of sinusitis and also part of the treatment plan on 6/4/99 that when we give orders—when I give Robin orders for treatment of sinusitis, not only do we include antibiotics, we also include other medicines for symptom relief.

And the Humibid was not given on 6/4 and I don't know the reason for that. Frequently we'll offer it and the patients will say, no, that's okay, I don't need anything else. I just want to take the antibiotic. But when Robin and I discuss it, I'll say, here's the antibiotic and you can give her what she would like, Humibid or Entex for the sinus infection.

So not only is there sort of a general thing that we can use Humibid for patients who cough, specifically for Patient No. 28, there was an order on 6/4/99 that Robin could give the patient a prescription for Humibid or Entex if they liked.

Q. (by Ms. Crawford): Where is that written in the progress notes?

A. It's not written.

Q. So it's, again, a standard order—standing order kind of thing?

A. Again, it is a standing order. If a patient were to come in for a cough who had never been seen before and Robin finds no evidence of any new condition and they need—they want something for congestion, yes, she could have authorized Humibid as part of a standard care plan. That's not the case with this patient, however, because there were specific orders given on 6/4/99 in regards to that patient's sinus infection.

Q. For Amoxil?

A. Correct.

Q. But not for Humibid?

A. Sinus infections can last for months and months and months.

Q But on 7/30, six or seven weeks later, the patient is not given Amoxil, but is given Humibid.

A. Right. I'm out of town. Dr. Buddie is the supervising physician. In Robin's estimation, she does not want to give the patient more antibiotics at that point because the patient hasn't—is—this is sort of an unusual situation that in some ways the patient's better, but in some ways they're not better because they're coming back.

So what do you do? So she chose not to give any additional antibiotics, give the patient a very simple medication that we use to treat the symptoms of cough and congestion and go from there to see if the patient got better. I would refer you to Page 29 dated 8/6, which is Friday, and I'm back and the patient said, still not better, has been taking the medication for five days, which is the Humibid, and at that point, Robin asked me what do I want to do, and I authorized a refill on her Amoxicillin.

Q. Now, you don't remember that specific conversation?

A. I don't remember that specific conversation, but if that would have been Robin's choice, she could have done it on 7/30, but she didn't, she chose to wait until I came back and we can talk about it to see if there was another way we wanted to go—another way I wanted to go with this patient's treatment plan.

(St. Ex. 28 at 29, 30a, 31-32; Tr. at 819-823)

Dr. Adamson acknowledged that "cough" had not been noted as a symptom on the progress note for June 4, 1999. (St. Ex. 28 at 32; Tr. at 826)

291. Dr. Gardner testified that, in her opinion, Patient 28 had presented with a new condition of cough and runny nose on July 30, 1999. Dr. Gardner further testified that bronchitis had been diagnosed. Moreover, Dr. Gardner testified that there is no documentation in the

chart of those symptoms or that diagnosis previous to that date. Finally, Dr. Gardner testified that the patient was treated with a prescription for Humibid DM . (Tr. at 1056-1057)

Patient 29

August 3, 1999

292. On August 3, 1999, Patient 29 was seen for a chief complaint of blood in his urine for four days. The plan indicates that the following tests were ordered: "C&S," "BUN/Creat," "Renal CT," "PSA," and "flex sig." The progress note indicates hematuria as the diagnosis. "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 29 at 67)

Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

Patient 30 (Ms. Adamson Patient 22)

February 23, 1998

293. On February 23, 1998, Ms. Adamson saw Patient 30 for a chief complaint of "cough off & on since Christmas. Has had dizzy spells." The progress note indicates that the diagnosis was sinusitis and "ok to get Depo & get repeat pap." Ms. Adamson testified that Patient 30 received a written prescription signed by Dr. Adamson for Amoxil and was given a Depo-Provera injection based on Dr. Adamson's order, as evidenced by "VOWCA/RRH." Dr. Adamson's initial, "A," also appears on the progress note. (St. Ex. 30 at 68a and 108; Tr. at 409-412) [Note that the handwriting on the prescription for Amoxil 500 mg #30 is consistent with handwriting previously identified to be that of Ms. Adamson, except for the signature. (St. Ex. 30 at 108)]

294. Ms. Adamson testified that she did not believe that Patient 30 had presented with a new condition on February 23, 1998. Ms. Adamson testified that Patient 30 had previously gone to an emergency room for a "syncopal episode" on Christmas Eve, and received an evaluation there. Moreover, Ms. Adamson testified that Patient 30 had been previously seen in Dr. Adamson's office for a cough on September 18, 1997, and for other respiratory ailments on many earlier occasions. (St. Ex. 30 at 71a; Tr. at 412-414)

295. Dr. Adamson testified that he does not believe that Patient 30 had needed to be personally evaluated by a physician prior to receiving treatment on February 23, 1998. Dr. Adamson testified that one of the things that she had been seen for was cough, which Dr. Adamson described as a minor, self-limiting complaint. Dr. Adamson further testified that the patient had had that complaint previously, and had been seen for that complaint in an emergency room on December 24, 1997, where she was diagnosed with sinusitis. Further, Dr. Adamson testified that Patient 28 had a history of multiple episodes of ear infections, bronchitis, and

upper respiratory infections "at various times in her life." Finally, Dr. Adamson testified that he could not recall if he had seen the patient on February 23, 1998. (St. Ex. 30 at 68b; Tr. at 827-829)

296. Dr. Gardner testified that, in her opinion, Patient 30 had presented with a new condition of cough and dizzy spells on February 23, 1998. Dr. Gardner testified that the diagnosis had been sinusitis. Dr. Gardner further testified that the medical records did not indicate that Patient 30 had had that problem previously. Moreover, Dr. Gardner testified that, had there been previous episodes, they should have been completely resolved. (Tr. at 1069-1072)

April 29, 1998

297. On April 29, 1998, Patient 30 was seen for a chief complaint of diarrhea, vomiting, abdominal cramping, and gas. The diagnosis states "Gastritis, Acute." Patient 30 received a written prescription for Bentyl 20 mg #20. The name "Michele L. Weber, BSN, RN, ACRN, NP Student OSU" is written on the progress note. Dr. Adamson's initial, "A," appears on the note. (St. Ex. 30 at 66 and 109; Tr. at 414-417, 2113) [Note that the handwriting on the prescription for Bentyl 20 mg #20 is consistent with handwriting previously identified to be that of Ms. Adamson, except for the signature. (St. Ex. 30 at 109)]

298. Ms. Adamson testified that she had seen Patient 30 on April 29, 1998, and that she knows this because she had written the word "Bentyl" on the progress note. Ms. Adamson could not recall at hearing if Dr. Adamson had seen the patient that day. (Tr. at 414-417)

    Ms. Adamson testified that she does not believe that Patient 30 presented with a new condition on April 29, 1998, because Patient 30 had been seen previously in Dr. Adamson's office for gastrointestinal complaints on March 22, 1996, and on earlier occasions. (St. Ex. 30 at 82a, 96, 97; Tr. at 415-417)

299. Dr. Adamson testified that he does not believe that Patient 30 needed to be personally evaluated by a physician prior to receiving treatment on April 29, 1998. Dr. Adamson testified that the patient had been complaining of diarrhea and vomiting, "which are examples of symptoms that in most cases are minor and self-limiting and will resolve without treatment." Dr. Adamson further testified that Patient 30 had a history of gastroenteritis and digestive tract symptoms. (St. Ex. 30 at 66; Tr. at 829-830)

    Dr. Adamson disputed the diagnosis on the progress note that indicated that the patient had had gastritis. Dr. Adamson testified that the symptoms of gastritis would not have included diarrhea. Dr. Adamson further testified that a conclusive diagnosis of gastritis would have required direct viewing of the stomach by a gastroenterologist. Moreover, Dr. Adamson testified that the treatment plan had consisted of a prescription for Bentyl, which is used for the treatment of gastroenteritis but not for gastritis. (Tr. at 830-832)

300. Dr. Adamson testified that he could not recall with certainty if he had personally seen Patient 30 prior to treatment on April 29, 1998, but believes that he may have. Dr. Adamson testified that he did review the chart. (Tr. at 832-833)

Dr. Adamson later testified that he had seen Patient 30 on April 29, 1998, along with a nurse practitioner student. Dr. Adamson testified that he knows that he had seen this patient along with the student based upon his review of the billing records for that visit. When asked if he had personally evaluated this patient, Dr. Adamson testified that he had seen her several times for gastroenteritis, but that he is not certain if he personally performed the examination on this occasion or if that had been performed by the student. Dr. Adamson testified that, in any case, he was working with the student and would have seen the patient. (Tr. at 2035, 2088-2090) Note that this testimony conflicts with Dr. Adamson's earlier testimony, and with the testimony of Ms. Adamson. (Tr. at 414-417, 832-833)

301. Dr. Gardner testified that, in her opinion, Patient 30 had presented with a new condition of acute gastritis on April 29, 1998. Dr. Gardner indicated that, in her written report, she had erroneously noted the diagnosis that day as acute gastroenteritis rather than the diagnosis of acute gastritis. In any event, Dr. Gardner testified that the Patient presented with a new condition on that date. Moreover, Dr. Gardner testified that there is no previous documentation of acute gastritis in the medical record. In addition, Dr. Gardner testified that, even if the patient had presented in previous years with acute gastritis, acute gastroenteritis, or with diarrhea, vomiting, or cramping, it would not change her opinion. (St. Ex. 72; Tr. at 1065-1069)

302. Dr. Adamson expressed disagreement with Dr. Gardner's conclusion that the patient had had acute gastritis that day. Dr. Adamson further testified that the patient had been suffering from watery diarrhea, which is not a symptom of gastritis. Moreover, Dr. Adamson testified that the patient had been treated with Bentyl, which is used to treat gastroenteritis and irritable bowel syndrome, but not gastritis. (St. Ex. 30 at 66; Tr. at 2035-2036)

February 23, 1999

303. On February 23, 1999, Patient 30 was seen for a chief complaint of fever, nausea, vomiting, and diarrhea. The diagnosis on the progress note states "acute gastroenteritis." A prescription for Phenergan 25 mg #25 was called in, and a sample of Imodium given. The initials "NK PA-C" are written on the progress note. A "REVIEWED" stamp dated February 23, 1999, is present. (St. Ex. 30 at 62, 110)

304. Dr. Adamson testified that he does not believe that Patient 30 had needed to be personally evaluated by a physician prior to treatment on February 23, 1999. Dr. Adamson testified that the patient had had symptoms "which are examples of minor self-limiting symptoms in most cases and are symptoms that this patient had had previously." Dr. Adamson testified

that Patient 30 had last been seen in his office for those symptoms on April 29, 1998. (Tr. at 835-836)

Dr. Adamson testified that he could not specifically recall having seen Patient 30 on February 23, 1999, prior to treatment. Dr. Adamson further testified that the only evidence that he had reviewed the chart was his "REVIEWED" stamp. Finally, Dr. Adamson testified that he had been in the office on that day. (Tr. at 836)

305. Concerning authorization for treating the patient, Dr. Adamson testified, "I gave Nancy Keeler a specific order on that date to give those samples because we happened to have those, which didn't happen very often with Imodium, and a prescription for Phenergan." When Dr. Adamson was asked how he knew that he had had that discussion with Ms. Keeler on that date, Dr. Adamson replied, "I don't have any specific recollection of that conversation, but I was in the office all that day." (Tr. at 836-837)

306. Dr. Gardner testified that, in her opinion, Patient 30 had presented with a new condition of acute gastroenteritis on February 23, 1999. Dr. Gardner further testified that that condition had not been previously mentioned in the chart. Dr. Gardner further testified that previous episodes of gastroenteritis in the chart, if there are any, would not change her opinion, because those episodes would have been resolved. Moreover, Dr. Gardner testified that treatment with Imodium samples and the prescription medication Phenergan was initiated on that date. (Tr. at 1063-1065)

September 1, 1999

307. On September 1, 1999, Ms. Adamson saw Patient 30 for an upper respiratory infection, chest pain, and weight consultation. An assessment of sinusitis was made. The diagnoses were GERD and obesity. Prescriptions for Amoxil 500 mg #30, and Tagamet 400 mg #60 were called in to a pharmacy. "VOWCA/RRH" is noted on the second page of the progress note, which concerns the weight consult and GERD. A "REVIEWED" stamp dated September 1, 1999, appears on both pages of the progress note. There is no physician signature. (St. Ex. 30 at 59, 60, and 111; Tr. at 418-419)

308. Ms. Adamson testified that the prescription for Tagamet had been called in for the patient's GERD "based upon the standing order that she had had GERD before, specific to her, that she could have it." Ms. Adamson acknowledged, however, that there was nothing in the medical record that reflects that standing order. (Tr. at 419)

Ms. Adamson testified that the prescription for Amoxil had been called in for the patient's sinusitis. Ms. Adamson could not recall if that prescription had been based upon a standing order, and testified, "I don't remember if that was a day that [Dr. Adamson] was in the office or not, but it could have been." Ms. Adamson further testified that if Dr. Adamson had been in the office that day, "we would have definitely talked about it, and he would have given me a verbal order." (Tr. at 419-420)

309. Dr. Adamson testified that he does not believe that Patient 30 had needed to be personally evaluated by a physician prior to being treated on September 1, 1999. Dr. Adamson testified that one of the patient's complaints had been obesity. Dr. Adamson testified that he does not believe that obesity is a disease, therefore it would not be a new condition. Dr. Adamson further testified that the patient had complained of chest pain and indigestion, "and those are symptoms that she had described previously." (St. Ex. 30 at 59-60; Tr. at 837-838)

    Dr. Adamson testified that he had been in the office on September 1, 1999, but could not recall if he had examined the patient on that date. (Tr. at 838)

310. Dr. Gardner testified that, in her opinion, Patient 30 had presented with a new condition, sinusitis, on September 1, 1999. Dr. Gardner further testified that, although Patient 30 had been diagnosed with sinusitis on February 23, 1998, she believed that that condition had resolved prior to the September 1, 1999, visit: "[l]ogical deduction would imply that it did, otherwise the patient would have been sick for a year and a half." Dr. Gardner further testified that the medical records did not indicate that the patient suffered from chronic sinusitis. (St. Ex. 30 at 68a; Tr. at 1057-1063, 1214-1219)

September 2, 1999

311. On September 2, 1999, Patient 30 called and left a message for Ms. Adamson concerning insurance issues for her obesity medication. The telephone message form indicates that a prescription for Xenical 120 mg #90 was called in to a pharmacy. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 30 at 58a)

November 8, 1999

312. On November 8, 1998, Patient 30 was seen by Ms. Adamson for a diagnosis of obesity. The history indicates among other things that the patient had been taking Xenical. The progress note states that Patient 30 was prescribed Xenical 120 mg #90 with two refills, and advised to follow up in three months. The initials "VOWCA/RRH" appear on the note, as does a "REVIEWED" stamp dated November 8, 1999. There is no physician signature. (St. Ex. 30 at 55)

313. Dr. Adamson testified that he does not believe that he had needed to countersign the November 8, 1999, entry because he had given a verbal order and the patient was given a written prescription. Dr. Adamson further testified that the Board's allegations indicate that he had not timely stamped the chart following a November 3, 1999, visit, but that that date is incorrect. Dr. Adamson further testified that Patient 30 was not seen on November 3, 1999. Nevertheless, Dr. Adamson acknowledged that he can see why

someone might have thought that the handwritten date on the progress note said November 3, 1998. (Tr. at 2011-2012, 2081)

Testimony of Patient 30

314. Patient 30 testified that she had been a patient at Apple Health, and that Dr. Adamson had been her physician. Patient 30 further testified that she liked Dr. Adamson and Ms. Adamson very much. Patient 30 testified that she believes that she had received quality care from Dr. Adamson and Ms. Adamson. (Tr. at 1268, 1274)

    Patient 30 testified that she had not seen Dr. Adamson at every visit to Dr. Adamson's office. Patient 30 further testified that, on the occasions she had not seen Dr. Adamson, she had seen Ms. Adamson. Patient 30 further testified that, on those occasions, Ms. Adamson had examined her and had advised her what was wrong. Patient 30 denied that Ms. Adamson had given or called in prescriptions for her. (Tr. at 1269-1270)

    Patient 30 testified that, on the occasions when Ms. Adamson had seen her, Dr. Adamson had come in and discussed her medical treatment "[w]hen [she] first started going there." Patient 30 further testified that Ms. Adamson had once given her samples of amoxicillin for sinusitis. Patient 30 could not recall if Dr. Adamson had come into the room prior to the samples being given. (Tr. at 1270-1271)

<u>Patient 31</u> (Ms. Adamson Patient 23)

August 2, 1999

315. On August 2, 1999, Ms. Adamson saw Patient 31 for a chief complaint of "medicine refill." The diagnosis states, "COPD." The progress note states that Patient 31 had been taking the following medications: Albuterol (both oral and inhaler), theophylline, Prednisone, Serax 15 mg, and Flovent inhaler. Refills of all of these medications except for the Albuterol inhaler were called in to a pharmacy and, except for the Serax, each of those prescriptions were given refills for one year. The progress note indicates "x5 only" for Serax. The progress note further indicates that the Albuterol inhaler that the patient had used previously was changed to Combivent inhaler, and a prescription was called in for Combivent inhaler with one year of refills. Finally, the progress note indicates that a prescription was called in for Zyban 150 mg #60, with two refills. A "REVIEWED" stamp dated July 30, 1999, appears on the progress note. (St. Ex. 31 at 24a; Tr. at 421-423)

    Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

316. Ms. Adamson acknowledged that the progress note for August 2, 1999, does not show any authorization from Dr. Adamson or any other physician to call in the prescriptions for Patient 31. Ms. Adamson further acknowledged that the progress note does not show the time that the order was written. (St. Ex. 31 at 24a; Tr. at 421-423)

317. Dr. Adamson testified that the prescriptions that were called in for Patient 31 on August 2, 1999, had been authorized as part of the individual treatment plan that Dr. Adamson had ordered for Patient 31. Dr. Adamson further testified that this treatment plan had been documented on the progress note dated July 6, 1998. Dr. Adamson testified that this treatment plan had authorized most of the prescriptions that Patient 31 received on August 2, 1999. (St. Ex. 31 at 29; Tr. at 1500-1503)

The progress note for July 6, 1998, lists the following medications, with a hand-drawn bracket and line leading to the pre-printed word, "Plan": Albuterol MDI, Prednisone 10 mg, Theophylline 24 400 mg, Serax 15 mg, Cimetidine 800 mg, Flovent 110, and Atrovent. (St. Ex. 31 at 29)

Dr. Adamson testified that Ms. Adamson had been authorized to switch the patient from Albuterol to Combivent on August 2, 1999, based upon his general authorization to Ms. Adamson "that any patients who were using both Albuterol and Atrovent previously * * * could be started on Combivent." Dr. Adamson noted that Combivent is a combination of Atrovent and Albuterol that saves patients an extra co-pay at the pharmacy. Finally, Dr. Adamson testified that Ms. Adamson had been authorized to call in a prescription for Zyban on August 2, 1999, because that was part of his office's standard care plan for smokers who had a willingness to quit. (Tr. at 1503-1504)

The following exchange occurred concerning Dr. Adamson's authorization for Patient 31's prescriptions:

Q. (by Ms. Crawford): [B]asically, you're saying that if you find in the chart anyplace where this patient is taking any of these medications, then that is the authorization for prescriptions to be called in a year later?

A. (by Dr. Adamson): In general, if it's a chronic condition and I've given an individual treatment plan for that patient and it was a very specific individual treatment plan for this patient that she needed to continue all of these medicines without interruption.

Q. And there's no requirement that you see this patient prior to them calling in all those numerous prescriptions?

A. No, it's an established patient with an established condition and the statute is very clear that a PA can see that.

Q. And that's your policy in your office, that you don't need to see the patient, you can just call in the prescription?

A. It's my policy to follow the statute.

Q. But the policy is what you had established as what you believe is the correct care for this patient is just to call in the prescriptions without you seeing her, correct?

A. No, the patient needed to be seen once a year and I believe the patient—the records reflect that the patient was seen by a provider in the office at least once a year.

Q. But not seen by you, right?

A. But not seen by me, that's correct.

(Tr. at 1506-1507) [Note that there is no statement on the progress note for July 6, 1998, indicating that "it was a very specific individual treatment plan for this patient that she needed to continue all of these medicines without interruption." (St. Ex. 31 at 29)]

Patient 32 (Ms. Adamson Patient 24)

November 17, 1998

318. On November 17, 1998, Patient 32 was seen for a chief complaint of pelvic pain. No diagnosis is indicated. A prescription for Floxin 300 mg #20 was issued. The plan indicated "CBC [with] diff," "Pap test," Hemocults," and follow up in 10 days. The name "N. Keeler PA-C" is written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 32 at 61)

January 18, 1999

319. On January 18, 1999, Patient 32 called to discuss her medication for diverticulitis. The telephone message form indicates that a prescription for Levsin 0.125 mg #90 with refills for one year was called in to a pharmacy. The notation, "Done N.K." is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 32 at 57)

July 30, 1999

320. Ms. Adamson testified that she saw Patient 32 on July 30, 1999, for a chief complaint of sore throat and earache for three weeks. The progress note stated that the diagnosis was left otitis media. Ms. Adamson had two prescriptions called in for Patient 32 that date: a ten-day regimen of E-Mycin 333, and Premarin 0.625 #30 with four refills. Ms. Adamson acknowledged that there is nothing on the progress note that indicated that a physician had authorized those prescriptions to be called in. The initials "MB-PAS" are written on the note. A "REVIEWED" stamp dated July 30, 1999, appears on the progress note. There is no physician signature. (St. Ex. 32 at 54 and 110; Tr. at 423-424)

Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

321. Ms. Adamson testified that she did not believe that she had violated any protocol or instructions from Dr. Adamson "because we had talked about this patient specifically. She had had extensive old records that came with her. She had [had] a lot of upper respiratory infections in the past that had been treated with that medicine, E-Mycin 333[.]" Ms. Adamson testified that this discussion had taken place on September 1, 1998, when Patient 32 was seen in Dr. Adamson's office for the first time. Ms. Adamson acknowledged that the progress note for the September 1, 1998, visit does not record such a discussion, but that Ms. Adamson remembers Dr. Adamson "with his wad of papers in the hall, looking through it, and we talked about it." When asked how a discussion between Ms. Adamson and Dr. Adamson in September 1998 had authorized Ms. Adamson to call in prescriptions for E-Mycin and Premarin in July 1999, Ms. Adamson replied:

> Because [we] talked about this patient on 9-1-98, reviewed her old records, which are pages of upper respiratory things, where she was previously given E-Mycin 333, and we specifically talked about that because that's not a medication that Dr. Adamson would typically order. But the patient felt that that's what worked for her, so that's what he wanted her to have. [The progress note for Patient 32's September 1, 1998, visit] also says, 'Several episodes of bronchitis yearly.'
>
> * * *
>
> [Concerning the prescription for Premarin,] when she was seen on 9-1-98, she was on the Premarin, and she was told to schedule back with me for her Pap test. And he would have said that she can have that—as long as she has her Pap, she can have her Premarin for a year, which was why on 7-30-99 she only got four refills, because she would be due, then, for a Pap four months after that, in November, because she had had her Pap in November [1998].

(St. Ex. 32 at 54 and 62a; Tr. at 425-427)

Ms. Adamson acknowledged that on July 30, 1999, she had not had any discussions with Dr. Adamson concerning prescribing Premarin for Patient 32. Further, Ms. Adamson acknowledged that her initials do not appear on the progress note for the July 30, 1999, visit, nor is the time of the order recorded. Finally, Ms. Adamson acknowledged that the name of the physician under whose authorization she had written the order was not recorded on the progress note. (St. Ex. 32 at 54; Tr. at 431)

322. Dr. Adamson testified that he did not personally evaluate Patient 32 on July 30, 1999, and was out of the office on that date. Dr. Adamson further testified that there was no supervising physician in the office on that date. However, Dr. Adamson testified that he does not believe that Patient 32 had needed to be personally seen by a physician prior to treatment on July 30, 1999. Dr. Adamson testified that, first, Patient 32 had complained of sore throat and earaches, which he described as minor, self-limiting problems that he does

not consider to be new conditions. Second, Dr. Adamson testified that he had seen Patient 32 on September 1, 1998, for her initial visit to his office, and at that time he had reviewed her old medical records. Dr. Adamson testified that those records revealed that Patient 32 had been treated with antibiotics on numerous occasions for upper respiratory infections including otitis media, sore throat, and bronchitis. (Tr. at 838-844)

Further, Dr. Adamson recalled "having a chuckle with this patient about the number of times that she had been prescribed Erythromycin, because that wasn't a medicine that we routinely used." Dr. Adamson testified that the patient had asked him if she got sick and knows that that is what she needs, would she receive it. Dr. Adamson testified that "we said, yes you can have the Erythromycin as long as you come in and we can check you out to make sure there's nothing more serious wrong." Further, Dr. Adamson testified that "there was a specific treatment plan for this patient in regards to her multitude of upper respiratory symptoms." Dr. Adamson testified that this treatment plan was given verbally to Ms. Adamson, and was not documented in writing. (St. Ex. 32 at 62a; Tr. at 838-841)

Dr. Adamson testified that the authorization for Ms. Adamson to have prescriptions for erythromycin and Premarin called in on July 30, 1999, was a specific order to Ms. Adamson given on September 1, 1998. (Tr. at 844-845)

323. Dr. Adamson testified that July 30, 1999, was the first time that Patient 32 had been seen in his office for otitis media. Nevertheless, Dr. Adamson testified that "[t]he physical exam line under ears is not completed. So I don't know if the patient had an otitis media on 7/30/99 or not" (Tr. at 841-842)

324. Dr. Gardner testified that, in her opinion, Patient 32 presented with a new condition of left otitis media on July 30, 1999. Dr. Gardner further testified that that condition does not appear earlier in the chart. Moreover, Dr. Gardner testified that the patient was treated with erythromycin that day. (Tr. at 1073-1074)

<u>Patient 33</u> (Ms. Adamson Patient 25)

August 3, 1999

325. On August 3, 1999, Patient 33 was seen by Ms. Adamson for a chief complaint that included right ear discomfort and pain on the right side of his face. It was noted that the patient had had root canal seven days earlier, and had been taking Tylenol No. 3. The medical record does not indicate the location of the root canal. No diagnosis is recorded on the progress note. Ms. Adamson had two prescriptions called in for the patient: Ibuprofen 800 mg #50, and Serevent Diskus with refills for one year. A "REVIEWED" stamp dated August 3, 1999, is present. (St. Ex. 33 at 55a; St. Ex. 70a; Tr. at 432)

Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

326. Ms. Adamson testified that she had been authorized to have the prescription for ibuprofen called in for Patient 33 because he had previously been seen for ear pain on March 26, 1999, and based upon Dr. Adamson's standing order that a patient "with minor pain, right ear discomfort, could have ibuprofen." (St. Ex. 33 at 60; Tr. at 432-433)

    Concerning the prescription for Serevent Diskus, Ms. Adamson acknowledged that Patient 33 had not previously been prescribed Serevent Diskus. Ms. Adamson further testified, however, that she had been instructed by Dr. Adamson to add Serevent to the treatment regimen of asthmatic patients who had been using Albuterol regularly. Ms. Adamson testified that it is not desirable for patients to use Albuterol daily. Ms. Adamson further testified that Dr. Adamson had told her during Patient 33's visit on March 23, 1999, that if Patient 33 did not reduce his Albuterol use then he was to receive Serevent. Ms. Adamson testified that, accordingly, she "made a decision based on Dr. Adamson's order that if [Patient 33] was still using his Albuterol on a daily basis * * * that he needed to go on Serevent." (St. Ex. 33 at 62; Tr. at 433-443)

327. Dr. Adamson testified that he had authorized the prescription for ibuprofen based upon his standard care plan for patients with pain from toothaches and dental procedures. Dr. Adamson noted that the patient had been taking Tylenol No. 3, which Dr. Adamson assumed had been prescribed by the patient's dentist, and that Patient 33 was being stepped down to ibuprofen from that narcotic pain reliever. When asked if there was any indication in the chart that the patient's dentist had been contacted regarding pain medication and possible problems in prescribing ibuprofen for a dental problem, Dr. Adamson testified that

    > [t]he patient reported to us that he was taking Tylenol No. 3, so I wouldn't see any need for additional conversation with the dentist. He's far enough out from the procedure that he wouldn't have bleeding complications or other complications and that's an assessment that could be made in our office and wouldn't require a call to a dentist.

    (Tr. at 1508, 1511-1513)

    With regard to the prescription for Serevent Diskus, Dr. Adamson testified that he had received a medication use report concerning Patient 33 and other patients from PCS, a pharmacy benefits company. Dr. Adamson testified that, based on that report and discussions with a pharmacist from PCS, he had decided to switch Patient 33 from Albuterol to Serevent, a longer acting form of a comparable medication. Moreover, Dr. Adamson testified that he had given Ms. Adamson "a specific order that the next time [Patient No. 33] came into the office, that he was to have Serevent added to his asthma treatment." Dr. Adamson acknowledged that Ms. Adamson's notation on the report from PCS that states "8-3 started Serevent RRH" is the only documentation of this order. (St. Ex. 33 at 57; Tr. at 1508-1510)

Patient 34

January 26, 1999

328. On January 26, 1999, Patient 34 was seen for a chief complaint of "[symptoms] came back." The progress note states that the diagnosis was left otitis media. Prescriptions were issued for Entex LA #20 with one refill, and Cefzil 250 mg #20 with one refill. "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 34 at 57a)

April 23, 1999

329. A telephone message taken on April 23, 1999, states, "Line #1. Chest congestion—takes toprol, can she take otc decongestant?" Below that message, "Robitussin" is written. Next to the word "Robitussin" the statement "per RRH" is circled. No "REVIEWED" stamp or physician signature is present (St. Ex. 34 at 50)

    Dr. Adamson testified that he does not believe that he had needed to countersign this entry because "[i]t's strictly answering a patient's question on whether or not they can take an over-the-counter medication. I don't consider answering a question a physician order." (Tr. at 2010-2011)

Patient 35 (Ms. Adamson Patient 26)

August 2, 1999

330. On August 2, 1999, Ms. Adamson saw Patient 35 for a chief complaint of bilateral leg swelling for four days. The progress note stated that the "swelling is better." The diagnosis states "MC headaches." Prescriptions were issued for Xenical 120 mg #90 with one refill, Flexeril 10 mg (quantity not noted), and Midrin #60 with three refills. A notation "Rx for mail in" is written next to the prescribed medications. Further, the progress note states that physical therapy for the patient's neck was advised based upon diagnoses of fibromyalgia and C-strain. "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 35 at 142b; Tr. at 444-446)

    Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

331. Ms. Adamson testified that Patient 35's headaches had been the focus of her August 2, 1999, visit. Ms. Adamson further testified that the prescriptions that Patient 35 had received had been "for mail in," clipped to the chart, and signed by Dr. Adamson when he returned to the office. Ms. Adamson noted that the Midrin had been prescribed for Patient 35's headaches, the Flexeril for her fibromyalgia, and the Xenical for weight loss. (Tr. at 444-446)

332. Ms. Adamson testified that she had not required authorization for the prescriptions because the prescriptions had not been given to the patient; Dr. Adamson authorized them when he returned to the office. (Tr. at 446-447)

333. Ms. Adamson testified that she did not believe that fibromyalgia and C-strain had been new conditions for Patient 35 because she had been previously treated for fibromyalgia and neck pain. However, Ms. Adamson was unable to find an earlier reference in the medical record that specifically stated that Dr. Adamson had previously treated Patient 35 for fibromyalgia. (Tr. at 447-451)

334. Dr. Adamson acknowledged that Patient 35 had not been seen by a physician on August 2, 1999. However, Dr. Adamson testified that he does not believe that Patient 35 had needed to be personally seen by a physician prior to treatment on that day. Dr. Adamson testified that the patient had complained of leg swelling, "which was an established condition for that patient." Dr. Adamson further testified that this visit had been a follow up to a visit on May 17, 1999, at which time the patient had been diagnosed with venous insufficiency. In addition, Dr. Adamson testified that fibromyalgia had been an established diagnosis for Patient 35. Dr. Adamson testified that he had seen the patient on July 12, 1999, for a variety "of nonspecific complaints, including dizziness, headaches, and these are all symptoms that can go along with fibromyalgia. And she was treated with Prozac on that date, which is a medication that's used to treat fibromyalgia." Moreover, Dr. Adamson testified that C-strain was secondary to the patient's fibromyalgia. Dr. Adamson acknowledged that the progress note for the July 12, 1999, visit does not mention fibromyalgia. (St. Ex. 35 at 142b, 145, 147a; Tr. at 846-848, 2037-2039, 2092)

    Dr. Adamson further testified that Patient 35 had not been given prescriptions on August 2, 1999. Dr. Adamson stated that "[t]he patient had requested prescriptions for mail-in and those prescriptions were signed by me when I returned to the office." (Tr. at 848)

335. Dr. Gardner testified that Patient 35 was seen for a number of problems on August 2, 1999. Dr. Gardner further testified that, among these, cervical strain, fibromyalgia, and "MC headaches" were new conditions. Dr. Gardner stated that the patient had not previously been evaluated for cervical strain or fibromyalgia. (Tr. at 1075-1079)

September 3, 1999

336. On September 3, 1999, Patient 35 was seen for a diagnosis of asthmatic bronchitis. Prescriptions were issued for, among other things, Xenical 120 mg #300, Darvocet N-100 #100 with three refills, Medrol Dospak, Z-Pak, and Humibid. The progress note further states "recall Tesalon Pearles [sic]." The patient was advised to be re-checked in two weeks. "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 35 at 137)

November 5, 1999

337. On November 5, 1999, Patient 35 was seen for a chief complaint of "refill HA meds." Prescriptions were issued for Imitrex nasal spray #6 with two refills, and Z-Pak. The plan indicates that a referral to another physician was made, a splint was applied to her right thumb, and a referral or recommendation made for physical therapy. "VOWCA/RRH" is written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 35 at 130)

Patient 36 (Ms. Adamson Patient 27)

August 3, 1999

338. On August 3, 1999, Ms. Adamson saw Patient 36 for a chief complaint of "follow up UTI." The history indicates, among other things, "Off Premarin since winter because of vaginal dryness & itching." The progress note indicates that the diagnoses were urinary tract infection and "atrophic vuv." Prescriptions for "Cipro Urapak," and Estratest HS #30 with one refill were called in. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated August 3, 1999, is present. (St. Ex. 36 at 69 and 145; Tr. at 451-452)

    Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

339. Ms. Adamson testified that she had been authorized to have the prescriptions called in for Patient 36 because, on July 21, 1999, Patient 36 had been seen in Dr. Adamson's office for a urinary tract infection and told to follow up in two weeks. A culture had been taken during the earlier visit. Two weeks later, when Ms. Adamson saw her, Patient 36 was still having problems. (St. Ex. 36 at 71; Tr. at 452-453)

    Ms. Adamson testified that the lab results had indicated that the pathogen was sensitive to Cipro. Patient 36 had previously been placed on Macrodantin. Ms. Adamson testified that "this culture report came back on [July 23, 1999]. And we saw that her Macrodantin—that MIC level was high. So he would have said to me, 'Call her and make sure she finishes it. When she follows up, if it doesn't work, giver her Cipro.'" This order was not recorded in the patient chart. (St. Ex. 36 at 14a; Tr. at 456-458)

340. Ms. Adamson testified that atrophic vulvovaginitis is a change that occurs to the vaginal area "when there's no estrogen, not enough estrogen on board." Ms. Adamson testified that atrophic vulvovaginitis had not been a new condition for Patient 36 because she had been treated with estrogen by her gynecologist. Ms. Adamson also noted that there is a notation on the August 2, 1999, progress note that states that the patient had been "off Premarin since winter because of vaginal dryness & itching." Ms. Adamson testified that the patient had taken herself off of Premarin because of discomfort; however, what the patient had needed was more estrogen, not less. (St. Ex. 36 at 69; Tr. at 453-454)

Ms. Adamson acknowledged that Dr. Adamson had not previously treated Patient 36 for atrophic vulvovaginitis. Nevertheless, Ms. Adamson chose to put Patient 36 on hormone-replacement therapy "[b]ased on Dr. Adamson's standing order that if they have atrophic vulvovaginitis, they need medication. And the Premarin wasn't doing this for her, so his next order would be Estratest HS." This order was not recorded in the medical record. (St. Ex. 36; Tr. at 454-455)

341. Dr. Adamson testified that Patient 36 was not personally evaluated by a physician prior to the commencement of treatment on August 3, 1999. Dr. Adamson further testified that he does not believe that Patient 36 had needed to be personally evaluated by a physician prior to treatment on that date. (St. Ex. 36 at 71; Tr. at 849, 852, 858)

Dr. Adamson testified that Ms. Adamson had been authorized to have a prescription for Estratest called in because the patient had been on hormone replacement therapy since 1995. Dr. Adamson testified that her hormone therapy was primarily managed by her gynecologist, but that the patient had regularly discussed her therapy with Dr. Adamson's office. Dr. Adamson further testified that Patient 35 had been taking Premarin. Dr. Adamson acknowledged that Estratest had not been prescribed to her previously by his office, and that "Estratest was a new medication for this patient on that date," as well as new to the market. (Tr. at 849-852)

Dr. Adamson testified that Ms. Adamson had been authorized to start Patient 36 on a new hormone replacement medication based on Dr. Adamson's general authorization concerning patients "who were having an inadequate clinical response to their Premarin[.]" Dr. Adamson further testified that there is no indication in the medical record of any discussion with Patient 36's gynecologist prior to Ms. Adamson initiating Estratest. Finally, Dr. Adamson testified that "[i]n general, we would not discuss our medication orders with outside physicians unless we thought there was some sort of potential problem" or the medication was outside Dr. Adamson's usual scope of practice. (Tr. at 852-853)

Dr. Adamson testified that Ms. Adamson had been authorized to have the prescription for Cipro called in based on his discussion with Ms. Adamson concerning the patient's July 23, 1999, laboratory report. Dr. Adamson testified that he remembered having that discussion because the patient was his brother's secretary. Dr. Adamson further testified that the patient had been previously prescribed Macrodantin on July 21, 1999. Dr. Adamson testified that he had wanted to give the patient Macrobid, which is a longer-acting form of Macrodantin, but the insurance company would not pay for that formulation. Dr. Adamson testified that that could have resulted in the patient missing doses. Moreover, Dr. Adamson testified that, when the lab report was received, Ms. Adamson had asked him what she should do if the patient comes in and is not better. Dr. Adamson stated the lab report had indicated that Patient 36's infection would be most sensitive to ciprofloxacin. Accordingly, Dr. Adamson testified that he had given Ms. Adamson a specific order to give the patient Cipro if the Macrodantin had not worked. Finally, Dr. Adamson testified that when

Patient 36 returned to his office on August 3, 1999, she had finished her Macrodantin and was still having symptoms. (St. Ex. 36 at 14a, 69, 71; Tr. at 853-858)

342. Dr. Gardner testified that, in her opinion, Patient 36 presented with a new condition of atrophic vulvitis on August 3, 1999. Moreover, Dr. Gardner testified that treatment was initiated with Cipro and Estratest. (Tr. at 1079-1084)

Patient 37

August 3, 1999

343. On August 3, 1999, a urinalysis and culture was ordered for Patient 37. The initials "RRH" are written on the urine analysis form. A "REVIEWED" stamp dated August 3, 1999, is present. There is no physician signature. (St. Ex. 37 at 8-9)

Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

Patient 38

June 19, 1998

344. On June 19 [no year recorded], a message states "here for PSA & wants new arthritis medicine." Below that, it states "Arthrotec samples given. Ok." "VOWCA/RRH" is written on the message form. A "REVIEWED" stamp dated June 24, 1998, is present. There is no physician signature. (St. Ex. 38B at 237)

August 11, 1998

345. A telephone message dated August 11, 1998, indicates that Patient 38 needed authorization from Prudential for Arthrotec 75 mg. A note on the form indicates that eighteen samples were issued. Another note on that page indicates that the authorization was faxed on August 18, 1998. No initials or signature appears on the page except for the initials of the person taking the message. There is no "REVIEWED" stamp or physician signature on the note. (St. Ex. 38B at 234)

Both Dr. Adamson and Ms. Adamson were out of state from August 7 through 16, 1998. (St. Ex. 83B; Tr. at 1305)

346. Dr. Adamson testified that the handwriting indicating that samples had been given appears to belong to Molly McCale. Dr. Adamson testified that he does not believe that he had needed to sign that chart entry because "[t]his was an order given to a medical assistant. And I'm not required by any statute that I know of to cosign chart entries of medical assistants." (Tr. at 2008-2009)

May 6, 1999

347. On May 6, 1999, Patient 38 was seen by Ms. Adamson for a chief complaint of flu. The physical examination section of the progress note states that the patient had pain in the left anterior of the chest. The progress note further states that Patient 38 needed to see a general surgeon; had seen Daniel Watson, M.D., on March 30; and needed to follow up. The plan indicates "[follow-up after] sees surgeon." The diagnosis section is blank. The initials "RRH" are written on the progress note. A "REVIEWED" stamp dated May 20, 1999, is present. There is no physician signature. (St. Ex. 38 at 201)

    Dr. Adamson testified that he does not believe that he had needed to countersign that entry because "[t]here are no orders. It's strictly a history and exam recorded by the physician assistant." (Tr. at 2009-2010)

July 29, 1999

348. On July 29, 1999, Patient 38 was seen for a chief complaint of flu. The diagnosis was "CAD." Fasting glucose, lipids, and PSA were ordered. The plan indicated that Patient 38 could return to work on Monday. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated July 30, 1999, is present. There is no physician signature. (St. Ex. 38 at 197)

    Dr. Adamson was out of state from July 29 through August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

<u>Patient 39</u> (Ms. Adamson Patient 28)

September 1, 1998

349. On September 1, 1998, Patient 39 was seen in Dr. Adamson's office for a follow-up to an emergency room visit; the date of the emergency room visit was not recorded on the progress note. Patient 39 had gone to an emergency room because a contact lens had become stuck in his left eye. The progress note indicates that the contact lens was removed in the emergency room, Patient 39 was told that he had scratches on his cornea, and he was given eyedrops that are not identified. The progress note also indicates that Patient 39 had stated at Dr. Adamson's office that he felt fine. Moreover, the progress note indicates that a fluorescein stain had been negative, and that Patient 39 should be rechecked as needed. The diagnosis indicates corneal abrasion. "VOWCA/RRH" is written on the progress note. There is no physician signature or "REVIEWED" stamp on the note. (St. Ex. 39 at 40)

    Dr. Adamson testified that he did not believe that he had needed to countersign the September 1, 1998, entry. Dr. Adamson testified that the patient had come in for an examination of his eye, which was performed, and which was negative. Dr. Adamson testified that it was a normal examination and the patient was healthy. Moreover,

Dr. Adamson testified "I don't need to sign that because there are no orders. He was told to follow-up whenever he needed to." (Tr. at 2015-2017)

July 26, 1999

350. On July 26, 1999, Ms. Adamson responded to a telephone message from Patient 39 wherein Patient 39 had asked, "Tried Robitussin for occasional cough—have had for 2-3 weeks. Not helping—can I get something stronger?" The message form indicates that a prescription for Humibid DM #40 was called in. "VOWCA/RRH" is written on the message form. A "REVIEWED" stamp dated July 26, 1999, is present. (St. Ex. 39 at 36; Tr. at 459-460)

351. Ms. Adamson testified that she did not believe that Patient 39's cough had constituted a new condition because he had been treated previously in Dr. Adamson's office for cold symptoms, cough, and pharyngitis. Ms. Adamson further testified that she had been authorized to have the prescription called in for Patient 39 based upon Dr. Adamson's standing order that patients who have a cough could have Humibid. (Tr. at 459-462)

352. Dr. Adamson testified that he does not believe that Patient 39 had needed to be personally evaluated by a physician prior to the initiation of treatment on July 26, 1999. Dr. Adamson testified that, first, the patient complained of a cough, which he considers to be a minor, self-limiting condition. Second, the patient had previously been seen in his office for a complaint of cough, the most recent visit having been December 17, 1996. (St. Ex. 39 at 47a; Tr. at 858-860)

353. Dr. Adamson testified that Ms. Adamson had been authorized to have a prescription for Humibid called in. Dr. Adamson further testified that "[i]t was a general authorization that patients who requested prescription medication for cough that had no other associated symptoms could be given Humibid to treat their symptoms." (St. Ex. 39 at 36; Tr. at 860, 1513-1514)

354. Dr. Gardner testified that, in her opinion, Patient 39's telephone complaint of cough had been a new condition. Dr. Gardner further testified that cough had not been mentioned in the medical records for Patient 39 for three years previous to the telephone complaint of July 26, 1999. Finally, Dr. Gardner testified that a prescription for Humibid was called in that day. (St. Ex. 39 at 36; Tr. at 1087-1088)

July 30, 1999

355. Ms. Adamson testified that, on July 30, 1999, Patient 39 was seen by Ms. Adamson and Marsha Bendle, a physician assistant student, for a chief complaint of "cough x 3 weeks." On the progress note, the diagnosis is listed as sinusitis. Prescriptions for Entex LA #30 and an unspecified quantity of Ceclor 250 mg were called in. The patient was advised to call if not better in two weeks. The initials "MB-PAS" are written on the note. A

"REVIEWED" stamp dated July 30, 1999, is present. There is no physician signature. (St. Ex. 39 at 34a; Tr. at 462-463)

Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

356. Ms. Adamson testified that she had been authorized to have the prescriptions called in for Patient 39 based upon Dr. Adamson's standing order that a patient with an upper respiratory infection who is allergic to penicillin could receive Ceclor and Entex. (Tr. at 463-464)

357. Dr. Adamson testified that he and Ms. Adamson had discussed Patient 39 the afternoon of July 27, 1999, or the morning of the following day. Dr. Adamson stated that this had been prompted by a July 27 or 28, 1999, telephone call from the patient complaining of a cough, but that that call had not been included in the medical record. Dr. Adamson further testified that he had told Ms. Adamson "specifically to examine [Patient 39] and that he could be treated with Entex and Ceclor." When Dr. Adamson was asked how he could remember a specific phone call from almost three years earlier, he testified:

> Because I think we've all gone on vacation and remember those two events prior to leaving that just make us crazy when everything seems to go wrong. This was a very whiney patient and I specifically, you know, remember Robin saying, Patient 39 called again, what do you want me to do? And I gave her specific orders on what I wanted her to do.

(St. Ex. 39 at 34a; Tr. at 860-862, 1514-1516) Finally, Dr. Adamson testified that this order had not been recorded in the record other than for Ms. Adamson's July 30, 1999, progress note. (Tr. at 1516)

358. Concerning the "REVIEWED" stamp dated July 30, 1999, on the progress note, Dr. Adamson testified that he had actually stamped the chart on August 4, 1999. Dr. Adamson testified that there were a number of charts that he had stamped with an incorrect date before noticing that he had not advanced the date. (Tr. at 1517)

<u>Patient 40</u> (Ms. Adamson Patient 29)

August 2, 1999

359. Ms. Adamson testified that she had seen Patient 40 on August 2, 1999. Diagnoses of non-insulin-dependent diabetes mellitus and plantar fasciitis are written on the progress note. Prescriptions were called in that day for Naprosyn 500 mg #60 with five refills, Glucatrol XL 10 mg #30 with refills for one year, and Avandia 4 mg #30 with refills for one year. Further, there is no "REVIEWED" stamp on the progress note. (St. Ex. 40 at 93; St. Ex. 70; Tr. at 472-474)

Lucinda Schmidt, pharmacist for Kroger, 55 West Schrock Road, Westerville, Ohio, testified that her review of the pharmacy records at that store indicate that the prescription for Patient 40 for Naprosyn and Glucatrol had been called in to the pharmacy on August 2, 1999. (Tr. at 1293-1296)

Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

360. Ms. Adamson testified that Patient 40 had presented for a diabetes follow up on August 2, 1999, which was not a new condition. Ms. Adamson noted that the prescriptions for Glucatrol and Avandia had been issued for his diabetes. Concerning the prescription for Naprosyn, Ms. Adamson testified that the patient had previously been prescribed Naprosyn on one occasion, February 17, 1997, for tennis elbow. Ms. Adamson testified that Naprosyn had been "a long-standing prescription that Dr. Adamson had ordered for his aches and pains related to his [350 pound] weight and his job." (St. Ex. 40 at 122a; Tr. at 475-477)

Ms. Adamson further testified that "plantar fasciitis" had been recorded as a diagnosis for coding purposes only. Moreover, Ms. Adamson denied that the patient had had plantar fasciitis, but had simply asked questions about it. Ms. Adamson testified that she "spent time teaching him about how to prevent plantar fasciitis. He didn't actually have it. His exam was normal." (Tr. at 475-477, 493-494)

361. Ms. Adamson testified that she had issued prescriptions to Patient 40 based upon "Dr. Adamson's specific order on this patient that he could have refills on his chronic medications." Ms. Adamson defined "chronic medication" as medication that a patient needs on an ongoing basis for a health condition. Ms. Adamson further testified that there was nothing written in the medical records concerning that authorization, and that Dr. Adamson's directions to her concerning prescription refills for Patient 40 had been verbal. (Tr. at 478-487)

362. Dr. Adamson testified that he does not believe that Patient 40 had needed to be personally evaluated by a physician prior to treatment on August 2, 1999, because "[t]he patient is an established patient with an established individual treatment plan for his diabetes." (Tr. at 862-863)

With regard to the prescription for Naprosyn, Dr. Adamson testified that he had given specific authorization for this patient to receive Naprosyn for his musculoskeletal complaints. Dr. Adamson further testified the patient had never received Naprosyn from his office before, although a progress note dated February 17, 1997, indicated that the patient had a supply, evidently obtained elsewhere. (St. Ex. 40 at 122a; Tr. at 866-872)

363. Dr. Gardner testified that, in her opinion, Patient 40 had presented with a new condition of plantar fasciitis on August 2, 1999. Dr. Gardner further testified that that diagnosis had not previously appeared in the chart. (Tr. at 1088-1089)

Patient 41 (Ms. Adamson Patient 30)

August 3, 1999

364. On August 3, 1999, Ms. Adamson saw three-year-old Patient 41 for a well child visit. Ms. Adamson had prescriptions called in for Zithromax liquid and Anusol HC. Ms. Adamson testified that the Zithromax was for the patient's sinuses, and the Anusol was for pruritus ani. No "REVIEWED" stamp or physician signature appears on the progress note. (St. Ex. 41 at 54a; Tr. at 495-496)

    Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

365. Ms. Adamson testified that the patient had been seen previously on July 9, 1999, for pruritus ani and to rule out a strep infection. Ms. Adamson further testified that Dr. Adamson had given her a specific order to give the patient Anusol HC if his pruritus ani did not improve, and to give him Zithromax if his upper respiratory infection recurred or did not improve. Moreover, Ms. Adamson testified that Patient 41 had received Zithromax previously. Ms. Adamson acknowledged that the progress note for the previous visit on July 9, 1999, does not reflect an order to give the patient Zithromax, but stated that that order had been given to her verbally. Finally, Ms. Adamson acknowledged that nothing on the progress note for July 9, 1999, indicates that she had had specific authorization to give the patient Anusol. (St. Ex. 41 at 55; Tr. at 496-498)

366. A "Child's Medical Statement" signed by Dr. Adamson states, in part, that "This is to certify that I have examined [Patient 41] on 8-3-99 * * *." Ms. Adamson testified that Dr. Adamson had not examined Patient 41 on that date, but that she had done so "acting as his agent." (St. Ex. 41 at 38; Tr. at 498-499)

367. Dr. Adamson testified that Patient 41 had been seen in his office on August 3, 1999, when he had been out of town. Dr. Adamson acknowledged that prescriptions for Zithromax and Anusol HC had been called in that day. Dr. Adamson testified that the prescription for Zithromax had been part of the patient's individual treatment plan for recurrent ear or sinus infections. Dr. Adamson further testified that the patient had previously been seen on February 3, 1999, for otitis media and nasal congestion and was prescribed Zithromax. Moreover, Dr. Adamson testified that he had had a discussion with Ms. Adamson on that date, and informed her that Patient 41 had been through a lot of different antibiotics and that he tolerated Zithromax best. Finally, Dr. Adamson acknowledged that this discussion had been recorded only as a "VO." (Tr. at 1536-1538)

    Dr. Adamson further testified that he and Ms. Adamson had discussed the selection of antibiotics on other dates as well. Dr. Adamson testified that, on July 9, 1999, Patient 41 was given amoxicillin "because it was only throat, it wasn't ear or sinus." Moreover, Dr. Adamson testified that, on February 24, 1999, he and Ms. Adamson "had another discussion because he was continuing to have symptoms even after taking the Zithromax,

and we elected to use Augmentin for a course." However, Dr. Adamson testified that, "even after taking the Augmentin, it was the mom's feeling that the Zithromax really worked better and he'd had it multiple times before." Dr. Adamson acknowledged that this discussion with Patient 41's mother was not recorded in the chart. Finally, Dr. Adamson testified that the February 3, 1999, prescription for Zithromax had authorized Ms. Adamson to give the patient Zithromax on August 3, 1999. (St. Ex. 55, 56, 58; Tr. at 1538-1541)

Dr. Adamson testified that the prescription for Anusol had been authorized because that is "part of our standard care plan for treatment of hemorrhoids." (Tr. at 1544)

Patient 42 (Ms. Adamson 31)

August 2, 1999

368. On August 2, 1999, Ms. Adamson saw Patient 42 for a laceration on his left leg that had occurred one week earlier. The diagnosis states "Laceration[.]" A culture was taken, and a Silvadene dressing was applied. A prescription for Keflex 250 mg #40 was called in. The initials "MB-PAS" are written on the note. A "REVIEWED" stamp dated July 30, 1999, is present. (St. Ex. 42 at 28 and 40; Tr. at 500-501)

    Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

369. Ms. Adamson testified that Patient 42 had presented with a new condition on August 2, 1999. Ms. Adamson testified, "I can see anybody. It's just whether or not I can implement treatment." Ms. Adamson testified, however, that she did implement treatment on Patient 42, and that no physician had seen Patient 42 for his new condition prior to her implementing that treatment. Ms. Adamson further testified that she had been authorized to do so because the patient had required immediate attention. Moreover, Ms. Adamson testified that she had been authorized to treat Patient 42 that day based upon Dr. Adamson's standing order concerning treatment of a soft tissue infection. (Tr. at 501-502)

370. Dr. Adamson testified that he does not believe that Patient 42 needed to be personally evaluated by a physician prior to treatment on August 2, 1999. Dr. Adamson noted that a laceration would normally be considered a new condition; however, in this case, the laceration was six days old. Dr. Adamson testified that what had actually been required at that time was an examination of the wound to ensure that there was no infection. Dr. Adamson testified that the risk that the wound could have been infected was something that required immediate attention. (St. Ex. 42 at 28; Tr. at 872-874)

371. Dr. Adamson testified that Patient 42 was 61 years old, and frail. Dr. Adamson testified that his standard care for an old wound on such a patient was to obtain a culture, dress the wound, and start the patient on an antibiotic. Nevertheless, Dr. Adamson testified that he believes that Ms. Adamson's authorization to treat Patient 42 had been based on the immediate attention clause rather than a standard order. Further, when asked if a necessity

for immediate attention would authorize a physician assistant to have a prescription called in, Dr. Adamson replied, "If they have a standard care plan for that situation, I believe they can. I don't believe that they are required to discuss immediate attention with their supervising physician." Moreover, Dr. Adamson testified that he believes that the immediate attention clause would authorize a physician assistant to treat a patient in what the physician assistant believed was an appropriate way as long as that treatment was within the supervising physician's scope of practice. Finally, Dr. Adamson testified that that would include calling in prescriptions "if it was within the scope and part of what was requiring immediate attention." (Tr. at 874-880)

372. Dr. Gardner testified that, in her opinion, Patient 42 presented with a new condition of laceration of the leg on August 2, 1999. Dr. Gardner further testified that the injury had not been previously noted in the chart. Moreover, Dr. Gardner testified that the fact that the injury was six days old was irrelevant; it was a new condition to Dr. Adamson. (Tr. at 1090-1092)

December 25, 1999

373. On December 25, 1999, Patient 42 left a message that he had a sore throat and was "coughing up watery fluid." The telephone message form states that a prescription for Cipro 500 mg #20 was issued. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 42 at 20)

<u>Patient 43</u> (Ms. Adamson Patient 32)

March 2, 1998

374. On March 2, 1998, Ms. Adamson saw Patient 43 for vaginal complaints. The progress note indicates that the diagnosis was "BV," which Ms. Adamson testified stands for bacterial vaginosis. Ms. Adamson had prescriptions called in for Cleocin, Premarin 0.625 mg #25, and Provera 10 mg #10. The pre-printed initials "RRH" are circled on the progress note. Ms. Adamson testified that Dr. Adamson had initialed the chart, but further testified that she could not recall if he had reviewed the chart before the medication had been called in. Ms. Adamson testified that "usually when you see the 'A,' it means he put it on at the time that order was written, but I think he wasn't in the office that day, 3-2-98. I'm not sure." (St. Ex. 43 at 135; Tr. at 504-505)

    Dr. Adamson was out of the state on March 2, 1998. (St. Ex. 83B; Tr. at 1298-1299, 1304-1305)

375. Ms. Adamson testified that she had been authorized to have the prescriptions called in for Patient 43 based on Dr. Adamson's specific order. Ms. Adamson testified with regard to the prescription for Cleocin that a telephone message form dated February 26, 1998, indicates that the patient had previously contacted the office concerning a vaginal

complaint. After noting that Patient 43 had had vaginal complaints for which she had been prescribed Flagyl (metronidazole) or Diflucan, Ms. Adamson testified that her normal course of action would have been to show the patient's chart to Dr. Adamson, point out that the patient had been repeatedly treated for vaginal complaints, and ask him what should be done the next time the patient came in. Ms. Adamson stated that "the answer was, 'If it's bacterial vaginosis, change the medication to Cleocin cream.' That was Dr. Adamson's step two therapy. If it had been yeast, step two therapy would have been Terazol." Ms. Adamson testified, however, that that order had not been recorded anywhere in the patient's chart. (St. Ex. 43 at 136a; Tr. at 505-508)

Ms. Adamson testified that she could not specifically recall the discussion with Dr. Adamson related above. However, Ms. Adamson testified that such would have been her normal course of action. Ms. Adamson further testified that she had had ongoing conversations with Dr. Adamson concerning Patient 43's medical condition. (Tr. at 508-509)

376. Ms. Adamson testified that she had been authorized to have prescriptions for Premarin and Provera called in for Patient 43 on March 2, 1998, based on discussions she had had with Dr. Adamson on November 3, 1997. Ms. Adamson testified that Patient 43 had been seen by Dr. Adamson on November 3, 1997, for a check up and to discuss hormone medication. Ms. Adamson testified that she had been told by Dr. Adamson that he was sending Patient 43 to her "for a complete physical, a Pap, and a mammogram, and that she could have hormone replacement." Nevertheless, the progress note for that date does not indicate that Patient 43 was prescribed any hormone medication. Moreover, Ms. Adamson acknowledged that the medical records do not indicate that Patient 43 was prescribed any hormone medication by Dr. Adamson's office between November 3, 1997, and March 2, 1998. However, Ms. Adamson testified that when Dr. Adamson had seen the patient, he would have discussed the pros and cons of hormone replacement therapy with Patient 43, and left the choice of whether she would use the therapy up to the patient. (St. Ex. 43 at 144a; Tr. at 509-512)

Ms. Adamson testified that Dr. Adamson's order concerning Patient 43's hormone replacement therapy had not been recorded in writing. Ms. Adamson further testified that it was their normal practice for Dr. Adamson to give Ms. Adamson oral information about a patient:

Q. (by Ms.Crawford): So he just—it was his normal—you're saying it was his normal practice to come and tell you that 'I've seen this patient, we've talked about hormone replacement, and she's coming in sometime, and when she comes in, prescribe her this and this at this level and to take it this many times a day'? Was that what his normal practice was?

A. (by Ms. Adamson): She had to get a Pap smear, she had to agree to a mammogram, and yes, he would have told me what dose to give her, because—yes.

Q. And that—not just with respect to this patient, but that was pretty much the normal practice, that he would talk to you about it and then just give you this oral information?

A. Yes. And that—the doses changed on—the doses and how to do it changed on different patients. So it wasn't the same for every patient.

Q. Oh, okay. So the dosage was an important factor that you would need to know for each patient?

A. Correct.

Q. And when you had those discussions with Dr. Adamson, would you write down in the patient chart what the dosage would be?

A. No.

Q. So in the case of Patient No. 43, Dr. Adamson saw this patient on 11-3-97, had a discussion with you on 11-3-97, and I believe you testified [had] indicated that she should be getting hormone replacement therapy in this specific dose, correct? Is that correct?

A. Correct. If she came in for her complete physical, Pap, agree to a mammogram.

Q. And there is no notation in the records as to that fact, of this discussion or the dosage, and then four months later, she came in and you called in the prescriptions for the hormone replacement therapy, correct?

A. Correct.

(Tr. at 513-514)

377. Dr. Adamson testified that the prescription that was called in for Cleocin on March 2, 1998, had been based on "an authorization on that date for her bacterial vaginosis[.]" Dr. Adamson further testified that he had given a specific order to Ms. Adamson "that a woman with lab findings and physical findings of bacterial vaginosis is to be treated with Cleocin." Moreover, Dr. Adamson testified that Cleocin had been his treatment of choice for that condition at that time. (Tr. at 1567-1568)

378. With regard to the prescriptions for Premarin and Provera called in for Patient 43 on March 2, 1998, Dr. Adamson testified that the matter of hormone replacement had been discussed previously with Patient 43. Dr. Adamson testified that the issue of hormone replacement for post-menopausal women is complex and somewhat controversial, and that information concerning hormone replacement therapy had been given to Patient 43 at an

earlier visit. Dr. Adamson further testified that the decision to prescribe Premarin and Provera had been made on November 4, 1997, when Dr. Adamson saw the results of a lab report, and on November 24, 1997, when Ms. Adamson did the examination. However, Dr. Adamson testified that "[t]he patient did not agree to go on hormone replacement until 3/2/98." (St. Ex. 43 at 42, 142; Tr. at 1549-1555)

Dr. Adamson acknowledged that his order to place the patient on those medications had not been written down. In addition, Dr. Adamson testified that there was nothing in the medical record to indicate that Patient 43 had been counseled concerning hormone replacement therapy or that the patient had had reservations about hormone replacement therapy. Dr. Adamson further testified, however, that Patient 43 had had a well woman examination on November 24, 1997, and that "hormone discussion is part of a well woman exam. It's done every time in a woman who is perimenopausal or menopausal." (Tr. at 1555-1558)

July 30, 1999

379. On July 30, 1999, Patient 43 was seen for a diagnosis of onychomycosis. The progress note indicates that a fungal culture was taken from the patient's left great toe. The initials "MB-PAS" are written on the note. A "REVIEWED" stamp dated July 30, 1999, is present. There is no physician signature. (St. Ex. 43 at 110)

Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

August 3, 1999

380. On August 3, 1999, Patient 43 left a message with Dr. Adamson's office complaining of vaginal discharge and odor. The records indicate that a prescription for Metrogel-Vaginal Gel (metronidazole), with one refill, was called in for the patient. A "REVIEWED" stamp dated August 3, 1999, appears on the message form, as does "VOWCA/RRH." (St. Ex. 43 at 109; Tr. at 515)

Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

381. Ms. Adamson testified that she had been authorized to have a prescription called in for Patient 43 based on Dr. Adamson's order that the patient's recurrent bacterial vaginosis could be treated. Ms. Adamson noted that, previously, on May 7, 1999, her condition had been treated with Cleocin. Ms. Adamson testified that she and Dr. Adamson had discussed Patient 43's problem at that time. She testified that bacterial vaginosis can be difficult to eradicate, and that "you have to try different medications. So at that point, if she didn't get better after using the refill of the Cleocin, then he said, 'Well, try Metrogel.'" This order was not recorded on the progress note for May 7, 1999. (St. Ex. 43 at 117; Tr. at 515-516)

382. Dr. Adamson testified that Patient 43 had suffered from multiple bouts of bacterial vaginosis prior to August 3, 1999. Dr. Adamson further testified that Patient 43 was prone to bouts of vaginal yeast infections and bacterial infections as a result of her diabetes. In addition, Dr. Adamson testified that her individual treatment plan had been Diflucan if the infection was yeast, and Flagyl or Metronidazole if it was bacterial. Moreover, Dr. Adamson testified that the fishy odor noted on the August 3, 1999, telephone message form is a characteristic that distinguishes bacterial vaginosis from a yeast infection. Finally, Dr. Adamson noted that Flagyl was an oral form of metronidazole, and that when Metrogel cream became available, they stopped using the oral medication because the cream had fewer side effects. (St. Ex. 43 at 109, 135, 140, 142; Tr. at 1544-1546)

    Dr. Adamson testified that Ms. Adamson had been given a specific order that bacterial vaginosis was to be treated with Metrogel. Moreover, Dr. Adamson testified that it had been a general standing order and, in this patient's case, had also been an individual order concerning the patient's recurring problem. Dr. Adamson acknowledged, however, that that order had not been recorded in writing. (Tr. at 1546-1548)

383. Dr. Adamson testified that "bacterial vaginosis is not a disease, it's not a condition, it's an odor to the vagina from an overgrowth of bacteria." (Tr. at 1548)

<u>Patient 44</u> (Ms. Adamson Patient 33)

December 31, 1998

384. On December 31, 1998, Patient 44 was seen for a chief complaint of tightness in her chest. The diagnosis was sinusitis. A prescription was issued for an unspecified quantity of Amoxil 500 mg with one refill. The initials "RRH" are written on the progress note. A "REVIEWED" stamp dated January 4, 1999, is present. There is no physician signature. (St. Ex. 44 at 77)

August 2, 1999

385. Ms. Adamson saw Patient 44 on August 2, 1999, for a chief complaint of cough and nasal congestion. The patient's diagnoses that day were chronic cough and rule out chronic sinusitis. The progress note indicates that chest and sinus x-rays were ordered. A prescription for Augmentin 875 mg #28 with one refill was called in that day. There is no indication on the progress note that Dr. Adamson or any other physician had reviewed the notes from that visit. Further, Ms. Adamson did not initial or sign the chart. (St. Ex. 44 at 69 and 109; Tr. at 519-521)

    Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

386. Ms. Adamson testified that she had been authorized to have the prescription called in for Patient 44. Ms. Adamson stated that the patient had called on July 15, 1999, complaining

of sinusitis that had not improved since having been last seen on June 28, 1999, when she received Z-Pak. Ms. Adamson spoke to Dr. Adamson on July 15, and Dr. Adamson told her, "'You can refill her Z-Pak, but if she doesn't get better, she needs treated with Augmentin for a month, and we need to work her up to rule out chronic sinusitis.'" Ms. Adamson testified that that authorization is not recorded in the medical record. (St. Ex. 44 at 71 and 72; Tr. at 520-521)

387. Dr. Adamson testified that he and Ms. Adamson had discussed Patient 44 on July 15, 1999, and that she had been seen previously for a sinus infection on June 28, 1999. Dr. Adamson testified that the Z-Pak that the patient had received in June had not effected a cure by July 15. Therefore, he authorized another round of Z-Pak and gave an order that Ms. Adamson could give the patient Augmentin and take sinus x-rays if that was not effective. Finally, Dr. Adamson testified that that discussion with Ms. Adamson had not been written down. (St. Ex. 44 at 71 and 72; Tr. at 1569-1571)

<u>Patient 45</u>

December 23, 1996

388. On December 23, 1996, Patient 45 was seen for a variety of complaints. The diagnoses were recorded as hypertension, flu, and stress incontinence. Prescriptions were issued for Naprosyn 500 mg #20 with five refills, and Flumadine 100 mg #14. The progress note states "urologist for stress incontinence" and that Patient 45 should be re-checked in two weeks. "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 45 at 103a)

January 30, 1997

389. On January 30, 1997, Patient 45 was seen for neck pain. The diagnosis was recorded as lymphadenitis. A prescription for Amoxil 500 mg #30 was issued. "VOWCA/RRH" is written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 45 at 96a)

June 2, 1997

390. On June 2, 1997, Patient 45 was seen for a pre-operative visit concerning an abnormal Pap result. The diagnoses were hypertension, "PAT - stress incontinence," and abnormal Pap. The progress note states "[increase] Toprol 200 mg #30 [one] qhs for HTN." "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 45 at 90)

December 8, 1997

391. On December 8, 1997, Patient 45 was seen for a chief complaint of hypertension. The diagnosis was hypertension. The progress note states "[increase] Toprol 200 mg #30 [one] qd" with five refills, and that Patient 45 was advised to be re-checked in four weeks. "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 45 at 85a)

July 30, 1999

392. On July 30, 1999, Patient 45 was seen for a follow up visit concerning hypertension. The diagnosis was hypertension, which was noted to be controlled. The plan states that Patient 45 was to "[r]eturn fasting for Lipids," and advised to be rechecked in six months. The initials "MB-PAS" are written on the note. A "REVIEWED" stamp dated July 30, 1999, is present. There is no physician signature. (St. Ex. 45 at 73)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

<u>Patient 46</u> (Ms. Adamson Patient 34)

August 3, 1999

393. Ms. Adamson saw Patient 46 on August 3, 1999, for a chief complaint of redness and swelling in her left eye. The diagnosis indicates "OS conjunctivitis." Ms. Adamson had a prescription called in for Sodium Sulamyd Ophthalmic 10 percent. Ms. Adamson testified that no physician had seen Patient 46 before that prescription was called in. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated August 3, 1999, is present. (St. Ex. 46 at 19 and 26; Tr. at 522-524)

    Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

394. Ms. Adamson testified that the patient had presented with a new condition on August 3, 1999. Ms. Adamson testified that she was nevertheless authorized to evaluate the patient "[b]ecause a red eye needs immediate attention." Ms. Adamson further testified that she had been authorized to have a prescription called in for the patient based upon Dr. Adamson's general standing order concerning treatment of patients with conjunctivitis. (Tr. at 524-525)

395. Dr. Adamson acknowledged that Patient 46 had not been personally seen and evaluated by a physician prior to the commencement of treatment on August 3, 1999. However, Dr. Adamson testified that he did not believe that Patient 46 had needed to be personally evaluated by a physician prior to treatment on that day. Dr. Adamson testified that the patient had presented with a red eye. Dr. Adamson testified that that will usually go away on its own, "but there are some vision-threatening diagnoses that can cause a red eye."

Accordingly, Dr. Adamson testified that a red eye requires immediate attention. Whereupon, the following exchange occurred:

Q. (by Ms. Crawford): And what kind of vision-threatening problems were present here in this Patient 46 on 8/3/99, if any?

A. (by Dr. Adamson): You don't know if they're there until after you evaluate the patient. You do a physical exam, including looking at the cornea. If you're worried about a foreign body or a scratch, you may do a fluorescein stain. And you also look inside the eye at what's called the disk. The vision threatening [diagnosis] that can present as red eye is acute glaucoma and if that's not treated within 24 hours, it can result in permanent blindness.

Q. And were those tests done on this patient on 8/3/99?

A. It's not documented that they were, but in our standard care for a red eye, it would involve a physical exam, a stain of the eye and looking into the eye with an ophthalmoscope, but those findings aren't specifically charted on this page.

Q. Are they charted anyplace else in the record?

A. As it relates to that date of service, no.

Q. And so after all those tests, if there was anything positive as a result of those tests, they would certainly be indicated in the progress notes, correct?

A. They would be here and I would have expected the patient to be referred urgently to an ophthalmologist.

Q. So after that assessment was done, it was determined that there was no immediate action that needed to be taken; is that right?

A. That there was no vision-threatening immediate problem, that the assessment was conjunctivitis.

(St. Ex. 46 at 19; Tr. at 880-884) Finally, Dr. Adamson testified that the authorization for Ms. Adamson to have a prescription called in was "the need for immediate attention of a red eye to rule out and potentially treat a bacterial conjunctivitis as is our standard care for treatment of a red eye." (Tr. at 884)

396. Dr. Gardner testified that, in her opinion, Patient 46 presented with a new condition of left conjunctivitis on August 3, 1999. Dr. Gardner further testified that there had been no previous documentation of that condition in the patient's chart. (Tr. at 1094-1095)

Patient 47

November 13, 1998

397. On November 13, 1998, Patient 47 was seen for chief complaints of laryngitis, cough, and bronchitis. The diagnoses were pharyngitis, laryngitis, and bronchitis. The progress note indicates that over-the-counter Robitussin DM was recommended, and prescriptions were issued for Z-Pak and Humibid DM. "N.Keeler PA-C" is written on the note. A "REVIEWED" stamp dated November 18, 1998, is present. There is no physician signature. (St. Ex. 47 at 43)

January 14, 1999

398. On January 14, 1999, Patient 47 left a message that he was having lower back pain. A prescription for Vicodin ES #150 was called in to a pharmacy. The initials "N.K." appear on the form. No physician signature or "REVIEWED" stamp is present. (St. Ex. 47 at 40)

July 29, 1999

399. On July 29, 1999, Patient 47 was seen in Dr. Adamson's office and his visit was recorded on two progress notes. On the first, his chief complaint is noted as an increase in hay fever symptoms. No diagnosis is noted. That note indicates that Celestone 1 cc was administered intramuscularly, and a prescription was issued for Zyrtec 10 mg #30 with refills for one year. A "REVIEWED" stamp dated July 30, 1999, appears on that note. (St. Ex. 47 at 38)

    The second progress note for July 29, 1999, indicates a chief complaint of poison ivy. It was noted that the patient had a cyst on the left side of his nose, and a referral was made to a plastic surgeon. No diagnosis is noted. A prescription for triamcinolone cream was called in. "VOWCA/RRH" is written on the note. (St. Ex. 47 at 39)

    No physician signature is present on either progress note for the July 29, 1999, visit. (St. Ex. 47 at 38-39)

    Dr. Adamson was out of the state on July 29 and 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

Patient 48 (Ms. Adamson Patient 35)

August 2, 1999

400. Ms. Adamson saw Patient 48 on August 2, 1999, for a follow up visit concerning a rash. Ms. Adamson had a prescription for Medrol Dospak called in for the patient. The initials "RRH" and "MB-PAS" are written on the note. A "REVIEWED" stamp dated July 30, 1999, is present. (St. Ex. 48 at 43; Tr. at 526)

Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

401. Ms. Adamson testified that she had been authorized to call in a prescription for Medrol Dospak based upon Dr. Adamson's standing order concerning treatment for patients "that had a rash that was spreading on their face." Ms. Adamson noted that Patient 48 had been seen previously on July 27, 1999, and at that time had been treated with triamcinolone cream and Claritin 24 samples. Ms. Adamson further testified that Dr. Adamson's "standing order on what to do with this patient's urticaria" had been, "'If this gets worse, give her a Medrol Dospak.'" Ms. Adamson acknowledged that Dr. Adamson's order was not recorded in the medical record. (St. Ex. 48 at 44; Tr. at 527-528)

402. Dr. Adamson testified that Patient 48 had been previously seen on July 27, 1999, for a rash on her face, abdomen, and hands, and that he and Ms. Adamson were not sure, on that date, what the patient had had. Dr. Adamson testified that, on July 27, 1999, he started the patient on a topical cream, and gave the patient Claritin samples to try to treat the rash. Dr. Adamson testified that he had also given orders that if the topical cream and Claritin did not work, then the patient should receive Medrol Dospak. Dr. Adamson acknowledged that those orders were not recorded in the patient chart. (St. Ex. 48 at 44; Tr. at 1571-1574)

August 20, 1999

403. Although the May 9, 2001, notice letter had alleged that a visit had occurred on August 20, 1999, there was no visit from Patient 48 on that date. (St. Ex. 48)

<u>Patient 49</u> (Ms. Adamson Patient 36)

September 21, 1998

404. On September 21, 1998, Patient 49 was seen for a follow up visit concerning memory loss. No diagnosis is noted. The plan was for an x-ray of the left knee, audiogram, and to continue Aricept. The initials "RRH" are written on the progress note. A "REVIEWED" stamp dated September 24, 1998, is present. There is no physician signature. (St. Ex. 49 at 166a)

December 22, 1998

405. On December 22, 1998, Patient 49 was seen for a follow up concerning knee problems. A prescription for Medrol Dospak was issued. Patient 49 was advised to follow up with a rheumatologist. The initials "N.K. PA-C" are written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 49 at 162)

August 2, 1999

406. Ms. Adamson saw Patient 49 on August 2, 1999, for a chief complaint of left knee discomfort. The diagnosis was rheumatoid arthritis. It was noted that the patient had poor short-term memory, was very grouchy, slept 14 hours each day, and was "[positive for] road rage." Ms. Adamson had a prescription for Medrol Dospak called in, and gave the patient samples of Zoloft 50 mg. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated July 30, 1999, is present. (St. Ex. 49 at 150a-150b; Tr. at 528-529)

    Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

407. Ms. Adamson testified that she had discussed Patient 49's care with Dr. Adamson during a patient visit on June 25, 1999. Ms. Adamson further testified that she had given Patient 49 samples of Zoloft because the patient had been previously treated for memory loss and mood disturbances. Ms. Adamson testified that she had given the Zoloft "to help his mood and his sleep." Finally, Ms. Adamson testified that she had done so based on a standing order of Dr. Adamson's concerning the treatment of patients with those symptoms. (St. Ex. 49 at 151; Tr. at 529-532)

    Ms. Adamson testified that Patient 49 had previously received Medrol Dospak on December 22, 1998. Ms. Adamson further testified that that medication is what Dr. Adamson had used for patients who have a flare-up of rheumatoid arthritis. (St. Ex. 49 at 162; Tr. at 531)

408. Dr. Adamson testified concerning the authorization for the prescription for Zoloft that was called in for Patient 49 on August 2, 1999. Dr. Adamson testified that the patient had a history of "mental status issues related to his rheumatoid arthritis and his chronic steroid use" for that condition. Dr. Adamson further testified that Patient 49 suffered from fatigue, dizziness, and "road rage." Dr. Adamson stated that these "can all be symptoms of an underlying organic depression secondary to the medications he's receiving on a longterm basis for his rheumatoid arthritis"; namely, Prednisone and frequent Medrol Dospaks. Moreover, Dr. Adamson testified that Patient 49 had received Aricept in the past for memory loss. (St. Ex. 49 at 155, 162, 163, 166; Tr. at 1574-1578)

    Dr. Adamson further testified that Patient 49 had been exhibiting signs of depression, but that medical issues had to be evaluated first. Dr. Adamson further testified:

    > He was seen by a neurologist. He had cat scans. He had brain stem auditoria. He was seen in the vestibular lab at Ohio State ruling out any other organic diseases as a cause.
    >
    > So as all these reports are coming in, we're looking at them and deciding what—what to do with this patient. And once it was all done, I don't recall

> the date of the conversation, but we said, you know, he might benefit from being on antidepressants. That's something we decided to do the next time he came into the office.

(Tr. at 1578-1579) Finally, Dr. Adamson testified that his order to give the patient antidepressants had been verbal, and was not written down. (Tr. at 1579-1580)

409. Dr. Adamson testified that the prescription for Medrol Dospak had been called in for Patient 49's rheumatoid arthritis. (St. Ex. 49 at 162; Tr. at 1580-1582)

Dr. Adamson testified that his plan for Patient 49 concerning Medrol Dospak had been recorded in his verbal order to Ms. Keeler on December 22, 1998. The progress note for December 22, 1998, states, in the area entitled "Plan":

> "Medrol Dose Pack
> "F/U Dr. Lee - Rheumatologist"

(St. Ex. 49 at 162; Tr. at 1580) Dr. Adamson testified that his authorization for the August 2, 1999, prescription for Medrol Dospak stemmed from that note and Dr. Adamson's conversations with Ms. Adamson that Patient 49 could have a Medrol Dospak if he had a flare-up. (Tr. at 1580-1582)

<u>Patient 50</u> (Ms. Adamson Patient 37)

August 2, 1999

410. Ms. Adamson testified that she had seen Patient 50 on August 2, 1999, for a chief complaint of head congestion. The diagnosis was recorded as "viral URI." A prescription for Entex LA #20 was called in for the patient. A "REVIEWED" stamp dated August 3, 1999, appears on the progress note. (St. Ex. 50 at 9 and 16; Tr. at 533)

Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

411. Ms. Adamson testified that she did not believe that Patient 50 had presented with a new condition on August 2, 1999, because the patient was 41 years old, and "we all have an average of five colds a year." Moreover, Ms. Adamson testified that she had the prescription called in based on Dr. Adamson's "general standing order that a patient with viral upper respiratory infections could have Entex LA." Ms. Adamson acknowledged that Patient 50 had not been previously treated by Dr. Adamson for head congestion or for an upper respiratory infection. (Tr. at 534-535)

412. Dr. Adamson testified that he did not believe that Patient 50 had needed to be personally evaluated by a physician prior to treatment on August 2, 1999. Dr. Adamson testified that Patient 50 "had a new symptom of head congestion. Head congestion is a symptom that,

for the most part, is self-limiting or will get better with minor treatment, either over the counter or by prescription that most patients would recognize." Dr. Adamson acknowledged that Patient 50 had not been seen previously in his office for head congestion. (St. Ex. 50 at 9; Tr. at 884-885)

Dr. Adamson testified that Ms. Adamson had been authorized to have the prescription called in because it was "part of our standard care plan for upper respiratory infections. The patients can be treated with Humibid or Entex by prescription if they choose a prescription treatment or over-the-counter treatments have not provided adequate relief for their symptoms." Dr. Adamson testified that that authorization was general rather than specific to this patient. (Tr. at 885-886)

413. Dr. Gardner testified that, in her opinion, Patient 50 presented with a new complaint of head congestion on August 2, 1999. Dr. Gardner further testified that the new condition was viral URI. Moreover, Dr. Gardner testified that there had been no previous documentation of viral URI or head congestion in the patient's chart. (Tr. at 1092-1093)

Patient 51 (Ms. Adamson Patient 38)

August 2, 1999

414. On Monday, August 2, 1999, Ms. Adamson saw fourteen-year-old Patient 51 for a chief complaint of earache and neck discomfort on her right side for four days. The history indicates that the patient had been seen Thursday afternoon in an emergency room, where she had been diagnosed with otitis externa, and given Vicodin and Amoxil. The physical examination performed by Ms. Adamson indicated that the patient had red exudate in her right ear canal. A culture was taken, and the patient was given samples of Floxin Otic. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated July 30, 1999, is present. (St. Ex. 51 at 46; Tr. at 535-536)

Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

415. Ms. Adamson testified that Patient 51 had not presented with a new condition on August 2, 1999, because Dr. Adamson had previously treated her for otitis externa on July 26, 1995, and on earlier occasions, and because she had been seen in an emergency room for the current episode. Ms. Adamson testified that she had not spoken to the emergency room physician or obtained documentation from the emergency room, but instead relied on the patient's mother for information concerning that visit. Moreover, Ms. Adamson testified that she had been authorized to give samples of Floxin Otic based upon Dr. Adamson's "standing order on how to treat a patient with otitis externa that was recurrent, not responding to medication." (St. Ex. 51 at 26, 76, 77; Tr. at 536-538)

416. Dr. Adamson testified that he does not believe that Patient 51 had needed to be personally evaluated by a physician prior to treatment on August 2, 1999. Dr. Adamson testified that,

first, the patient had been seen in an emergency room and diagnosed with otitis externa, and had had recurrent episodes of otitis media and otitis externa; second, "this complaint of earache is an example of the minor self-limiting condition that we've talked about previously." Dr. Adamson noted that the patient's last episode of otitis media had been July 25, 1994. Dr. Adamson also referenced problems the patients had in 1991 and 1992, when she was six and seven years old. (St. Ex. 51 at 46, 76, 77, 102; Tr. at 886-887)

Dr. Adamson testified that Ms. Adamson had been authorized to give Patient 52 samples of prescription medication based upon his standard care plan for otitis externa, which was Floxin. Dr. Adamson testified that this had been a general authorization, and not specific to this patient. (Tr. at 887-888)

417. Dr. Gardner testified that, in her opinion, Patient 51 had presented with a new condition of otitis externa on August 2, 1999. Dr. Gardner further testified that the patient's chief complaint of right earache and right neck discomfort had not been previously mentioned in the medical record. Moreover, Dr. Gardner testified that the patient had been treated that day with Floxin Otic. (Tr. at 1095-1098)

Dr. Gardner testified that the patient had complained of right earache previous to August 2, 1999. Nevertheless, Dr. Gardner testified that that does not change her opinion that the condition that the patient presented with on August 2, 1999, was a new condition. Dr. Gardner further testified that "[t]his particular condition, complaint, or diagnosis, whichever word you choose to use, had not been evaluated by this physician and this practice." Moreover, Dr. Gardner testified that "this is a new condition because it has recurred. That—that condition, if it had occurred previously, would have resolved." (Tr. at 1098-1100)

418. Dr. Gardner noted that her written report contained a typographical error concerning this patient visit. She noted the date of the visit as "08/02/00" when, in fact, the date was August 2, 1999. (St. Ex. 72 at 4; Tr. at 1096-1097)

<u>Patient 52</u> (Ms. Adamson Patient 39)

June 30, 1998

419. On June 30, 1998, Ms. Adamson saw Patient 52 for a diagnosis of "skin tags[.]" The progress note states, "1% lidocaine infused[.] Skin tag shaved midline [anterior] neck[.] Shave excision pigmented papule between breasts[.]" Ms. Adamson testified that she numbed the area with Lidocaine and shaved the skin tags off with a blade. The initials "RRH" are written on the progress note. A "REVIEWED" stamp dated June 30, 1998, is present. (St. Ex. 52 at 117; Tr. at 538-539)

420. Ms. Adamson testified that she did not believe that the patient had presented with a new condition because Patient 52 had worked in Dr. Adamson's office, "and we had seen her

skin tags on her neck." Ms. Adamson acknowledged that Patient 52 had not previously been treated for skin tags in Dr. Adamson's office. (St. Ex. 52 at 117; Tr. at 538-539)

421. Dr. Adamson testified that he did not believe that Patient 52 had needed to be personally evaluated by a physician prior to treatment on June 30, 1998. Dr. Adamson further testified that he does not consider skin tags to be a new condition because they are not a disease or ailment. Moreover, Dr. Adamson testified that the patient was an employee in his office, the skin tags were in plain view, and Dr. Adamson had been aware of them. In addition, Dr. Adamson testified that he does not recall if he had seen the patient on June 30, 1998, but that he recalls having had discussions with the patient concerning whether the skin tags could be removed. Finally, Dr. Adamson testified that he and Ms. Adamson "had discussions about medications and about procedures performed on patients who were employees, so Robin would have asked me, is it okay to take those skin tags off this patient's neck?" (St. Ex. 52 at 117; Tr. at 889-890)

422. Dr. Gardner testified that, in her opinion, Patient 52 had presented with a new condition of skin tags on June 30, 1998. Dr. Gardner further testified that that condition had not been previously recorded in the patient's chart. Moreover, Dr. Gardner testified that there is no indication in the chart that Patient 52 had ever been personally evaluated by a physician for that condition. Finally, Dr. Gardner testified that the patient received treatment on June 30, 1998. (Tr. at 1103-1105)

December 18, 1998

423. On December 18, 1998, Ms. Adamson saw Patient 52 for "[u]pper respiratory symptoms" with an onset of three to four days. The diagnoses were sinusitis and pharyngitis. The progress note indicates that Ms. Adamson gave Patient 52 samples of Z-Pak. A "REVIEWED" stamp dated December 18, 1998, appears on the progress note. There is no physician signature. (St. Ex. 52 at 106; Tr. at 540)

    Moreover, on that same date, Patient 52 called Dr. Adamson's office, and a prescription for Vicodin #20 with one refill was called in. Ms. Adamson testified that this had been "[p]er Dr. Adamson's verbal order." The initials "VOWCA/RRH" are written on the telephone message form. A "REVIEWED" stamp dated January 19, 1999, is present. There is no physician signature. (St. Ex. 52 at 105 and 187; Tr. at 540)

424. Ms. Adamson testified that she did not believe that Patient 52 had presented with a new condition on December 18, 1998, because the patient worked in the office, the patient had had her symptoms for three or four days, and Ms. Adamson and Dr. Adamson had heard about them. Ms. Adamson further testified that Patient 52 had previously been seen in Dr. Adamson's office for upper respiratory complaints on January 11, 1996. (St. Ex. 146a; Tr. at 540-541)

Ms. Adamson testified that her authorization for dispensing samples of Zithromax had been based upon Dr. Adamson's specific authorization. Ms. Adamson testified that that authorization is not recorded in the medical record except for Dr. Adamson's "REVIEWED" stamp dated the same day. (Tr. at 541-542)

425. Dr. Adamson testified that he does not recall if he had personally evaluated Patient 52 on December 18, 1998. Nevertheless, Dr. Adamson testified that he does not believe that Patient 52 had needed to be personally evaluated by a physician prior to treatment on that date. Dr. Adamson testified that that day had been a Friday, and the patient/employee had been complaining of being ill for the majority of the week. Dr. Adamson further testified that he had been in the office when Ms. Adamson evaluated the patient. Finally, Dr. Adamson testified that, because Patient 52 was an employee, Ms. Adamson would have obtained his specific authorization before giving samples of Z-Pak to the patient. (St. Ex. 52 at 106; Tr. at 890-891, 894)

Dr. Adamson testified that a prescription for Vicodin had been called in on December 18, 1998, based on "a specific verbal order given to Robin for that medication." Dr. Adamson testified that Ms. Adamson had not been authorized to initiate or continue controlled substances. Dr. Adamson further testified that he had authorized this prescription because the patient was in discomfort, the patient was prone to migraines, and Dr. Adamson wanted to "keep her from getting into a bad headache cycle." Dr. Adamson acknowledged that pain from sinusitis was not documented on the progress note, but that "[t]hat's what she was seen for that day and that is the only reason that we would prescribe her that medication and in that circumstance." Finally, Dr. Adamson testified that he had had experience running drug and alcohol treatment centers, and was "very judicious" in his prescribing of controlled substances. (St. Ex. 52 at 105-106; Tr. at 891-894)

426. Dr. Gardner testified that, in her opinion, Patient 52 had presented with a new condition of sinusitis and pharyngitis on December 18, 1998. Dr. Gardner further testified that there had been no mention in the chart of those conditions previous to that date. Moreover, Dr. Gardner testified that, had Patient 52 previously presented with an upper respiratory infection, it would not change her opinion "[b]ecause a previously occurring sinusitis and pharyngitis, had it been treated, should have resolved." In addition, Dr. Gardner testified that the progress note for that visit had indicated that the onset had been only three or four days earlier. (Tr. at 1105-1107)

March 8, 1999

427. On March 8, 1999, Patient 52 was seen for a chief complaint of a lump under the skin on her left forearm. The progress note states that the patient denied "pain or pruritus." The examination section states that Ms. Keeler observed a "small 0.5 cm round nodule" that was not tender and not infected. The assessment states "nodule." The treatment was "N_2." The initials "NK PA-C" are written on the note. There is no "REVIEWED" stamp or physician signature present. (St. Ex. 52 at 104)

428. Ms. Adamson testified that she had not participated in the attempted removal of Patient 52's lump. Nevertheless, Ms. Adamson testified that she is aware of the circumstances that led to Patient 52's March 8, 1999, visit. Ms. Adamson testified that, one day as she walked past Patient 52 at the front desk, Patient 52 had asked Ms. Adamson to look at a lump on her forearm, and asked Ms. Adamson if she would freeze it. Ms. Adamson testified that she informed Patient 52 that Dr. Adamson would not permit her to do that, that it was too deep, that freezing would not work, and that Patient 52 would need to see a surgeon. Ms. Adamson further testified that, about a week later, Patient 52 had shown her a Band-Aid on Patient 52's arm, removed it, and revealed what appeared to be a burn. Ms. Adamson testified that she had asked Patient 52 what happened, and that Patient 52 replied that "'Nancy froze my lump.'" Moreover, Ms. Adamson testified:

> And I said, 'I told you that we can't freeze that. It won't work. You have to have it taken off by a surgeon. And, oh, by the way, when you go, tell them that Wally and I didn't do that so the surgeon doesn't think we were doing something we shouldn't have been doing.'

(St. Ex. 52 at 104; Tr. at 1855-1857)

429. Dr. Adamson testified that he does not see anything in the progress note for March 8, 1999, that leads him to believe that Patient 52 "needed to be seen prior to that visit." Dr. Adamson testified that it is very difficult to tell from the record if the lump on the patient's forearm had been a new condition. Dr. Adamson testified that the length of time that the patient had had the lump was unclear, and he would not consider it new if the patient had had it her entire life but had simply noticed it recently for the first time. Moreover, Dr. Adamson testified that a lump could have be anything, including a normal bone process or a normal lymph node. Dr. Adamson testified that it could also have been cancer. (St. Ex. 52 at 104; Tr. at 894-896)

Dr. Adamson testified that he did not believe that the patient had had a new condition because the patient had previously discussed the lump with Ms. Adamson and Ms. Adamson "relayed that conversation" to Dr. Adamson. Dr. Adamson testified, however, that he had not personally evaluated the lump prior to March 8, 1999. Moreover, Dr. Adamson testified that the patient had not been personally evaluated by a physician prior to the initiation of treatment on March 8, 1999. (Tr. at 901-902)

Dr. Adamson testified that he did not discuss the case with Ms. Keeler or authorize Ms. Keeler to apply liquid nitrogen to the patient's lump because liquid nitrogen is not an appropriate treatment for a lump if the cause of the lump is unknown. Finally, Dr. Adamson testified that he later referred the patient to a surgeon. (Tr. at 901-902)

430. Dr. Adamson testified that he does not believe that he had needed to countersign the entry for March 8, 1999, because he had not authorized the care that was rendered at that visit.

Dr. Adamson further testified that he had not been aware that the patient was being seen for that problem. Moreover, Dr. Adamson testified that he did not learn what had transpired until later. (Tr. at 2017-2018)

431. Dr. Gardner testified that, in her opinion, Patient 52 had presented on March 8, 1999, with a new condition of lump on left forearm. Dr. Gardner noted that no diagnosis had been noted on the chart for that visit. Dr. Gardner further testified that that condition had not been previously mentioned in the chart. Finally, Dr. Gardner testified that treatment was rendered that day using cryotherapy. (Tr. at 1107-1109)

September 10, 1999

432. On September 10, 1999, Ms. Adamson saw Patient 52 for a chief complaint of headache, nausea, and shakiness. The diagnosis states "URI." A prescription was called in for Phenergan 25 mg #20 with one refill. The initials "RRH" are written on the progress note. A "REVIEWED" stamp dated September 10, 1999, is present. (St. Ex. 52 at 96; Tr. at 542-546)

433. Ms. Adamson testified that Patient 52 had not presented with a new condition that day because the patient had previously been seen numerous times for the same symptoms. Moreover, Ms. Adamson testified that Dr. Adamson had specifically authorized her to give Patient 52 Phenergan to treat the nausea that accompanied Patient 52's headaches. (St. Ex. 52 at 96, 99, 124, 186; Tr. at 542-546)

434. Dr. Adamson testified that he could not recall if he had seen Patient 52 on September 10, 1999. However, Dr. Adamson testified that he does not believe that Patient 52 had needed to be personally evaluated by a physician prior to treatment at that visit. Dr. Adamson further testified that the patient had a long history of headaches, nausea, fatigue, and shakiness. Finally, Dr. Adamson testified that the patient had received Phenergan for "the nausea that comes along with the headaches." (St. Ex. 52 at 96; Tr. at 903-904)

    Dr. Adamson testified that there had been two bases that authorized Ms. Adamson to have the prescription for Phenergan called in. First, Ms. Adamson had received his specific approval to issue the prescription, and Dr. Adamson testified that he knows this because the patient had been an employee. Second, the patient had previously received Phenergan for nausea associated with headaches, and that had been part of her individual care plan. (Tr. at 904-905)

435. Dr. Gardner testified that, in her opinion, Patient 52 had presented with a new condition of nausea on September 10, 1999. Dr. Gardner further testified that the diagnosis had been listed as upper respiratory infection. Dr. Gardner further testified that a recommendation for Tylenol and a prescription for Phenergan were given that day. Moreover, Dr. Gardner testified that Phenergan is an antinausea medication. Finally, Dr. Gardner testified that nausea had never been mentioned previously in the patient record; if the patient had had

nausea previously that had not resolved, it should have been noted in the chart. (Tr. at 1109-1112)

Testimony of Patient 52

436. Patient 52 testified that she had been a patient of Dr. Adamson's from approximately 1993 until approximately 1998. Patient 52 further testified that when she had been seen as a patient in that office, someone other than Dr. Adamson had usually seen her. Patient 52 testified that, during this time, she had seen Dr. Adamson "maybe five times." The other times, Patient 52 had been seen by Ms. Adamson, a couple of physician assistant students, and Dr. Ghiloni. (Tr. at 1377-1379)

437. Patient 52 testified concerning specific occasions when she had received treatment from Ms. Adamson. Patient 52 testified that on one occasion, she had seen Ms. Adamson, but did not see Dr. Adamson, for removal of moles or skin tags. Patient 52 testified that Ms. Adamson had used Lidocaine and cut them off. Moreover, Patient 52 testified that Dr. Adamson had never looked at those skin tags or moles, and had not been there that day. Finally, Patient 52 testified that on another occasion Ms. Adamson and a physician assistant student had treated her for a lump on her arm with liquid nitrogen; the treatment "didn't work" and she was referred to another physician for surgical removal. (Tr. at 1381-1383)

438. Patient 52 testified that she had liked working at Apple Health. Patient 52 described the atmosphere as "laid back." Patient 52 further testified that she believes that she had been an excellent employee. (Tr. at 1408, 1413)

439. Patient 52 testified that, at one point while she was working at Apple Health, the practice had had problems collecting its accounts receivable. Dr. Adamson had asked Patient 52 to address that problem. Subsequently, Dr. Adamson had informed Patient 52 that he had not been happy with her efforts, that he was going to give that responsibility to another employee, and cut Patient 52's pay. Patient 52 testified that she had been angry when Dr. Adamson cut her pay, that she left and took her personal belongings from the office, and that she had received notice the following week that she had been terminated. Finally, Patient 52 testified that her termination from Apple Health had had a significant impact on her family. (Tr. at 1413-1416)

<u>Patient 53</u> (Ms. Adamson Patient 40)

June 11, 1997

440. On June 11, 1997, Patient 53 was seen by Dr. Ghiloni for diabetes-related issues. Dr. Adamson identified the signature on the progress note as being that of Dr. Ghiloni. Dr. Adamson further testified that Dr. Adamson's signature was not required, since another physician had seen the patient. (St. Ex. 53 at 124a; Tr. at 2019-2020)

January 6, 1998

441. A telephone message form indicates that Patient 53 had contacted Dr. Adamson's office on January 6, 1998, and requested a medication refill. The form indicates that a prescription for Norvasc 10 mg #30 was called in to a pharmacy. The form further indicates that the patient needed to be seen. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 53 at 119)

July 30, 1999

442. On July 30, 1999, Ms. Adamson saw Patient 53 for a diabetes follow-up, and had a prescription called in for Prandin 2 mg #150 with refills for one year. A "REVIEWED" stamp dated July 30, 1999, appears on the progress note for that visit, as does "VOWCA/RRH." There is no physician signature. (St. Ex. 53 at 106; Tr. at 546-549)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

443. Ms. Adamson testified that, on June 4, 1999, she had been authorized by Dr. Adamson to start Patient 53 on samples of Prandin. Ms. Adamson testified that the patient's diabetes had been poorly controlled up to that point. Ms. Adamson further testified that the patient was to follow up in one month. Ms. Adamson further testified that the patient showed "remarkable" improvement in his fasting blood glucose level between June 4 and July 30, 1999. Ms. Adamson testified that Dr. Adamson's order had been specific to this patient. Finally, Ms. Adamson testified that the order had not been recorded in the medical record. (St. Ex. 53 at 107; Tr. at 547-549)

444. Dr. Adamson testified that he had given a verbal order to Ms. Adamson on June 4, 1999, to start Patient 53 on Prandin. The progress note for June 4, 1999, states "start Prandin 2 mg. ac." It further indicates that Patient 53 was to be rechecked in one month. Dr. Adamson testified that he expected this order to be carried out until he changed it. (St. Ex. 53 at 107; Tr. at 1601-1603)

    Dr. Adamson testified that the only reasons to discontinue Prandin for this patient would have been as a result of a side effect or because the medication hadn't been working. Dr. Adamson testified that the medication had, in fact, been very effective: on June 4, Patient 53's blood sugar was 288; on July 30 it was between 115 and 130. (St. Ex. 53 at 106-107; Tr. at 1603)

August 2, 1999

445. On August 2, 1999, Patient 53 called Dr. Adamson's office and left a message that was recorded, in part, as "Prescription for his arm was not called in." Ms. Adamson had a prescription called in for Naprosyn 500 mg #60 with five refills. "VOWCA/RRH" is

written on the form. A "REVIEWED" stamp dated July 30, 1999, is present. (St. Ex. 53 at 99; Tr. at 549-550)

Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 1307-1310)

446. Ms. Adamson testified that she had been authorized to have the prescription called in for Patient 53 based upon Dr. Adamson's order that patients could have refills of "their standard chronic medications." However, Ms. Adamson acknowledged that the last reference in Patient 53's medical record for a prescription for Naprosyn had been November 1995. (St. Ex. 53 at 129a and 130a; Tr. at 550-551)

447. Dr. Adamson testified that the Naprosyn that was called in for Patient 53 on August 2, 1999, had been authorized as "a maintenance medication that this patient has taken in the past for a variety of musculoskeletal problems." Dr. Adamson further testified that "[i]t was the individual treatment plan for this patient that he could have Naprosyn for his shoulder." When asked if Ms. Adamson had been authorized to prescribe Naprosyn on August 2, 1999, because of the prescription Patient 53 had received four years earlier, Dr. Adamson replied:

> It was a specific order for this patient that he could have Naprosyn on an ongoing basis.
>
> The reason we—again, this is a diabetic patient that we talk about regularly. He had asked about the Naprosyn previously. You have to be very careful with medicines like Naprosyn because he has diabetes, because Naprosyn can affect the kidneys.
>
> So you want to stay in touch with him of what he's doing. And if he's tolerating it, you don't want to change it, but we specifically addressed that.
>
> If we had a diabetic patient, we specifically talked about what medicines they were to be taking and Naprosyn was the medicine he was to take for his musculoskeletal problems.

(Tr. at 1606)

February 28, 2000

448. On February 28, 2000, Patient 53 left a telephone message that stated that he had swollen glands and difficulty swallowing. A prescription for Augmentin 875 mg #20 was called in to a pharmacy. "VOWCA/RRH" is written on the telephone message form. A "REVIEWED" stamp dated March 4, 2000, is present. There is no physician signature. (St. Ex. 53 at 96)

Patient 54 (Ms. Adamson Patient 41)

August 3, 1999

449. On August 3, 1999, Ms. Adamson saw Patient 54 and, as a result of that visit, had prescriptions called in for Diovan 160/12.5 #60, Isoptin SR 240 mg #60, and Cardura 4 mg #120, all with refills for one year. Ms. Adamson testified that she had been authorized to have those prescriptions called in for Patient 54 based upon Dr. Adamson's order "[t]o give this man those specific medications for his blood pressure." (St. Ex. 54 at 66; Tr. at 551-554)

    Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

450. Dr. Adamson testified that the prescriptions called in for Patient 54 on August 3, 1999, represented "the individual treatment plan for this patient." Dr. Adamson further testified that Patient 54 had a history of bleeding from an aneurysm brought on by hypertension, that the patient had required those medications to keep his blood pressure stable, and that "stopping those medications could result in a rebound in his blood pressure and a very untimely death." (St. Ex. 54 at 67; Tr. at 1608-1611)

Patient 55

June 22, 1998

451. On June 22, 1998, Patient 55 was seen in Dr. Adamson's office. No diagnosis is recorded. Prescriptions for gentamicin and Z-Pak were issued. The signature "S.T. Riedlinger PA-S" is written on the progress note. There is no physician assistant signature or initials. No "REVIEWED" stamp or physician signature is present. (St. Ex. 55 at 185)

January 19, 1999

452. On January 19, 1999, Patient 55 was seen for a follow up visit. The diagnoses were epicondylitis and a partially illegible notation that appears to say "DeQ's tenosy." A prescription for Motrin 600 mg #90 was issued. The initials "RRH" are written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 55 at 161)

March 19, 1999

453. On March 19, 1999, Patient 55 was seen for a well woman examination. The diagnoses noted were "CPE," bronchitis, cervical polyp, and exophthalmos. The plan called for Codiclear DH, "PFTs," Pap, lipid profile, glucose, mammogram, "GC/Chlam," and "RPR." "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated March 25, 1999, is present. There is no physician signature. (St. Ex. 55 at 160)

Patient 56 (Ms. Adamson Patient 42)

August 2, 1999

454. On August 2, 1999, Ms. Adamson saw Patient 56, a five-year-old male, for a checkup. The diagnoses were "WCC," cystic fibrosis, and ankle strain. The notation "Ibuprofen x2-3d" was recorded. The initials "RRH" and "MB-PAS" are written on the progress note. There is no "REVIEWED" stamp or signature present. (St. Ex. 56 at 78; Tr. at 554)

    Dr. Adamson was out of the state on August 2, 1999. (St. Ex. 83B; Tr. at 916, 1307-1310)

455. Ms. Adamson testified that Patient 56 had come in for immunization, and his mother reported that he had been roller-skating and had fallen. Ms. Adamson testified that the mother had asked Ms. Adamson to look at his ankle. Ms. Adamson further testified, "I told the mother the standard treatment for ankle strain is RICE, which is rest, ice, compression, and elevation, and Dr. Adamson also gave a general order that if people had ibuprofen at home, they could take it." (St. Ex. 56 at 78; Tr. at 554-556)

456. Dr. Adamson testified that Patient 56 had not been personally evaluated by a physician prior to the commencement of treatment on August 2, 1999. Dr. Adamson further testified that he does not believe that had been necessary. Dr. Adamson testified that the patient was a five-year-old with a history of cystic fibrosis who had been seen for a preschool checkup and for immunizations. While in the office, his mother had stated that Patient 56 had had ankle pain since rollerblading the previous weekend. Dr. Adamson testified that the patient's mother had been advised that she could give the patient ibuprofen or other over-the-counter medication. (St. Ex. 56 at 78; Tr. at 914-916)

457. Dr. Gardner testified that, in her opinion, Patient 56 had presented with a new condition of ankle strain on August 2, 1999. Dr. Gardner further testified that ankle strain had not been previously diagnosed or mentioned in the chart. Moreover, Dr. Gardner testified that treatment with ibuprofen had been initiated on that date. (Tr. at 1112-1114)

Patient 57 (Ms. Adamson Patient 43)

Background Information

458. Patient 57, a female patient whose date of birth is September 24, 1962, was a patient of Dr. Adamson's who had a number of health problems, and who was confined to a wheelchair. Ms. Adamson testified that Patient 57 "lived in a group situation" where she had full-time care. Ms. Adamson further testified that Patient 57 suffered from, among other things, cerebral palsy and diabetes, and was unable to care for herself. Dr. Gardner, the State's expert, acknowledged that Patient 57 had been a complicated patient. (St. Ex. 57A at 4; St. Ex. 57B at 3A; Tr. at 566-570, 1115-1121)

January 16, 1998

459. On January 16, 1998, Patient 57 left a telephone message concerning, among other thing, loose bowel movements. The telephone message form contains the notation, "take Imodium." The pre-printed initials "RH" are circled at the top of the form, and the initials "RRH" are written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 372)

May 8, 1998

460. On May 8, 1998, Patient 57 called concerning difficulty breathing, and asked for suggestions. A note on the telephone message form states: "Tried Albuterol breathing tx & seems better now - gave 3 hrs ago. Advised OK to give another & continue q6h." The pre-printed initials "RRH" are circled at the top of the form, and the initials "RRH" are written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 360)

May 21, 1998

461. On May 21, 1998, Patient 57 called concerning menstrual difficulties. A note on the telephone message form states "to see Dr. Hackett 5-28[.] [R]estart OCS & FU [with] him." The pre-printed initials "RRH" are circled at the top of the form, and the initials "RRH" are written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 357)

June 6, 1998

462. On June 6, 1998, a telephone message was left by Patient 57 concerning a rash. An illegible signature appears at the bottom of the message form. A "REVIEWED" stamp dated November 24, 1998, also appears on the form. (St. Ex. 57B at 323a)

    Dr. Adamson testified, "This is an on-call telephone message. It was a message taken by a physician who would have been covering on the date of 6-6-98." Dr. Adamson further testified that he is not required to countersign the work of other physicians. (St. Ex. 57B at 323a; Tr. at 2020-2021)

June 12, 1998

463. On Tuesday, June 2, 1998, ten days prior to Patient 57's June 12, 1998, visit, a telephone message from or on behalf of Patient 57 indicated that Patient 57 had been experiencing pain on her left side. The message form states, among other things, "Experiencing pain on left side—lift fell on top of her Sun pm. [Left] hip hurts." The form further stated "x-ray [left] hip" and that a prescription for Tylenol No. 3 was given. An additional note on the form dated June 3, 1998, states, among other things, that a caregiver would take the patient

to the hospital for an x-ray. "VOWCA/RRH" is written on the form, as well as Dr. Adamson's initial "A." (St. Ex. 57B at 356)

On June 3, 1998, Patient 57 was seen in the emergency department of St. Ann's Hospital, Westerville, Ohio. The chief complaint was left hip pain. The Emergency Report contained in Dr. Adamson's medical record for Patient 57 gives the following history:

> This is a 35-year-old female who presents to the Emergency Department on 06/03/98. She does have cerebral palsy. She states that she has developed some left hip pain approximately seven days ago. She states it is in the ball and socket of her hip. She states it worsened when she was placed on a bed pan. Apparently the pain does go down the leg a little bit at this time too. She denies any back pain. She was sent over here by her physician for x-rays and to be evaluated by the Emergency Department physician. She is non-ambulatory. There is no abdominal pain, no other complaints at this time. No known trauma at this time either.

(St. Ex. 57B at 106)

An x-ray report dated June 4, 1998, reported the following impression: "There is a congenital abnormality in both hips. No acute bone abnormalities are seen. The appearance is unchanged when compared to an exam from 1995." (St. Ex. 57B at 108-109)

On June 12, 1998, Patient 57 was seen by Ms. Adamson and a physician assistant student for a chief complaint of severe left hip pain, to follow up with "St. Ann's X-ray[,]" and "wants darvocet refill[.]" The assessment was noted to be candidiasis "thigh skinfold & buttocks" and bursitis in her left hip. The plan states as follows:

> "1. Refill meds - see back
> "2. Diflucan 150 mg x 1 per week x 4 wks
> "3. Home PT—eval [illegible] WC & treat
> "4. Restart Glucotrol XL 5 mg qd."

(St. Ex. 57 at 354a) The name "S.T. Riedlinger PA-S" is written on the note. A "REVIEWED" stamp dated June 12, 1998, is present. The back of the progress note lists a number of medications, including Diflucan, Glucotrol, and Darvocet N-100, which are bracketed together. Handwriting at the bottom of the note indicated that Patient 57 "has refills on all til Dec 98 or longer. I left them the same but called in Lo Ovral 11 refills[.]" The back of the progress note is reproduced below. Areas that are blank except for the page number were cropped for space considerations:

Alluteral # puffs q6h ~~PRN~~ ref x 1 year
Support Office
~~$300 Cleveland Ave~~
Ovral qd 8 AM - take pack as directed ref 11
~~Crosby Drug~~
Prilosec ~~5mg qd~~ 20 mg qd #30 ref 11
~~Wendell Bristol~~
Diazepam 5mg BID q 8 AM, 6 PM #60 ref 11
~~High St. delivery~~
Naproxyn 500 mg BID 1 tab 8A+6P #60 ref 11
~~home~~ support care.
Miacalcin Nasal Spray 1 each nostril qd ref 1 yr
Glucotrol XL 5mg qd #30 ref 11
Diflucan 150 mg qd x 1 wk for 4 wks #3
Darvocet N-100 q 4-6 hrs for pain PRN. #60 ref x 1
Needs PT - medicaid at home.
Cds Prescription (M) 662
pt has refills on all tel Dec 98
885 4079
no longer lift then
but called in board

(St. Ex. 57B at 354a-b; Tr. at 1858-1861) Finally, documents obtained from a pharmacy indicate that a prescription for Darvocet N-100 #60 with one refill had been called in for Patient 57 on June 12, 1998, by "Molly/Adamson[.]" (St. Ex. 57B at 386)

464. On June 12, 1998, Dr. Adamson had gone to Mammoth Cave in Kentucky. Dr. Adamson testified at hearing that he had been in his office in the morning and left around 1:00 p.m. However, at his October 26, 2000, deposition, Dr. Adamson had testified that he had left in the morning, and did not believe that he had gone to his office that day. (St. Ex. 83B; Tr. at 1303-1304)

465. Ms. Adamson testified that Patient 57 was seen on June 12, 1998, as a follow up to the patient's emergency room visit concerning the lift falling on her, and to check her diabetes and chronic rashes. Ms. Adamson testified that she did not believe that Patient 57 had presented with a new condition on June 12, 1998, "[b]ecause Dr. Adamson knew about the condition from the phone call on [June 2, 1998,] and he had also received a phone call at home from the emergency room physician that evaluated her." Ms. Adamson acknowledged that the call from the ER physician is not noted in the medical record. Ms. Adamson further acknowledged that the June 12, 1998, visit had been the first time that Patient 57 was seen in Dr. Adamson's office concerning the lift accident. Finally, Ms. Adamson testified that she thinks that Dr. Adamson had been out of the office on June 12, 1998. (Tr. at 559-565, 573-574, 1858-1861)

466. Ms. Adamson denied that a prescription for Darvocet N-100 had been called in that day because the progress note indicated that "the patient has refills on all that stuff."

Ms. Adamson testified that the only prescription called in for Patient 57 on June 12, 1998, had been for Lo Ovral. Finally, Ms. Adamson testified that, although no one had ordered Darvocet N-100 for Patient 57 on that date, it had apparently been called in. (Tr. at 560-564, 1858-1861)

467. Dr. Adamson testified that the June 2, 1998, telephone message "says that [Patient 57] was experiencing pain on her left side, and it says that a lift fell on top of her, but it does not say that the pain was the result of the lift falling on her." Dr. Adamson testified that he does not know the details of the situation, such as the size of the lift and where it fell on the patient. Dr. Adamson further testified that he had been in the office that day, but that he does not recall if he spoke to the patient on June 2. (St. Ex. 57B at 345a-356; Tr. at 917-920)

468. Dr. Adamson testified that he does not believe that Patient 57 had needed to be personally evaluated by a physician prior to treatment on June 12, 1998. Dr. Adamson testified that the patient had been seen and x-rayed at a hospital on June 3, 1998, and the results were faxed to his office. Dr. Adamson further testified that the x-ray report had indicated that Patient 57 had congenital abnormalities in both hips, but that there had been no acute bone abnormality. Moreover, Dr. Adamson testified that his office had already been aware of her congenital hip problems. (St. Ex. 57B at 106-107; Tr. at 922-924)

Dr. Adamson further testified that a lift falling on a patient is an event, and is not a new condition. If, as a result of that event, the patient had been found to have a fracture, then that fracture would have been a new condition. Dr. Adamson testified that, in Patient 57's case, she had had a congenital hip problem, "[b]ut there's no evidence of any other trauma here. There's no recorded bruising. There's no recorded fracture. All this patient has is her congenital hip problem." (Tr. at 924-925)

469. Dr. Adamson testified that he could not recall if he saw Patient 57 on June 12, 1998. Dr. Adamson further testified, however, that he had stamped the chart on June 12, 1998. Dr. Adamson acknowledged that he had stated, during an October 26, 2000, deposition by the Board, that he had left to go to Mammoth Cave the morning of June 12, 1998, and that he did not believe that he had come to his office on that date. Nevertheless, Dr. Adamson testified that "[f]or me to have stamped it on the 12th, I had to have been in the office at some point while she was being seen." (St. Ex. 57B at 354a-b; St. Ex. 61B at 129-130; Tr. at 920-922, 931)

470. Dr. Gardner testified that, in her opinion, Patient 57 presented with a new complaint and new condition of severe left hip pain on June 12, 1998. Dr. Gardner further noted that it is her understanding that a lift had fallen on the patient. Moreover, Dr. Gardner further testified that treatment had been initiated with Darvocet on that date. In addition, Dr. Gardner testified that severe left hip pain had not been previously documented in the chart. (Tr. at 1121-1123)

June 16, 1998

471. On June 16, 1998, Patient 57 called to request a prescription for Miacalcin nasal spray. The note indicates that 2 bottles were ordered, and the patient was directed to use "two squirts each nostril" each day. However, it was further noted that Patient 57 "has refills per pharmacy." The initials "RRH" are written on the form. A "REVIEWED" stamp dated June 23, 1998, is present. There is no physician signature. (St. Ex. 57B at 353)

August 6, 1998

472. On August 6, 1998, Ms. Adamson saw Patient 57 for a chief complaint of burning with urination and "some frequency." The diagnosis as stated on the progress note is "TRICH." Ms. Adamson had prescriptions called in for Flagyl 500 mg #4, and Diflucan 150 mg #1. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated August 6, 1998, is present. (St. Ex. 57B at 344a; Tr. at 565)

473. Ms. Adamson testified that Patient 57 had been seen many times previously for burning with urination, and that that had not been a new condition for her. Ms. Adamson testified that the last time Patient 57 had been seen for a urinary tract infection had been May 13, 1997, "but she had many kind[s] of vulvar and buttock problems" such as ulcers. Ms. Adamson further testified that she did not know if Dr. Adamson had seen Patient 57 on August 6, 1998. (St. Ex. 57B at 344a; Tr. at 570-573)

474. Dr. Adamson testified that he does not believe that Patient 57 had needed to be personally evaluated by a physician prior to treatment on August 6, 1998. Dr. Adamson testified that, first, the patient had had similar complaints a number of times previously. Second, Dr. Adamson testified that the patient had been diagnosed with "Trich," which he acknowledged had been a new diagnosis for Patient 57. However, Dr. Adamson testified that "Trich" is a sexually transmitted disease, and that Patient 57 was "a patient who's completely dependent and wheelchair bound, living in a group home—I would consider a sexually transmitted disease something that required immediate attention. We had no idea if she had been sexually assaulted." Finally, Dr. Adamson testified that history obtained by Ms. Adamson had revealed that Patient 57 in fact had had a boyfriend. (St. Ex. 57B at 344a; Tr. at 933-936)

475. Dr. Gardner testified that, in her opinion, Patient 57 had presented with a new condition of trichomonas on August 6, 1998. Dr. Gardner further testified that Patient 57 had been treated with Flagyl for that condition, as well as with Diflucan, which is an antifungal medication. (Tr. at 1128-1133)

September 23, 1998

476. A telephone message form dated September 23, 1998, indicated that Glucatrol 40 mg had been called in for the patient the previous day. The initials "RRH" are written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 335)

November 30, 1998

477. On November 30, 1998, Patient 57 called concerning a medication refill. The telephone message form indicates that a prescription was issued for Valium 5 mg #60 with refills for one year. The initials "NK" are written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 322)

February 18, 1999

478. On February 18, 1999, Patient 57 called concerning pain in her left leg and hip. A note on the telephone message form states to discontinue Naprosyn, and a prescription was issued for Cataflam 50 mg #90 with refills for one year. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 316)

March 4, 1999

479. On March 4, 1999, Patient 57 was seen concerning her diabetes. The plan included testing for hemoglobin A_{1C}, microalbumin, lipids, "Basic Met," and an ophthalmology referral. Current medications were continued, and a Depo Provera shot was administered. In addition, a prescription was issued for a new medication, Rezulin 400 mg #30 with refills for one year. "VOWCA/RRH" is written on the progress note. A "REVIEWED" stamp dated March 18, 1999, is present. There is no physician signature. (St. Ex. 57B at 313)

March 8, 1999

480. A telephone message form states "Rezulin 400 mg[.] [Telephone number] press 4." Beneath that, it is noted, "Done" followed by the initials "N.K." A "REVIEWED" stamp dated March 18, 1999, is present. There is no physician signature. (St. Ex. 57B at 310)

March 23, 1999

481. On March 23, 1999, Patient 57 called concerning a rash. The telephone message form indicates that a prescription was issued for Mycelex Cream 30 gm with 2 refills. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 308)

July 9, 1999

482. On July 9, 1999, Patient 57 called and asked if she should continue her Rezulin. The telephone message form indicates that she should continue to take it until her next visit. In addition, the form indicates a prescription was issued for Granulex spray to treat an ulcer, and the patient was told to change the dressing. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 288)

July 9, 1999

483. On July 9, 1999, Patient 57 was seen concerning her diabetes. The plan called for testing of hemoglobin A_{1C}, blood sugar, and lipid profile, and the patient was referred to an ophthalmologist. There is no indication on the progress note concerning the identity of the provider. A "REVIEWED" stamp dated July 19, 1999, is present. There is no physician signature. (St. Ex. 57B at 287)

July 30, 1999

484. On July 30, 1999, Patient 57 was seen for her diabetes. The plan indicated that Patient 57 needed time off work. Further, she was referred to the Grant Wound Clinic. In addition, Cipro was discontinued, the patient was to continue tetracycline, and to use Tylenol No. 3 for pain. The initials "MB-PAS" are written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 280)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

August 3, 1999

485. On August 3, 1999, Patient 57 was seen for a diagnosis of vulvitis. The plan called for a home health check, for the patient to be off work through August 16, to finish her Rezulin and then start Avandia, and to be rechecked in two months. Prescriptions were issued for Diflucan 150 mg #1 with refills for one year, and Avandia 4 mg #30 with refills for one year. There is no indication on the progress note concerning the identity of the provider. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 272)

    Dr. Adamson was out of the state on August 3, 1999. (St. Ex. 83B; Tr. at 1307-1310)

November 5, 1999

486. On November 5, 1999, Ms. Adamson saw Patient 57 for a follow up visit concerning medication. It was noted that the patient had a circular rash on her scalp. Prescriptions were issued for, among other things, Oxistat 1% 13 gm with one refill, and Paxil 20 mg with refills for 1 year. A "REVIEWED" stamp dated November 8, 1999, is present. (St. Ex. 57B at 243a-b; Tr. at 574-575)

Ms. Adamson testified that she did not believe the circular rash on Patient 57's scalp to have been a new condition because the patient had been treated for rashes previously. Ms. Adamson acknowledged that there is no indication on the progress note for November 5, 1999, that Dr. Adamson saw Patient 57 that day and evaluated her. (St. Ex. 57B at 243a; Tr. at 574-580)

487. Dr. Adamson testified that he does not believe that Patient 57 had needed to be personally evaluated by a physician prior to treatment on November 5, 1999. Dr. Adamson testified that the patient had come that day for a follow-up concerning her diabetes, which had been an established condition. (St. Ex. 57 at 243a-b; Tr. at 936-937)

Dr. Adamson further testified that he did not believe that Patient 57 had needed to be personally evaluated by a physician prior to receiving Oxistat for a rash on November 5, 1999. Dr. Adamson testified that, first, the patient had had longstanding problems with rashes due to tinea and yeast; second, the rash had been "a minor self-limiting problem that would get better with a minor treatment or a straightforward treatment that most patients would recognize." Moreover, Dr. Adamson testified that a rash cause by tinea or yeast would not be a new condition for a patient diagnosed with diabetes. (Tr. at 937-939)

The medical record does not indicate the source of the "circular rash in scalp," or whether it had been tinea or yeast. Dr. Adamson testified that "[i]t was described as circular and in the scalp, so you would make the assumption that it was tinea, especially knowing this patient's history." Dr. Adamson further testified that the patient had been treated with Oxistat, which he stated is used to treat tinea. Dr. Adamson acknowledged, however, that he had assumed that the circular rash had been tinea because of the treatment that was rendered for it. (St. Ex. 57 at 243a; Tr. at 939-940)

488. Dr. Gardner testified that, in her opinion, Patient 57 had presented with a new condition, a scalp rash, on November 5, 1999. Dr. Gardner further testified that she found no previous mention of a scalp rash in the chart. Moreover, Dr. Gardner testified that treatment with Oxistat, an antifungal medication, was started on that date. (Tr. at 1133-1134)

Dr. Gardner testified that Patient 57 had been diagnosed with seborrhea capitis on October 11, 1996. (St. Ex. 57A at 260a; Tr. at 1230-1231) Dr. Gardner further testified that, in its worst form, seborrhea capitis can cause nodules and sores on the scalp, with flaking, fissuring, and itching. Moreover, Dr. Gardner testified that it generally presents as a circular rash. Nevertheless, Dr. Gardner testified that the October 11, 1996, diagnosis does not affect her opinion concerning the November 5, 1999, scalp rash. Dr. Gardner explained that "there's been approximately three years in between the mention of any scalp rash" in the medical record. Finally, Dr. Gardner testified that, if it wasn't written down in the medical record, it didn't happen. (Tr. at 1243-1244, 1250-1251)

December 27, 1999

489. On December 27, 1999, Patient 57 called concerning a need for more medication, and stated that she still had bronchitis. The telephone message form indicates that a prescription for Z-Pak was called in. "VOWCA/RRH" is written on the form. A "REVIEWED" stamp dated December 29, 1999, is present. There is no physician signature. (St. Ex. 57B at 246)

February 21, 2000

490. On February 21, 2000, Patient 57's father called asking that Patient 57's nebulizer be restarted. The telephone message form indicates that the patient was authorized to use Albuterol nebulizer as needed. "VOWCA/RRH" is written on the form. No "REVIEWED" stamp or physician signature is present. (St. Ex. 57B at 205)

Testimony of Patient 57

491. Patient 57 testified that she had been a patient of Dr. Adamson for approximately seven years, and visited his office on a regular basis during that time. Patient 57 testified that she probably had seen Ms. Adamson more often than Dr. Adamson, and that she had seen Dr. Adamson about four or five times. (Tr. at 1617-1620)

    Patient 57 testified that when she went to Dr. Adamson's office concerning a rash on her head that she saw Dr. Adamson, and he examined her head. (Tr. at 1620)

    Patient 57 further testified that, when Ms. Adamson would see her, she usually had a student with her. After the examination, Ms. Adamson and the student would go and talk to Dr. Adamson. Finally, Patient 57 testified that, on those occasions when Ms. Adamson left to talk to Dr. Adamson, Dr. Adamson did not come in and examine her. (Tr. at 1617-1620)

    Patient 57 testified that she believes that she had received good quality medical care from Dr. Adamson and Ms. Adamson. (Tr. at 1623)

<u>Patient 58</u> (Ms. Adamson Patient 44)

November 18, 1998

492. On November 18, 1998, Patient 58 was seen to follow up on back and neck complaints. The diagnoses were C-strain and hypertension. Prescriptions were issued for Cataflam 50 mg #90 with five refills, Elavil 25 mg #30 with five refills, and Accupril 20 mg #30. "VOWCA/RRH" is written on the progress note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 58 at 67)

July 30, 1999

493. On July 30, 1999, Ms. Adamson saw Patient 58 for a chief complaint of ear discomfort for five days. The diagnosis was bilateral otitis media. Ms. Adamson testified that she had had a prescription called in for Amoxil 500 mg #30. The initials "MB-PAS are written on the progress note. A "REVIEWED" stamp dated July 30, 1999, is present. (St. Ex. 58 at 60; Tr. at 580-581)

    Dr. Adamson was out of the state on July 30, 1999. (St. Ex. 83B; Tr. at 1307-1310)

494. Ms. Adamson testified that she had been authorized to have the prescription called in based on Dr. Adamson's "standing order concerning patients who had this constellation of symptoms. (Tr. at 581)

495. Dr. Adamson testified that a prescription for Amoxil 500 had been called in for Patient 58 on July 30, 1999, when Dr. Adamson was out of state. Dr. Adamson testified that that prescription had been authorized because "that was part of our standard care plan for the initial treatment of otitis media." (St. Ex. 58 at 60; Tr. at 1612)

Patient 59

July 12, 1999

496. On July 12, 1999, Patient 59, a ten-day-old female, was seen for a preventative health examination. The progress note indicates that "thrush" was diagnosed. The plan indicated that a "PKU" was done that day, and that the patient was to be re-checked in one month. "VOWCA/RRH" is written on the note. No "REVIEWED" stamp or physician signature is present. (St. Ex. 59 at 55)

Dr. Adamson's Countersigning of Orders

497. Dr. Adamson testified that, in addition to his testimony concerning specific instances identified elsewhere in the Summary of the Evidence concerning individual patients, he did not believe that he had needed to countersign the remaining entries identified in paragraphs 3 and 4 of the Board's May 9, 2001 notice. Dr. Adamson cited two reasons:

    > On some of the dates in question, I was not the supervising physician. I was more than 60 minutes away from the office, and by statute, I'm not allowed to sign those charts as a supervising physician.
    >
    > In all the other cases, those—in my review, they represent verbal orders from me for the care of my patients, and I am not required to sign my own verbal orders within 24 hours, or any time.

(St. Ex. 60A; Tr. at 2022)

Recording of Specific Treatment Plans

498. Dr. Adamson testified regarding why his specific treatment plans were not recorded in writing:

> Number one, I didn't see a reason to write them down. By keeping track of what we're doing with the patient [in the patient chart], that's our treatment plan. If we—if I give them medication X and I write and sign a prescription for them to take medicine X on an ongoing basis for their chronic health problem, that's my treatment plan. I don't need to write something else down that says, here's my treatment plan for that patient. It's there. It's in the chart.

(Tr. at 1995-1996)

Dr. Adamson also testified that the shingling of progress notes in his medical charts left the bottom portion of the previous five or six progress notes exposed, which made it easy to find previous examples of the same complaint. (Tr. at 2047-2048)

499. Ms. Adamson testified that the specific orders referenced by the notation "VOWCA/RRH" were not written in the charts, "but the clues were there to remind" Ms. Adamson what the orders were. Ms. Adamson further testified that she did not write down the exact order, and did not think that she had to because they were things that she would remember: "It made—what he was telling me made good sense. It was good medicine. So, you know, that's—as a PA, that's what you learn." Finally, Ms. Adamson testified that their patient chart folders were structured in such a way "that you knew what the condition was, what the patient was on, and kind of where they were in their health continuum." Finally, Ms. Adamson testified regarding what happened if Dr. Adamson gave her an order that was out of the ordinary:

> I would put a notation that would trigger my memory. Like, there's one chart floating around here that says—I can't remember who it's on. There's a couple, actually. One says, 'DC Paxil, consider Wellbutrin.' That was the way I wrote, oh, this is not the normal treatment plan. We talked about it. Wean her Paxil and [consider Wellbutrin.]

(St. Ex. 24 at 74; Tr. at 1805-1817) Ms. Adamson testified that "consider Wellbutrin" had not been part of the standard care plan, but was her trigger. Ms. Adamson stated that she and Dr. Adamson had discussed Wellbutrin for that patient, and that, if the patient's sweating had not gone away after she was weaned off of Paxil, and the patient had needed another antidepressant, then Dr. Adamson wanted Ms. Adamson to start the patient on Wellbutrin. (Tr. at 1817-1818)

Dr. Adamson's QA Program

500. Dr. Adamson testified that he had instituted a P.A. Quality Improvement and Utilization Review Plan [QA Plan] and attached it to his Physician Assistant Utilization Plan. Dr. Adamson testified that the QA Plan set forth the items that he looked for in each chart that he reviewed. (Tr. at 1352-1355)

501. Ms. Adamson testified that she and Dr. Adamson reviewed her work each quarter. Ms. Adamson testified that they did quality assurance reviews on a random selection of 30 of her patient charts. Ms. Adamson further testified that they also reviewed whether the patients she had seen were appropriate for her, including whether new patients were on her schedule. In addition, they "looked at if [Ms. Adamson] saw a patient and that patient needed to be seen by the physician, was the physician involved. * * * If the patient—if it was something that [she] needed help on, if it was something that needed a referral to the physician or was a new issue with the patient, like a new case of hypertension, new diabetes, was the physician involved." (Tr. at 57-58, 61-63)

    Ms. Adamson further testified that they reviewed the amount of well care and preventative care she was doing. Moreover, they reviewed whether the correct history and physical exam had been performed, whether the correct tests had been ordered, and whether all of her charts had been countersigned. (Tr. at 57-58, 61-62)

    Ms. Adamson testified that, in order to perform the quarterly review, they relied on the patient records, the schedule and their recollection. (Tr. at 63)

502. Ms. Adamson testified at length concerning the QA Plan at Apple Health. Ms. Adamson testified that she and Dr. Adamson developed that program together. Ms. Adamson further testified that the purpose of the QA Plan "was to ensure the quality care of our patients and the proper processing of the records." Moreover, Ms. Adamson testified that she and Dr. Adamson developed nine or ten "indicators." Each quarter, beginning in 1994, they pulled thirty charts for patients that Ms. Adamson had seen. Ms. Adamson testified that they did not know ahead of time which charts would be selected, but divided the total number of patients that she had seen for that time period by thirty, and used that number to select charts, such as every sixth chart or every tenth chart. Finally, Ms. Adamson testified that she and Dr. Adamson "sat down together and went through those records." (Resp. Ex. N; Tr. at 1827-1830)

    In their quality assurance plan, Dr. Adamson and Ms. Adamson listed the following "Measures" for "Statistical Review":

    1.0 All new patients scheduled with physician. Goal 100%

    1.1 All procedures performed are appropriate and with-in the scope of practice. Goal 100%

1.2 Appropriate total # of office visits. Goal 100%

1.3 At least 20% of visits are well-care. Goal >20%

1.4 Supervising physician identified. Goal 100%

Moreover, they listed the following "Measures" for "Chart Review":

2.1 Countersignature on note and all ordered tests. Goal 100%

2.2 Physician referral when appropriate. (% is of charts reviewed with referral). Goal 10-50%

2.3 Appropriate diagnostics ordered. Goal 90%

2.4 Appropriate history. Goal 100%

2.5 Appropriate exam. Goal 100%

2.6 Preventive guidelines. Goal 100%

2.7 Treatment planning. Goal 100%

2.8 Documentation of teaching. Goal 100%

2.9 PE/WW
physical exam
well woman care

(Resp. Ex. N at 1-2)

Additional Information

503. Dr. Adamson testified that he does not believe that any of the treatment that Ms. Adamson rendered to Patients 1 through 59 that either he or Ms. Adamson had testified about at hearing had violated any of his protocols or procedures for physician assistants in his office. Dr. Adamson further testified that he does not believe that any of the treatment rendered by Ms. Adamson to Patients 1 through 59 that either he or Ms. Adamson had testified to at hearing had violated any of his protocols or procedures concerning the prescribing of medication. Moreover, Dr. Adamson testified that he does not believe that any of the treatment that Ms. Adamson rendered to Patient 1 through 59 that either he or Ms. Adamson had testified about at hearing exceeded Ms. Adamson's authority as a

physician assistant, or exceeded the authority approved in any Physician Assistant Utilization Plan under which she had worked. (Tr. at 1612-1614)

504. Dr. Adamson testified that he does not believe that he violated the laws governing physician assistants in Ohio in the way that he supervised Ms. Adamson or other physician assistants. Dr. Adamson further testified that he does not believe that he violated any Physician Assistant Utilization Plan that he participated in that was in effect from 1995 through 2000. (Tr. at 2041)

505. Ms. Adamson testified regarding the Board's May 9, 2001, notice of opportunity for hearing. Ms. Adamson testified that, for each of the patient encounters referenced in paragraph 1 of that notice, when treatment was rendered, Dr. Adamson had ordered that treatment. Ms. Adamson further testified that, for each of the patient encounters noted in paragraph 2 of that notice, Dr. Adamson had ordered the medication listed, and every medication was ordered for a legitimate medical purpose. (St. Ex. 60K; Tr. at 1861-1862)

    Ms. Adamson further testified that she never prescribed medication. Ms. Adamson also testified that she never made a diagnosis for any of the patient encounters identified in the Board's notice letter. (St. Ex. 60K; Tr. at 1862-1863)

    Moreover, Ms. Adamson testified that she did not believe that any of the prescriptions that she had called in for the patients about which she had testified in this matter violated Dr. Adamson's protocols, procedures, or guidelines for physician assistants in his office. Ms. Adamson further testified that she does not believe that she had exceeded her authority as a physician assistant practicing under the Physician Assistant Utilization Plans for Dr. Adamson and for American Health Network. Further, Ms. Adamson testified that, between 1995 and May 10, 2001, Dr. Adamson had never told her that she had exceeded her authority as a physician assistant by seeing and treating patients, or for calling in prescriptions for patients. (Tr. at 581-587)

506. Dr. Buddie testified that he knows Dr. Adamson to be a good and conscientious physician. Dr. Buddie further testified that he does not have any reservations concerning Dr. Adamson's competency or ability to practice medicine. (Tr. at 1596-1597)

507. Ms. McCale testified that she liked Dr. Adamson and Ms. Adamson, and that she had enjoyed working for them. (Tr. at 1681-1682)

508. Ms. Adamson testified that she loved her patients. Ms. Adamson further testified that she believes that she and Dr. Adamson had given excellent care to their patients. (Tr. at 1863)

FINDINGS OF FACT

I. The evidence presented at hearing supports the following allegations made by the Board in the May 9, 2001, notice of opportunity for hearing in the matter of Wallace C. Adamson, M.D.:

A. Dr. Adamson entered into two Supervision Agreements with Robin Rae Hawn, P.A., now known as Robin Rae Adamson, P.A. Pursuant to these supervision agreements, effective on or about January 31, 1997, and February 14, 1997, Dr. Adamson certified that he would supervise Ms. Adamson in accordance with both Dr. Adamson's and American Health Network of Ohio's Physician Assistant Utilization Plans ["Utilization Plans"], as approved by the Board. Among other things, the Utilization Plans required that established patients with new conditions be seen and personally evaluated by the supervising physician prior to the initiation of treatment.[2]

Contrary to the requirements of the Utilization Plans and Section 4730.21(D), Ohio Revised Code[3], Dr. Adamson authorized Ms. Adamson to practice and Dr. Adamson failed to see and personally evaluate the following established patients, who presented with new conditions[4], prior to the initiation of treatment for these new conditions by Ms. Adamson or physician assistant students under her supervision, and Ms. Adamson and/or physician assistant students under her supervision examined, diagnosed[5] and/or initiated treatment for these new conditions. Moreover, Ms. Adamson failed to consult with, and/or Dr. Adamson's patient records fail to reflect any consultation with, Dr. Adamson or any other supervising physician prior to the initiation of treatment of the patients' new conditions.

---

[2] In defending against these allegations, the Respondents argued, through their counsel, that the State had failed to prove that the Board had ever approved the Utilization Plans that the State alleged had been violated. This argument is rejected. The State submitted certified copies of the Utilization Plans, the Supervision Agreements, and letters sent to Dr. Adamson by Board staff informing him that the Utilization Plans had been approved. Further, testimony offered by both Dr. Adamson and Ms. Adamson supports a finding that the two plans presented by the State were the plans under which Dr. Adamson's practice had operated during the time period relevant to this hearing. Accordingly, the evidence is sufficient to support a finding that these Utilization Plans had been approved by the Board.

[3] Paragraph one of the May 9, 2001, notice letter erroneously cited Section 4731.21(D), Ohio Revised Code. However, no party objected to the error. Further, the correct section number was subsequently referenced in the letter. Finally, as the hearing record makes clear, this error did not impair the notice to the Respondents concerning the conduct that was alleged to be inappropriate.

[4] See the section entitled Legal Issues, below, concerning the term, "new condition."

[5] The Respondents argued that Ms. Adamson had not made diagnoses, but rather made "assessments." Nevertheless, the evidence is clear that Ms. Adamson regularly recorded a diagnosis in the section of the progress note labeled "Diagnosis," although many of the progress note forms also had a section labeled "Assessments." Further, the evidence shows that Ms. Adamson treated patients based upon her diagnoses of patients' new conditions without Dr. Adamson first seeing and personally evaluating those patients. Accordingly, the evidence supports a finding that Ms. Adamson diagnosed patients' new conditions.

1. The following established patients with new conditions received treatment from Ms. Adamson when Dr. Adamson was out of town; therefore, Dr. Adamson did not see and personally evaluate these patients prior to the initiation of treatment:

   a. On July 30, 1999, Ms. Adamson treated Patient 5 with a prescription for ketoconazole for a chief complaint of rash, which was diagnosed as tinea. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

      The Respondents denied that tinea had been a new condition for Patient 5 on July 30, 1999. Ms. Adamson noted that the patient "had been treated for the same rash on 5-18-98." However, the progress note for May 18, 1998, which includes a diagnosis of tinea versicolor, gives no location of any rash and, under the physical examination for skin, it was noted that there was "no rash." What led Ms. Adamson to believe that it had been "the same rash" was not disclosed.

      The Respondents also argued that Ms. Adamson had merely followed Dr. Adamson's specific treatment plan for this patient, given on May 18, 1998. Therefore, the Respondents reasoned, Patient 5's care had actually been directed by Dr. Adamson rather than by Ms. Adamson. However, there is no credible evidence that any such treatment plan existed.[6] The only written evidence of such a purported order is a May 18, 1998, prescription for Nizoral tablets. Nevertheless, at the time Dr. Adamson ordered that prescription, there had been an examination finding that Patient 5 did *not* have a rash. Therefore, even if such an order had existed, it could not have authorized Ms. Adamson to treat a new condition, rash, without Dr. Adamson having first seen and personally evaluated the patient. Finally, the Utilization Plans under which Ms. Adamson practiced required that a patient be referred to the supervising physician if the patient has a new complaint.[7] Accordingly, this argument is rejected.

   b. On July 30, 1999, Ms. Adamson treated Patient 6 with Zoloft samples for having scored "moderate" on a patient self-evaluation for anxiety disorder, a new condition, and instructed Patient 6 to return one month later for a re-evaluation of anxiety.

      The Respondents argued that anxiety was a symptom, and that a symptom is not a condition. This argument is rejected. As noted by Dr. Gardner, a

---

[6] Note: this reasoning applies to all of the Respondents' arguments that are based on Dr. Adamson's unwritten treatment plans for specific patients.

[7] Note: this reasoning applies to all of the Findings of Fact herein concerning patients who presented with new complaints.

"condition" could be a symptom, a complaint, or a diagnosis. [See also the section entitled Legal Issues, below.][8]

The Respondents also argued that Ms. Adamson had merely followed Dr. Adamson's standard treatment plan for patients who suffered from anxiety. Ms. Adamson testified that she had given Patient 6 "a patient self-evaluation form for anxiety disorder, which Dr. Adamson ordered us to do if patients had anxiety symptoms. And if they scored moderate or above, then they were to be started on an SSRI [selective serotonin reuptake inhibitor][9] and referred to counseling."[10] Therefore, the Respondents reasoned, Patient 6's care had actually been directed by Dr. Adamson rather than by Ms. Adamson. However, neither this standard treatment plan, nor any other standard treatment plan that the Respondents claimed to have existed, had been documented in writing. There is no credible evidence that any such treatment plan existed.[11] Moreover, even if such a treatment plan had existed, it could not have authorized Ms. Adamson to treat a new condition, anxiety disorder, without Dr. Adamson having first seen and personally evaluated the patient. Finally, the Utilization Plans under which Ms. Adamson practiced required that a patient be referred to the supervising physician if the patient has a new complaint, which Ms. Adamson failed to do. Accordingly, this argument is rejected.

c. On July 26, 1999, Ms. Adamson treated Patient 12 for a skin abscess, which was diagnosed as cellulitis. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated. Ms. Adamson performed an incision and drainage, and a prescription for Keflex was called in to a pharmacy that day.

The Respondents denied that the patient had actually had cellulitis, or that the patient's cyst had been infected. The Respondents drew attention to a lab report, which indicated that only a light growth of diphtheroids had been present, as evidence that the patient did not have an infection. Nevertheless, the diagnosis in Dr. Adamson's progress notes for that date clearly states "cellulitis." Moreover, that diagnosis was never corrected or updated, and the same diagnosis continued to be recorded during numerous follow-up visits—including follow-up visits that occurred after the lab

[8] Note: this reasoning applies to all of the Findings of Fact herein for which the Respondents had argued that symptoms are not conditions.
[9] Evidently, the choice of which SSRI to implement had been left to the physician assistant.
[10] Note that there was no evidence that Ms. Adamson had referred Patient 6 to counseling.
[11] Note: this reasoning applies to all of the Respondents' arguments that are based on Dr. Adamson's unwritten standard treatment plans.

report had been received—culminating on August 11, 1999, when a fistula was found and the patient was referred to a surgeon.

d. On August 3, 1999, Ms. Adamson treated Patient 13 with a prescription for Oxistat for a chief complaint of a rash on her back and legs for three weeks, which was diagnosed as ringworm. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

e. On August 2, 1999, Ms. Adamson treated Patient 20 for a diagnosis of viral pharyngitis, a new condition, by advising Patient 20 to use over-the-counter Tylenol. Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

Ms. Adamson's assertion that pharyngitis had not been a new condition because the patient had been seen approximately ten months earlier for "viral syndrome" is rejected.

f. On August 3, 1999, Ms. Adamson treated Patient 21 with a prescription for Tagamet for a diagnosis of gastroesophageal reflux disease [GERD]. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

Ms. Adamson stated that the patient did not actually suffer from GERD, but was later diagnosed with duodenitis. Both Respondents argued that GERD had merely been Ms. Adamson's initial "assessment." This argument is rejected. The diagnosis clearly states "GERD" despite the fact that there is space on the progress note labeled for "Assessment," which was left blank. If GERD was not the correct diagnosis, then it should have been corrected in the medical record.

The Respondents further stated that Ms. Adamson was authorized to treat Patient 21 based on the "immediate attention" clause. The only statutory reference to "immediate attention" is contained in Section 4730.21(D), Ohio Revised Code, which states, in part:

> Countersignature by the supervising physician is necessary before any person may execute the physician assistant's order, except in situations in which a patient requires immediate attention and any other circumstances specified in a supplemental utilization plan under which countersignature is not necessary.

R.C. 4730.21(D)

First, it is by no means clear that the immediate attention clause authorizes a physician assistant to initiate treatment for an established patient with a new condition prior to the patient having been personally seen and evaluated by a supervising physician. Only a strained reading of that statute could yield that conclusion. The "immediate attention" clause merely states that a physician assistant's order shall be countersigned by a supervising physician prior to the order being executed "except in situations in which a patient requires immediate attention* * *." It does not specify that physician assistants may initiate treatment for a patient with a new condition prior to that patient first being seen and personally evaluated by a physician. In fact, the preceding paragraph of that section specifically prohibits that conduct.

Furthermore, the Respondents stated that the patient had required immediate attention because he had complained of heartburn, which can be a symptom of a heart attack. This argument is ludicrous, and is flatly rejected. First, there is no indication in the medical record that a cardiac event was even considered by Ms. Adamson, much less ruled out. Second, if Ms. Adamson did rule out cardiac problems, the supposed need for immediate attention would have ceased. Therefore, she could not base her continued treatment of Patient 21 on a need for immediate attention. Finally, Ms. Adamson, as a physician assistant, is not qualified and has no authority to rule out cardiac problems for a patient. If a heart attack had truly been suspected, then Patient 21 should have been sent immediately to an emergency room to receive the necessary care from a qualified individual.

Finally, Ms. Adamson was required to practice within the parameters of the Utilization Plans approved by the Board. Pursuant to those plans, Ms. Adamson was required to "call 911" if a patient required immediate attention and a supervising physician was not on the premises.

g. On July 30, 1999, Ms. Adamson treated Patient 23 with prescriptions for Amoxil and Cipro HC Otic for an examination finding of "right canal with green exudate." This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated. No diagnosis was noted in the medical record. The Respondents' argument that the patient's condition had not been new because the patient had previously been treated for ear complaints is rejected.

h. On July 30, 1999, Ms. Adamson treated Patient 26 with a prescription for Amoxil for a diagnosis of "probable strep," a new condition. Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

i. On July 30, 1999, Ms. Adamson treated Patient 28 with a prescription for Humibid DM for a chief complaint of cough and runny nose for five days, which was diagnosed as bronchitis. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

j. On July 30, 1999, Ms. Adamson treated Patient 32 with E-Mycin for a chief complaint of sore throat and earache for three weeks, which was diagnosed as left otitis media. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

k. On August 2, 1999, Ms. Adamson treated Patient 35 with a prescription for Flexeril, and advised Patient 35 to obtain physical therapy, for diagnoses of fibromyalgia and C-strain. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

See also Findings of Fact II.A.1 concerning the prescription for Xenical.

l. On July 26, 1999, Ms. Adamson treated Patient 39 with a prescription for Humibid DM for a complaint of cough for two to three weeks. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

See also Findings of Fact II.A.3 concerning the diagnosis of pharyngitis.

m. On August 2, 1999, Ms. Adamson treated Patient 40 with a prescription for Naprosyn for a diagnosis of plantar fasciitis. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

Despite having recorded a diagnosis of plantar fasciitis, Ms. Adamson denied that Patient 40 had suffered from plantar fasciitis. Ms. Adamson testified that she had noted plantar fasciitis as a diagnosis for coding purposes only, because she had provided patient education concerning that condition. Nevertheless, the diagnosis on the progress note clearly states plantar fasciitis. Moreover, there is no indication that this was only a working diagnosis that was to be ruled out. Further, if the patient had not suffered from that condition, there would have been no need to provide patient education concerning that condition.

Both Respondents testified that the prescription for Naprosyn had been prescribed for general musculoskeletal complaints; however, the medical records for August 2, 1999, say nothing about general musculoskeletal complaints. Moreover, Ms. Adamson testified that Naprosyn had been "a long-standing prescription that Dr. Adamson had ordered for" the patient. Nevertheless, the medical records indicate that Dr. Adamson had never before prescribed Naprosyn for Patient 40. The medical records indicate only that, on February 17, 1997, the patient had had a supply of Naprosyn, evidently obtained elsewhere.

n. On August 2, 1999, Ms. Adamson treated Patient 42 with Silvadene ointment and dressing, and a prescription for Keflex, for a diagnosis of a laceration on his leg, a new condition. Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

Ms. Adamson argued that she had been authorized to treat Patient 42's leg laceration despite its being a new condition because it had required immediate attention. On the other hand, Dr. Adamson argued that Patient 42's laceration had not been a new condition because it had occurred six days earlier, but that immediate attention had been required to treat or prevent infection. For the reasons discussed previously in Findings of Fact I.A.1.f, above, the "immediate attention" argument is rejected.

o. On August 3, 1999, Ms. Adamson treated Patient 46 with a prescription for Sulamyd Ophthalmic for a diagnosis of conjunctivitis, a new condition. Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

Respondents argued that Patient 46 had presented with a red eye, and that Ms. Adamson was authorized to treat him because he had required "immediate attention." Dr. Adamson testified concerning the more serious causes of red eye, such as a foreign body or glaucoma, and the examinations that would be given to determine the cause of a red eye, such as a fluorescein stain and looking in the eye with an ophthalmoscope.

Nevertheless, the medical record does not document that the more serious causes of a red eye were considered or ruled out, or that any particular examination was administered. Further, if Ms. Adamson ruled out the more serious causes of a red eye, the supposed need for immediate attention would have ceased. Moreover, Ms. Adamson is not qualified by training, nor is she authorized by law, to rule out possible diagnoses. Finally, for the reasons discussed previously in Findings of Fact I.A.1.f, above, the "immediate attention" argument is rejected.

p. On August 2, 1999, Ms. Adamson treated Patient 50 with a prescription for Entex LA for a chief complaint of head congestion, which was diagnosed as "viral URI." This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

q. On August 2, 1999, Ms. Adamson treated Patient 51 with Floxin Otic samples for a diagnosis of otitis externa, a new condition. Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

The Respondents argued, among other things, that Patient 51 had been seen a few days earlier in an emergency room where she had been diagnosed with otitis externa and treated with Amoxil and Vicodin. Accordingly, they testified, Patient 51 did not have a new condition. This argument is not persuasive. Section 4730.21(D), Ohio Revised Code, states, in part, that "an established patient of a physician with a new condition shall be seen and personally evaluated by a *supervising physician* prior to initiation of any treatment plan proposed by a physician assistant for the * * * established patient's new condition. * * *" R.C. 4730.21(D). (Emphasis added.) There is nothing in the hearing record that indicates that the physician who saw Patient 51 in the emergency room had been a supervising physician of Ms. Adamson. The statute does not permit Ms. Adamson to act on the evaluation of just any physician, it must be a supervising physician listed in the Supervision Agreement under which she is practicing. Therefore, the statute did not authorize her conduct.

2. The following established patients with new conditions received treatment even though Dr. Adamson failed to see and personally evaluate these patients prior to the initiation of treatment:

a. On October 30, 1998, Ms. Adamson treated Patient 7 with Amoxil for a diagnosis of bronchitis, a new condition. Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated. The Respondents' arguments that the patient did not present with a new condition are rejected.

Ms. Adamson argued, among other things, that she had "probably" called Dr. Adamson concerning this patient because the patient had presented with multiple issues. Dr. Adamson testified that he had been in the office that day and had personally authorized the prescription for Amoxil. This communication was not recorded in the medical records, however, and, even if it had occurred, it would not be sufficient. The law requires that a

patient with a new condition be seen and personally evaluated by the supervising physician. This did not occur.

b. On November 20, 1998, Ms. Adamson treated Patient 8 with a prescription for Flexeril for a diagnosis of viral meningitis. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

The Respondents argued that Patient 8's viral meningitis was not a new condition because she had been seen for that condition the previous day in an emergency room. For the reasons discussed in Findings of Fact I.A.1.q, above, that argument is rejected.

The Respondents further argued that they had discussed the patient's situation, and that Dr. Adamson had signed the prescription for Flexeril. These arguments are also not persuasive. As noted above, the law does not require that a supervising physician discuss a patient's new condition with the physician assistant prior to the initiation of treatment. The statute requires that the supervising physician see and personally evaluate the patient. This did not occur.

See also Findings of Fact II.B.2 concerning the diagnosis of C-strain.

c. On December 16, 1999, Ms. Adamson treated Patient 8 with prescriptions for Ceftin and Entex-LA for a chief complaint of right ear pain, which was diagnosed as otitis media. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

d. On August 18, 1999, Ms. Adamson treated Patient 9 with a prescription for Zyrtec and samples of Flonase for a chief complaint of headache and blurred vision, which was diagnosed as allergies and chronic multiple headaches. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated. The diagnosis of chronic multiple headaches had been based upon a history related by the patient.

e. On August 20, 1998, Ms. Adamson treated Patient 24 for a chief complaint of profuse sweating and fatigue, which was diagnosed as fatigue and hyperhidrosis. This was a new condition. The treatment consisted of lab work and weaning the patient from Paxil. The Respondents' assertions that Patient 24 did not present with a new condition are rejected.

Moreover, Dr. Adamson testified, among other things, that he had directed the care that was rendered to Patient 24 by Ms. Adamson. However, the law requires that a patient with a new condition be seen and personally evaluated by the supervising physician. This did not occur.

f. On September 15, 1998, Ms. Adamson treated Patient 24 with a prescription for Elocon cream for a chief complaint of a red spot on her temple, which was diagnosed as "rash." This was a new condition.

Dr. Adamson testified that Patient 24, who was an employee of his office, had shown him the spot on her temple. Nevertheless, there is nothing in the medical record to indicate that Dr. Adamson had seen and personally evaluated Patient 24 for that condition.

See also Findings of Fact II.B.6 concerning the Depo Provera injection.

g. On January 12, 1998, Ms. Adamson advised Patient 25 to take over-the-counter medication[12] for a chief complaint of lung pain, which was diagnosed as costochondritis. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

h. On July 1, 1998, Ms. Adamson treated Patient 25 with a prescription for Daypro for a complaint of "something on [her] right foot/ankle snapped," a new condition.

Ms. Adamson testified that she had spoken to Dr. Adamson and he advised her to give Daypro to Patient 25. This testimony is not persuasive. First, there is nothing in the medical record to support this statement. Second, even if true, the patient had to be seen and personally evaluated by Dr. Adamson prior to treatment. This did not occur.

On the other hand, Dr. Adamson testified that he did not believe that the patient needed to be seen by a physician that day because the patient had been evaluated at an emergency room, and an x-ray report had been faxed to Dr. Adamson's office. For the reasons discussed in Findings of Fact I.A.1.q, above, that argument is rejected.

---

[12] The evidence is insufficient to support a finding that Tylenol was specifically recommended, as the notice letter had charged. However, the Respondents had been placed on notice concerning the date, the new condition and the diagnosis. Further, Ms. Adamson did recommend an over-the-counter medication. Accordingly, the allegation that Tylenol had been used for treatment did not impair the notice to the Respondents concerning the conduct that was alleged to be inappropriate.

i. On February 23, 1998, Ms. Adamson treated Patient 30 with a prescription for Amoxil for a chief complaint of coughing and dizzy spells, which was diagnosed as sinusitis. This was a new condition.

Dr. Adamson's initial "A" appears on the progress note, and the prescription for Amoxil had evidently been signed by Dr. Adamson. However, Ms. Adamson testified that Dr. Adamson's initial "A" being written on a progress note does not necessarily mean that Dr. Adamson had seen the patient for that visit. Further, the prescription appears to have been written by Ms. Adamson, except for the signature. Accordingly, there is sufficient evidence to support a finding that Ms. Adamson had initiated the treatment without Dr. Adamson having seen and personally evaluated the patient prior to treatment being rendered.

j. On April 29, 1998, Ms. Adamson treated Patient 30 with a prescription for Bentyl for a chief complaint of diarrhea, vomiting, and cramps, which was diagnosed as acute gastritis.[13] This was a new condition.

Dr. Adamson's initial "A" appears on the progress note, and the prescription for Amoxil had evidently been signed by Dr. Adamson. However, as noted above, Ms. Adamson testified that Dr. Adamson's initial "A" being written on a progress note does not necessarily mean that Dr. Adamson had seen the patient for that visit. Further, the prescription appears to have been written by Ms. Adamson, except for the signature.

Further, Dr. Adamson's protestation that the patient had actually had gastroenteritis, rather than gastritis as Dr. Gardner had testified, is rejected as a defense. Although it may well be true that the patient did have gastroenteritis rather than gastritis, Dr. Gardner cannot be faulted for referencing the diagnosis that was recorded in Dr. Adamson's medical records. Dr. Adamson had had the opportunity to correct that diagnosis upon reviewing the chart, and Dr. Adamson testified that he *had* reviewed the chart. Moreover, Dr. Adamson's protestation undermines his other testimony that he had actually seen the patient—if Dr. Adamson had actually seen the patient, it is reasonable to expect that the correct diagnosis would have been recorded. Accordingly, there is sufficient evidence to support a finding that Ms. Adamson had initiated the treatment without Dr. Adamson having seen and personally evaluated the patient prior to treatment being rendered.

---

[13] Although the Board's notice letter alleged that the diagnosis had been acute gastroenteritis rather than acute gastritis, this did not impair the notice to the Respondents concerning the conduct that was alleged to be problematic. Furthermore, Dr. Adamson testified that the correct diagnosis had actually been acute gastroenteritis.

k. On September 1, 1999, among other things, Ms. Adamson treated Patient 30 with a prescription for Amoxil for an assessment of sinusitis, a new condition. No diagnosis of sinusitis was recorded for that visit. Dr. Adamson did not see and personally evaluate the patient prior to the initiation of treatment.

See also Findings of Fact II.B.9 concerning the prescription for Phenergan.

l. On June 30, 1998, Ms. Adamson treated Patient 52 for a diagnosis of skin tags, a new condition, by shaving off the skin tags with a blade. There is no evidence in the medical record that Dr. Adamson had personally seen and evaluated Patient 52 for this condition.

The Respondents asserted that the skin tags were not a new condition because Patient 52 had been an employee of Dr. Adamson's office, and that Dr. Adamson had been aware of the patient's skin tags. This argument is not persuasive.

m. On December 18, 1998, Ms. Adamson treated Patient 52 with samples of Z-Pak and a prescription for Vicodin for diagnoses of sinusitis and pharyngitis. These were new conditions. There is no evidence in the medical record that Dr. Adamson had personally seen and evaluated Patient 52 for the conditions for which she was treated on December 18, 1998.

The Respondents asserted that the patient's condition was not new because Patient 52 had been an employee of Dr. Adamson's office, and Dr. Adamson had been aware of the patient's illness. This argument is not persuasive.

n. On September 10, 1999, Ms. Adamson treated Patient 52 with a prescription for Phenergan for a chief complaint of headache, nausea, and shakiness, which was diagnosed as an upper respiratory infection. This was a new condition.

Respondents asserted that Dr. Adamson had authorized the prescription. There is nothing in the medical record to support that assertion, but even if it were true, it would not be sufficient. Dr. Adamson was required to personally see and evaluate Patient 52, and there is no evidence that that occurred.

o. On June 12, 1998, Ms. Adamson treated Patient 57 with a prescription for Darvocet N-100 for severe left hip pain possibly resulting from a lift having fallen on the patient. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

A telephone message form dated June 2, 1998, indicated as follows: "Experiencing pain on left side—lift fell on top of her Sun pm. [Left] hip hurts." The telephone message form further indicated an order for "X-ray [left] hip." An emergency room report dated June 3, 1998, stated that she had been evaluated by an emergency room physician and had undergone x-rays. The report states, among other things, "[n]o known trauma at this time." The x-ray results showed congenital abnormalities of Patient 57's hip, of which Dr. Adamson had already been aware, but no acute bone abnormality. None of the ER documents referenced a lift falling on the patient.

On June 12, 1998, Patient 57 was seen in Dr. Adamson's office by Ms. Adamson and a physician assistant student. A prescription for Darvocet N-100 was called in to a pharmacy that day.

Dr. Adamson asserted that Patient 57's hip pain had not been a new condition, but had resulted from a congenital problem of which he had already been aware. Dr. Adamson further argued that the June 2, 1998, telephone message "says that [Patient 57] was experiencing pain on her left side, and it says that a lift fell on top of her, but it does not say that the pain was the result of the lift falling on her." However, the patient had originally complained on June 2, 1998, of left hip pain in relation to a lift having fallen on her. Based upon that complaint, Dr. Adamson's office sent Patient 57 to have an x-ray. It is unlikely that Dr. Adamson's office would have ordered an x-ray of Patient 57's hip based on pain resulting from a congenital problem of which Dr. Adamson was already aware. It is therefore reasonable to find that Dr. Adamson's office had ordered an x-ray as a result of the patient's complaint that a lift had fallen on her. Therefore, when Patient 57 subsequently presented to Ms. Adamson on June 12, 1998, for a follow-up from that x-ray, it was for the new condition of severe left hip pain in relation to the lift having fallen on her.

Alternatively, Dr. Adamson asserted that it was not a new condition because Patient 57 had already been seen and evaluated by a physician at the emergency room. For the reasons discussed in Findings of Fact I.A.1.q, above, that argument is also rejected. Patient 57 should have been evaluated by Ms. Adamson's supervising physician before Ms. Adamson initiated treatment with Darvocet N-100.

In yet another alternative argument, Ms. Adamson asserted that she had not authorized a prescription for Darvocet N-100 for Patient 57. However, pharmacy records indicate that a prescription for Darvocet N-100 was called in for Patient 57 that day from Dr. Adamson's office. Further, Ms. Adamson had seen and treated the patient that day, and was

responsible for the care that was given. Accordingly, Ms. Adamson's argument is rejected.

Finally, Dr. Adamson asserted that he had been in his office during Patient 57's June 12, 1998, visit because he had stamped the progress note with the "REVIEWED" stamp. Nevertheless, in light of the numerous examples in the hearing record of the "REVIEWED" stamp being dated when Dr. Adamson was not in the office, and evidence that Ms. Adamson herself used the "REVIEWED" stamp on a regular basis, the evidence supports a finding that the "REVIEWED" stamp has no probative value whatsoever.[14] In addition, it would not matter if Dr. Adamson had been in his office at the time of the patient visit, because there is no evidence in the record that he saw and personally evaluated Patient 57. Accordingly, this argument is rejected.

p. On August 6, 1998, Ms. Adamson treated Patient 57 with prescriptions for Flagyl and Diflucan for a chief complaint of burning with urination and urinary frequency, which was diagnosed as Trichomonas. This was a new condition, and Dr. Adamson did not see and personally evaluate the patient prior to treatment being initiated.

Dr. Adamson argued that the patient had required "immediate attention" because she suffered from a sexually transmitted disease, lived in a group home, was wheelchair-bound, and was dependent on others for her care. Accordingly, Dr. Adamson reasoned, Patient 57 may have been the victim of abuse. This argument is flatly rejected. First, Patient 57 suffers from a variety of physical ailments, but there is nothing in the record to indicate that she is mentally impaired. She is verbal and, in fact, testified at this hearing. If Patient 57 had been the victim of an assault, she was quite capable of informing Ms. Adamson or Dr. Adamson of that fact. Second, the determination that Patient 57 suffered from Trichomonas was a *diagnosis* made by Ms. Adamson. Ms. Adamson is not qualified by training or authorized by law to make a diagnosis. Accordingly, there is a conflict in the Respondents' defense: in order to validate a need for "immediate attention"—which, the Respondents erroneously argue, would have given Ms. Adamson the authority to initiate treatment for a patient with a new condition—a diagnosis of the condition requiring "immediate attention" must first be made. Only a physician can make such a diagnosis. Finally, Dr. Adamson testified that Ms. Adamson had obtained a history from Patient 57 that revealed that Patient 57 had a boyfriend. With that information, the need for any supposed "immediate attention" vanished. Yet, Ms. Adamson continued to diagnose and initiate treatment for the patient.

[14] Note: this reasoning applies to all Findings of Fact herein for which the "REVIEWED" stamp is relevant.

q. The evidence is sufficient to support a finding that on November 5, 1999, Ms. Adamson treated Patient 57 with a prescription for Oxistat for an examination finding of a circular rash in her scalp, a new condition. Dr. Adamson did not see and personally evaluate the patient prior to the initiation of treatment.

Patient 57 testified that when she had gone to Dr. Adamson's office concerning a rash on her head, she had been seen and examined by Dr. Adamson, rather than by Ms. Adamson. However, Patient 57 did not testify concerning which visit that had been, and the evidence indicates that Patient 57 had been previously seen for a rash on her scalp on another occasion. In addition, Dr. Adamson did not claim to have seen the patient on November 5, 1999, and Ms. Adamson testified that she had.

See also Findings of Fact II.B.11 concerning the prescription for Paxil.

B. Dr. Adamson authorized and/or allowed Ms. Adamson to issue prescriptions for and/or dispense dangerous drugs to patients without Dr. Adamson's or any other physician's specific order, as follows:

Patient	Date	Drug
5	07/30/99	Ketoconazole
6	07/30/99	Zoloft samples
11	08/03/99	Celebrex
11	08/03/99	Flonase samples
12	07/26/99	Keflex
13	08/03/99	Oxistat
14	08/02/99	Claritin
15	08/03/99	Z-Pak
15	08/03/99	Piroxicam
16	07/30/99	Wellbutrin
17	03/02/98	Prozac[15]
19	08/02/99	Prevacid samples
21	08/03/99	Tagamet

[15] Dr. Adamson asserted that his February 9, 1998, notation, "Prozac 20 [mg] qd #21 samples," had constituted an order that Patient 17 was to continue receiving Prozac until he changed the order. Dr. Adamson further asserted that that order had authorized Ms. Adamson to have a prescription for Prozac 20 mg #30 called in for the patient on March 2, 1998. Moreover, Dr. Adamson asserted that anytime one of his medical records indicated that a medication had been given, it meant that that medication was to be given continuously until Dr. Adamson changed his order, "[u]nless there's a time limit or a quantity limit or there are certain types of medication that aren't continuous[]" such as Z-Pak. Finally, Dr. Adamson asserted that the notation "#21 samples" on his February 9, 1998, note had not constituted a quantity limit, but merely indicated how many samples the patient had received. These assertions are found to be patently ridiculous, and a deliberate falsehood.

Patient	Date	Drug
22	07/26/99	Augmentin samples
22	07/26/99	Bactrim DS
23	07/30/99	Amoxil
23	07/30/99	Cipro HC Otic
26	07/30/99	Amoxil
28	07/30/99	Humibid DM
31	08/02/99	Theophylline
31	08/02/99	Prednisone
31	08/02/99	Serax
31	08/02/99	Combivent
31	08/02/99	Zyban
32	07/30/99	E-Mycin
32	07/30/99	Premarin
33	08/03/99	Serevent
33	08/03/99	Ibuprofen[16]
35	08/02/99	Xenical
35	08/02/99	Flexeril
35	08/02/99	Midrin
36	08/03/99	Cipro Urapak
36	08/03/99	Estratest NS
39	07/26/99	Humibid DM
39	07/30/99	Cechlor
39	07/30/99	Entex LA[17]
40	08/02/99	Naprosyn
40	08/02/99	Glucotrol
40	08/02/99	Avandia
41	08/03/99	Zithromax
41	08/03/99	Anusol HC
42	08/02/99	Keflex
43	03/02/98	Cleocin
43	03/02/98	Premarin

[16] Note that the testimony of Dr. Adamson and the testimony of Ms. Adamson is in conflict concerning the authorization for this prescription. Ms. Adamson testified that she had been authorized to have the prescription called in based on Dr. Adamson's standing order that a patient "with minor pain, right ear discomfort, could have ibuprofen." Dr. Adamson testified that he had authorized the prescription based upon his standard care plan for patients with pain from toothaches and dental procedures. Neither purported order was documented in writing.

[17] Note that the testimony of Dr. Adamson and the testimony of Ms. Adamson is in conflict concerning the authorization for this prescription. Ms. Adamson testified that the prescriptions had been called in based on Dr. Adamson's standing order that a patient with an upper respiratory infection who is allergic to penicillin could receive Ceclor and Entex. Dr. Adamson testified that a telephone call from the patient, which was not included in the medical record, had prompted him to tell Ms. Adamson "specifically to examine [Patient 39] and that he could be treated with Entex and Ceclor." Neither purported order was documented in writing.

Patient	Date	Drug
43	03/02/98	Provera
43	08/03/99	Metrogel-Vaginal Gel
44	08/02/99	Augmentin
46	08/03/99	Sodium Sulamyd Ophthalmic
48	08/02/99	Medrol Dospak
49	08/02/99	Zoloft samples
49	08/02/99	Medrol Dospak
50	08/02/99	Entex LA
51	08/02/99	Floxin Otic samples
53	07/30/99	Prandin
53	08/02/99	Naprosyn
54	08/03/99	Isoptin
54	08/03/99	Diovan
54	08/03/99	Cardura
58	07/30/99	Amoxil

C. Dr. Adamson failed to countersign patient chart entries reflecting medical orders signed or initialed by physician assistants under his supervision for Patients 1[18], 3, 7, 9, 12, 13, 15, 16, 17, 22, 24, 25, 27, 29, 30, 32, 34, 35, 37, 39, 40, 41, 42, 44, 45, 47, 49, 52, 53, 55, 56, 57, 58 and 59 on the following dates:

Patient	Date of Chart Entry
1	03/06/00
3	01/20/98
3	02/24/98
3	03/23/98
3	01/15/99
3	07/30/99[19]
3	11/23/99
3	04/24/00
7	10/30/98
7	10/30/98
9	11/29/99
12	08/06/99
12	08/09/99

[18] Identified as Patient 2 in Dr. Adamson's notice letter.

[19] Although Ms. Adamson's initials do not appear on this progress note, there is sufficient evidence to support a finding that she had supervised the physician assistant student who did initial it. The evidence indicates that Dr. Adamson had been out of state, Ms. Adamson was in the office, and there was no other physician supervising Ms. Adamson.

Patient	Date of Chart Entry
12	08/13/99
13	11/30/98
15	08/03/99
16	08/25/95
16	09/19/95
16	07/15/98
17	03/02/98
22	12/17/98
22	07/21/99
24	06/04/98
25	11/25/98
27	08/02/99[20]
29	08/03/99
30	09/02/99
32	11/17/98
32	01/18/99
34	01/26/99
35	08/02/99
35	09/03/99
35	11/05/99
37	08/03/99
39	09/01/98[21]
40	08/02/99
41	08/03/99
42	12/25/99
44	08/02/99
45	12/23/96
45	01/30/97
45	06/02/97
45	12/08/97
47	01/14/99

[20] See Footnote 19, above.

[21] The evidence indicated that Patient 39 had come in for an examination of his eye as follow-up to an emergency room visit. The medical records indicate that the examination that Ms. Adamson performed was negative, and the patient was advised to follow-up as needed. Dr. Adamson argued that he did not "need to sign that because there are no orders." This argument is rejected. An order to follow up as needed, or to do nothing, is still an order. A physician assistant's order concerning the treatment of the patient must be approved and countersigned by the supervising physician before being carried out. In a case such as Patient 39's, it is conceivable that the supervising physician could, for example, question the examination that was performed, determine that examinations or tests that were not performed should have been performed, question the way that the examination was performed, or question the results of the examination. A clean bill of health requires physician approval because a clean bill of health that is not warranted endangers the patient.

Patient	Date of Chart Entry
49	12/22/98
52	03/08/99[22]
53	01/06/98
55	01/19/99
56	08/02/99
57	01/16/98
57	05/08/98
57	05/21/98
57	11/30/98
57	02/18/99
57	03/23/99
57	07/09/99
57	07/30/99[23]
57	08/03/99[24]
57	02/21/00
58	11/18/98
59	07/12/99

Moreover, Dr. Adamson failed to review and countersign within 24 hours one or more patient chart entries reflecting medical orders signed or initialed by physician assistants under his supervision for Patients 2[25], 3, 4, 7, 9, 10, 11, 12, 13, 16, 18, 20, 23, 24, 26, 28, 32, 38, 39, 43, 44, 45, 47, 49, 52, 53, 55, 57 and 58 on the following dates:

Patient	Date of Chart Entry
2	07/30/99[26]

[22] Dr. Adamson argued that he was not required to countersign the order because he did not believe that the physician assistant's order had been appropriate. However, Section 4730.21(D), Ohio Revised Code, requires that the supervising physician countersign the physician assistant's order prior to its execution. The statute presupposes that, if the order is inappropriate, the supervising physician will refuse to countersign the order and the order will not be carried out. In this case, the order was executed. Accordingly, Dr. Adamson's argument is rejected.
[23] See Footnote 19, above.
[24] Although there is no indication on the progress note concerning the identity of the provider, there is sufficient evidence elsewhere in the hearing record that Dr. Adamson had been out of state on that date, and that Ms. Adamson had seen patients on that date with no other physician supervising.
[25] Identified as Patient 1 in Dr. Adamson's notice letter.
[26] The Respondents argued that "VOWCA/RRH" [verbal order Wallace C. Adamson/Robin Rae Hawn] written on the progress note proves that this had been Dr. Adamson's order, and not Ms. Adamson's order. This argument is rejected. There are numerous examples in the hearing record where this notation was used when Dr. Adamson was out of state and had not provided the order. Moreover, Ms. Adamson testified that that notation did not always indicate who her supervising physician had been. Further, Ms. Adamson's testimony that her initials on a progress

Patient	Date of Chart Entry
3	03/10/99
3	03/15/99
3	03/23/99
3	08/27/99
4	02/16/99
4	05/27/99[27]
7	10/05/99
9	05/04/99
10	07/30/99
11	12/09/98
11	10/04/99
12	07/30/99
13	08/15/98[28]
16	07/30/99
18	05/27/99[29]
20	08/02/99
23	07/30/99
24	06/19/98
26	07/30/99
28	07/30/99
32	07/30/99
38	05/06/99
38	06/19/98
38	07/29/99
39	07/30/99
43	07/30/99[30]
44	12/31/98[31]

---

note do not necessarily mean that she had seen a patient is not credible. Accordingly, the "VOWCA/RRH" notation is found to have no probative value beyond establishing that Ms. Adamson saw the patient.

[27] Dr. Adamson testified that both he and Ms. Adamson had been out of state, and that another physician had acted as the supervising physician of Jamie Price, P.A. However, the medical records do not indicate that any other physician had acted as the supervising physician on this date.

[28] The evidence indicates that the order was issued on August 17, 1998, and the "REVIEWED" stamp is dated August 18, 1998. Nevertheless, a violation is found because, as stated above in Findings of Fact I.A.2.o, the "REVIEWED" stamp has no probative value whatsoever. It does not prove that Dr. Adamson reviewed and countersigned this order.

[29] See Footnote 27, above. In addition, despite the fact that Dr. Adamson had been out of state, the progress note appears to bear the handwritten initials of Dr. Adamson.

[30] See Footnote 19, above.

[31] The Respondents argued, through counsel, among other things, that the order had been countersigned by Dr. Adamson the following business day, which was four days later. This argument is rejected. Section 4730.21(D), Ohio Revised Code, states that physician assistant orders must be countersigned by the supervising physician within 24 hours. It does not state that orders should be countersigned by the following day or business day.

Patient	Date of Chart Entry
45	07/30/99[32]
47	11/13/98
47	07/29/99
49	09/21/98
52	12/18/98[33]
53	07/30/99
53	02/28/00
55	03/19/99
57	06/16/98
57	03/04/99
57	03/08/99
57	12/27/99
58	07/30/99

D. The evidence is sufficient to support a finding that Dr. Adamson had been the supervising physician with regard to all of the Findings of Fact noted above. The Respondents argued that Dr. Adamson had not been Ms. Adamson's supervising physician during times when he was out of state. This argument is rejected. There is no credible evidence that any other physician had acted as the supervising physician for physician assistants working in Dr. Adamson's practice for any patient visit relevant to this matter.

E. For many of the patient encounters noted above, the Respondents argued that Dr. Adamson had directed Ms. Adamson's treatment of patients by means of general or patient-specific standing orders. This treatment often included the calling in of prescriptions. The Respondents argued that Ms. Adamson merely carried out these orders. Therefore, the Respondents argued, the treatment at issue was actually ordered by Dr. Adamson rather than Ms. Adamson.

The Respondents' argument is rejected. First, treatment cannot be given until a diagnosis is made, and Ms. Adamson was not authorized to make diagnoses. Further, none of the general standing orders was written down, which leaves open to question what the orders actually were, or if they had even existed. Moreover, the patient-specific orders were rarely written down and, when they were, the "order" could be as ephemeral as a patient having received a particular medication years in the past. Often, however, the patient-specific orders were entirely oral, and the Respondents asserted that Ms. Adamson could recall verbal orders for specific

[32] See Footnote 19, above.
[33] With regard to having the prescription called in for Vicodin #20.

medications and dosages for specific patients given to her by Dr. Adamson months or years previously.[34] This testimony is not credible.

II. The evidence presented is insufficient to support the following allegations contained in the Board's May 9, 2001, notice letter:

A. The evidence is insufficient to support a finding concerning the following allegations made in paragraph 1.a of the Board's May 9, 2001, notice letter:

1. The notice letter alleged that on August 2, 1999, Patient 35 had been prescribed Xenical to treat C-strain and fibromyalgia. However, the evidence indicates that Xenical was prescribed for weight control rather than for C-strain and fibromyalgia. Accordingly, there is insufficient evidence to support this allegation.

2. The notice letter alleged that on August 3, 1999, Patient 36 had been treated with Cipro Unipak for a new condition of atrophic vulvitis. The evidence is insufficient to support this allegation. The evidence indicates that Cipro Unipak had instead been prescribed to treat a urinary tract infection. Estratest HS had been prescribed to treat atrophic vulvovaginitis on that date, but this was not alleged in the notice letter.

3. The notice letter alleged that on July 26, 1999, Patient 39 had been diagnosed with pharyngitis. However, the telephone message form for that date does not state that the patient was diagnosed with pharyngitis. Accordingly, the evidence is insufficient to support this allegation.

4. The notice letter alleged that on August 2, 1999, Patient 56 had been advised to take ibuprofen for a diagnosis of "Ankle Sprain," a new condition. However, the evidence indicates that the diagnosis had actually been "ankle strain." Accordingly, the evidence is insufficient to support this allegation.

B. The evidence is insufficient to support a finding concerning the following allegations made in paragraph 1.b of the Board's May 9, 2001, notice letter:

1. Among other things, paragraph 1 of the notice letter alleged that Dr. Adamson had failed to see and personally evaluate patients who presented with new conditions "prior to the initiation of treatment for these new conditions by [Ms. Adamson] or Physician Assistants or Physician Assistant students under her supervision and [Ms. Adamson] and/or Physician Assistants and/or Physician Assistant students under her supervision examined, diagnosed and/or initiated treatment for these new conditions." Among the specific allegations

[34] The Respondents even argue that written orders can be more confusing than orally communicated orders. See Tr. at 1494, and Resp. Ex. U at 26, fn. 15. This argument is ludicrous.

set forth in the notice letter under paragraph 1, the notice letter stated that on September 10, 1999, Patient 8 had been referred for an x-ray, advised to take Tylenol, and to ice, elevate, and exercise her ankle for a new condition and diagnosis of ankle injury.

The evidence indicates that Patient 8 was seen and treated that day by Marsha Bendle, P.A. However, the evidence is insufficient to support a finding that Ms. Adamson had any contact with Patient 8 on September 10, 1999, or that Ms. Adamson supervised the medical practice of other physician assistants in Dr. Adamson's office. Accordingly, the evidence is insufficient to support this allegation.

2. The notice letter alleged that on November 20, 1998, Patient 8 had been treated with a prescription for Flexeril based upon, among other things a diagnosis of "C-sprain," a new condition. However, the evidence indicates that the diagnosis had actually been "C-strain." Accordingly, the evidence is insufficient to support this allegation.

3. The notice letter alleged that on November 9, 1998, Patient 9 had been treated with prescriptions for Amoxil, Robitussin DM, and Sudafed for a new condition and diagnosis of acute sinusitis. The evidence indicates that Patient 9 was seen and treated that day by Nancy Keeler, P.A. However, there is insufficient evidence in the record to support a finding that Ms. Adamson had any contact with Patient 9 on November 9, 1998, or that Ms. Adamson supervised Nancy Keeler's physician assistant practice. Accordingly, the evidence is insufficient to support this allegation.

4. The notice letter alleged that on May 18, 1999, Patient 9 had been treated with a prescription for Suflucan [sic] for a new condition of "Bleeding 17 days," and a diagnosis of yeast vulvitis. The evidence indicates that on May 18, 1999, Patient 9 had been treated with a prescription for Diflucan for a diagnosis of yeast vulvitis. It was merely noted on the progress note that the patient had had menstrual bleeding for seventeen days beginning April 24, 1999. The evidence is not sufficient to support the allegation because menstrual bleeding for seventeen days is not the new condition for which yeast vulvitis had been diagnosed. It may have been one of the causes of the yeast vulvitis diagnosis, but it was not the underlying condition.

5. The notice letter alleged that on June 30, 1998, Patient 24 had presented with a new condition and diagnosis of skin tags and warts, and that the skin tags and warts had been removed by a physician assistant student using liquid nitrogen and a scalpel. However, there is insufficient evidence in the record to support a finding that Ms. Adamson had had any contact with Patient 24 on September 10,

1999, or that Ms. Adamson had supervised the physician assistant student during that visit. Accordingly, the evidence is insufficient to support this allegation.

6. The notice letter alleged that on September 15, 1998, among other things, Patient 24 had been treated with a Depo Provera injection for red spot on temple, a new condition, and diagnoses of rash and costochondritis. However, the evidence is insufficient to support a finding that the diagnosis of costochondritis had been based upon the new condition of red spot on the temple. Further, the evidence is insufficient to support a finding that the Depo Provera injection had been given to treat the new condition of red spot on the temple.

7. The notice letter alleged that on March 9, 1999, Patient 25 had been diagnosed with pregnancy, a new condition. A prescription for prenatal vitamins was called in to a pharmacy, and Patient 25 was referred to an obstetrician. The evidence indicates that Patient 25 was seen and treated that day by Nancy Keeler, P.A. There is insufficient evidence in the record to support a finding that Ms. Adamson had any contact with Patient 25 on March 9, 1999, or that Ms. Adamson supervised Nancy Keeler's physician assistant practice.

8. The notice letter alleged that on February 23, 1999, Patient 30 had been treated with a prescription for Imodium for a new condition and diagnosis of acute gastroenteritis. The evidence indicates that Patient 30 was seen and treated that day by Nancy Keeler, P.A. There is insufficient evidence in the record to support a finding that Ms. Adamson had any contact with Patient 30 on February 23, 1999, or that Ms. Adamson supervised Nancy Keeler's physician assistant practice.

9. The notice letter alleged that on September 1, 1999, among other things, Patient 30 had been treated with Phenergan for a diagnosis of sinusitis, a new condition. The evidence is insufficient to support a finding that Phenergan had been prescribed to treat Patient 30's sinusitis.

10. The notice letter alleged that on March 8, 1999, Patient 52's new condition of a lump on her left forearm was treated by Nancy Keeler, P.A., by freezing it with liquid nitrogen. This was clearly inappropriate conduct. Dr. Adamson's assertion that he was not responsible for this conduct because he had not authorized Ms. Keeler to perform it is not persuasive. The hearing record is rife with evidence that Dr. Adamson gave Ms. Adamson considerable authority to see and treat patients with new conditions without any meaningful physician intervention. That Ms. Keeler had evidently believed that she could do likewise should have come as no surprise. Moreover, Dr. Adamson's statement that Patient 52's condition may not have been a new condition, and that he did not believe that Patient 52 "needed to be seen prior to that visit" is remarkable.

Nevertheless, there is insufficient evidence in the record to support a finding that Ms. Adamson had supervised Nancy Keeler's physician assistant practice. Accordingly, for the reasons discussed previously in Findings of Fact II.B.1, the evidence is insufficient to support this allegation.

11. The notice letter alleged that on November 5, 1999, among other things, Patient 57 had been treated with Paxil for a new condition of circular rash in her scalp. The evidence is insufficient to support a finding that Paxil had been given for that condition.

C. The evidence is insufficient to support a finding that Dr. Adamson failed to countersign entries reflecting medical orders signed or initialed by physician assistants under his supervision for Patients 12, 34, 38, 48, 53, 55, and 57 on the following dates:

Patient	Date of Chart Entry
12	10/15/97[35]
34	04/23/99[36]
38	08/11/98[37]
48	08/20/99[38]
53	06/11/97[39]
55	06/22/98[40]
57	09/23/98[41]

Moreover, the evidence is insufficient to support a finding that Dr. Adamson failed to review and countersign within twenty-four hours one or more patient chart entries reflecting medical orders signed or initialed by physician assistants under Dr. Adamson's supervision for Patients 14, 16, 30, and 57 on the following dates:

Patient	Date of Chart Entry
14	12/09/98[42]
16	06/05/98[43]
30	11/03/99[44]

[35] Insufficient evidence of physician assistant involvement.
[36] The evidence is insufficient to support a finding that Ms. Adamson's answering a patient query concerning medication had constituted a physician assistant medical order.
[37] Insufficient evidence of physician assistant involvement.
[38] The wrong date was referenced in the Board's May 9, 2001, notice letter.
[39] The patient was seen and the order signed by Dr. Ghiloni.
[40] Insufficient evidence of physician assistant involvement.
[41] Insufficient evidence of an order. The note merely indicates that a prescription had been called in the previous day.
[42] Insufficient evidence of physician assistant involvement.
[43] Insufficient evidence of physician assistant involvement.
[44] The wrong date was referenced in the Board's May 9, 2001, notice letter.

Patient	Date of Chart Entry
57	06/06/98[45]
57	07/09/99[46]

LEGAL ISSUES

A great deal of testimony and argument engendered in this hearing concerned the definition of the term, "new condition." Testimony and argument offered by the Respondents and their expert witness would lead one to believe that the lack of a Board rule defining this term had left the Respondents wholly without ability to comprehend its meaning. Much study was given and many dictionaries referenced concerning whether "condition" referred to an ailment, a symptom, a complaint, a diagnosis, a disease, or a multi-system disorder—the possibilities went on and on and on. The term "new" caused similar confusion—does it mean new to the patient, to the physician, or to the physician's practice?

If one were asked to define "new condition" in the absence of any context whatsoever, it would be difficult to define. It could have different meanings when applied to an automobile, a union contract, or an individual's health status. Fortunately, as that term is used in Section 4730.21(D), Ohio Revised Code, a context is provided. That section states as follows:

> A patient new to a physician's practice may be seen by a physician assistant only when a supervising physician is on the premises, except in those situations specified in a standard or supplemental utilization plan under which the presence of the physician is not necessary. **A patient new to a physician's practice or an established patient of a physician with a new condition shall be seen and personally evaluated by a supervising physician prior to initiation of any treatment plan proposed by a physician assistant for the new patient or the established patient's new condition.** A supervising physician may authorize a physician assistant to practice in any setting within which the supervising physician routinely practices. When a supervising physician authorizes a physician assistant to practice in a facility's emergency department, the supervising physician shall provide on-site supervision of the physician assistant.
>
> Each time a physician assistant writes a medical order, the physician assistant shall sign the form on which the order is written and record on the form the time and date that the order is written. When writing a medical order, the physician assistant shall use forms that clearly identify the physician under whose supervision the physician assistant is authorized to write the order. The supervising physician named on the order shall review each medical order written by the physician assistant not later

[45] Insufficient evidence of physician assistant involvement.
[46] Insufficient evidence of physician assistant involvement.

> than twenty-four hours after the order is written, unless the supervising physician's utilization plan specifically authorizes a longer period of time for review. After reviewing an order, the supervising physician shall countersign the order if the supervising physician determines that the order is appropriate. Countersignature by the supervising physician is necessary before any person may execute the physician assistant's order, except in situations in which a patient requires immediate attention and any other circumstances specified in a supplemental utilization plan under which countersignature is not necessary. The supervising physician shall review each medical order executed without countersignature not later than twenty-four hours after the order is written.

R.C. 4730.21(D). (Emphasis added.) This statute must in turn be read within the context of Chapter 4730, Ohio Revised Code, which governs the practice of physician assistants. Chapter 4730 recognizes that physician assistants are skilled professionals who are "qualified by academic and clinical training to provide services to patients * * * under the supervision and direction of one or more physicians who are responsible for the physician assistant's performance." R.C. 4730.01(A). Nevertheless, physician assistants are not qualified to practice medicine; that function is reserved to physicians. See R.C. 4730.01(B).

The clear purpose of Section 4730.21(D) is to promote patient safety. When read in that context, the term "new condition" should hold no mystery for a reasonable practitioner. Dr. Gardner, the State's expert, defined a new condition as either a condition that had not presented before to the supervising physician, or a condition previously treated by that physician that has reoccurred after having been completely resolved. Under Dr. Gardner's definition, a "condition" could be a symptom, a patient's complaint, or a diagnosis. Under this definition, if a patient comes in with a new complaint, symptom, or problem, that patient needs to be seen and personally evaluated by a physician. A physician assistant lacks the training and the legal authority to diagnose the cause of the new complaint, symptom, or problem. It cannot be assumed, as the Respondents appear to argue, that an established patient who visits a physician's office with a chief complaint of sore throat, and who had had strep throat years before, simply has strep throat again. It could be strep, but it might be something else. Accordingly, the statute forbids a physician to allow his or her physician assistant to initiate treatment for this new condition without the patient first being seen and personally evaluated by the physician.

Within the context of Section 4730.21(D), Dr. Gardner's definition of "new condition" is logical and reasonable. However, the Respondents characterized Dr. Gardner's definition as "[i]n contravention of law and logic," as well as "indecipherable and illogical." (Resp. Ex. T at 2) The Respondents' expert, Dr. Borg, characterized Dr. Gardner's definition as "extreme," and offered his "more prudent definition of new condition":

> My professional opinion of the meaning of the phrase "new condition" is that it refers to the actual physical state of the body as a whole, or as to one of its parts, constituting an abnormality or ailment that has not occurred before. This would exclude all recurrent conditions that may experience exacerbation and new episodes

> of a condition that has previously resolved. To determine whether a new condition is presented, therefore, a patient history is required. That history may be garnered from discussions with the patient, a review of the patient's medical records, as well as from the practitioner's overall knowledge of and past association with the patient even if relevant information is not set forth in the patient's medical records.
>
> Moreover, whether a patient complaint presents a "new condition" involves a differentiation between the condition itself—which is the underlying ailment or abnormality—and the symptoms of the condition that might be presented, which evidences the condition. The symptoms that present, including the complaints made by the patient, are not necessarily the medical condition of the patient.

(Resp. Ex. P) (Emphases in original) Dr. Borg testified that his definition would "exclude recurrent conditions or new episodes of old conditions or old symptoms or old diagnoses." (Tr. at 2126-2127)

When questioned by the State's counsel, Dr. Borg had an opportunity to provide examples of practical applications of his "prudent" definition. First, Dr. Borg testified that if a patient had had otitis media at age two, and never had it again until age eighty, the second occurrence would not be a new condition. Further, if a patient had had a heart attack, then ten years later had another heart attack, the second heart attack would not be a new condition. Dr. Borg acknowledged, however, that a reoccurrence of breast cancer *might* be a new condition because breast cancer can be caused by different cell types. (Presumably, then, all heart attacks share a common etiology.) Clearly, from these few examples, Dr. Borg's convoluted and tortured definition of "new condition" conflicts with the obvious purpose of Section 4730.21(D), which is to promote patient safety. Therefore, Dr. Borg's definition is not reasonable.

Dr. Adamson offered his definition of the term "new condition" as used in his practice. Dr. Adamson defined a new condition as a new, multisystem diagnosis that would have a major impact on a patient's long-term health. Dr. Adamson excluded from the umbrella of "new condition" minor self-limiting complaints, or complaints that would resolve with "minor, straightforward treatment that most patients would recognize." The statute does not support this definition. Nowhere in the statute is there any allusion to a "condition" as a multisystem disorder that would have a long-term impact on a patient's health. Further, Dr. Adamson's exclusion of minor complaints from his definition puts the cart before the horse: a practitioner cannot know that a patient's complaint is evidence of a minor or self-limiting condition until a diagnosis is made, and a physician assistant cannot make a diagnosis. For example, a cough could be caused by a minor, self-limiting condition like a virus, or it could be caused by bronchitis, but it could also be pneumonia, congestive heart failure, tuberculosis, lung cancer, or a myriad of other serious diseases, regardless of how many times the patient had previously presented with a cough. Accordingly, Dr. Adamson's definition conflicts with the obvious purpose of Section 4730.21(D), which is to promote patient safety. Again, such a definition is not reasonable.

The Respondents testified that a Board investigator had told them that it was the position of the Board that minor, self-limiting problems were not new conditions, and that if a patient had been seen for a problem in the past, that would also not be a new condition. Unfortunately, at the time of the hearing, that investigator was not available to testify to either confirm or deny those statements. In any case, the Hearing Examiner finds that the Respondents' credibility is, at the very least, questionable. These statements should therefore be accorded little weight.

Ms. Adamson testified that she had been a member of the Physician Assistant Policy Committee [PAPC], and that there had been discussions during meetings of the PAPC concerning the term "new condition." Minutes of those meetings indicate that one physician member of the committee commented that the committee "needed to define condition. Condition should not include self limiting disorders." (Resp. Ex. H at 7) However, the minutes fail to confirm Ms. Adamson's testimony that there had been a consensus of opinion that agreed with that statement. Further, it is undisputed that the committee never formally adopted any such definition.

In summary, Dr. Gardner's definition of the term "new condition" is found to be reasonable and in accordance with Section 4730.21(D), Ohio Revised Code. On the other hand, the definitions propounded by the Respondents and their expert witness are rejected.

CONCLUSIONS OF LAW

1. Section 4730.02(E), Ohio Revised Code, states, "No physician shall authorize a physician assistant to perform services as a physician assistant in a manner that is inconsistent with the standard or supplemental physician assistant utilization plan under which that physician assistant practices." R.C. 4730.02(E). The evidence indicates that, contrary to the Physician Assistant Utilization Plans of Dr. Adamson and the American Health Network of Ohio, Dr. Adamson allowed Ms. Adamson to initiate treatment for established patients with new conditions, he did not require that Ms. Adamson refer patients who presented with new complaints to Dr. Adamson, he failed to countersign physician assistants' orders on some occasions and, on other occasions, he failed to countersign them in a timely manner.

   Accordingly, the conduct of Wallace C. Adamson, M.D., that occurred prior to March 9, 1999, as set forth in Findings of Fact I.A, I.D, and I.E, constitutes "[c]ommission of an act that constitutes a misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Section 4730.02(E), Ohio Revised Code. Moreover, pursuant to Section 4730.99, Ohio Revised Code, each violation of Section 4730.02, Ohio Revised Code, constitutes a misdemeanor offense.

2. The conduct of Dr. Adamson that occurred on or after March 9, 1999, as set forth in Findings of Fact I.A, I.D, and I.E, and as discussed in Conclusions of Law 1, constitutes "[c]ommission of an act in the course of practice that constitutes a misdemeanor in this

state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 4730.02(E), Ohio Revised Code. Moreover, pursuant to Section 4730.99, Ohio Revised Code, each violation of Section 4730.02, Ohio Revised Code, constitutes a misdemeanor offense.

3. The conduct of Dr. Adamson, as set forth in Findings of Fact I.A through I.E, constitutes "[f]ailure of a physician supervising a physician assistant to maintain supervision in accordance with the requirements of Chapter 4730. of the Revised Code and the rules adopted under that chapter," as that clause is used in Section 4731.22(B)(32), Ohio Revised Code, to wit: Section 4730.21(D), Ohio Revised Code.

4. Rule 4731-4-03, Ohio Administrative Code, as in effect prior to September 1, 2000, states, in part, as follows:

> The physician's assistant shall not perform functions or acts including, but not limited to, the following:
>
> (A) Make a diagnosis of a disease or ailment or the absence thereof independent of the employing physician;
>
> (B) Prescribe any treatment or a regimen not previously set forth by the employing physician;

Ohio Adm.Code 4731-4-03, as in effect prior to September 1, 2000.

The conduct of Dr. Adamson, as set forth in Findings of Fact I.A., I.D, and I.E, demonstrates that Dr. Adamson permitted Ms. Adamson to practice in a manner that directly violated this rule. Such conduct constitutes "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-4-03(A) and (B), Ohio Administrative Code, as in effect prior to September 1, 2000.

5. Rule 4731-4-03, Ohio Administrative Code, as in effect prior to September 1, 2000, states, in part, as follows:

> The physician's assistant shall not perform functions or acts including, but not limited to, the following:
>
> * * *
>
> (B) Prescribe any treatment or a regimen not previously set forth by the employing physician;

(C) Prescribe medication; sign or stamp prescriptions on behalf of the employing physician; have prescription blanks available that have been presigned or stamped by the physician; or dispense or order medication, although the employing physician's order for medication may be carried out or relayed by the physician's assistant in accordance with existing drug laws;

Ohio Adm.Code 4731-4-03, as in effect prior to September 1, 2000.

The evidence presented supports a conclusion that Dr. Adamson permitted Ms. Adamson to prescribe treatments or regimens not previously set forth by him, and that he permitted Ms. Adamson to dispense and/or order prescription medication for patients in the absence of any valid order for medication from a physician. Accordingly, the conduct of Dr. Adamson, as set forth in Findings of Fact I.B, I.D, and I.E, constitutes "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-4-03(B) and (C), Ohio Administrative Code, as in effect prior to September 1, 2000.

6. The conduct of Dr. Adamson that occurred prior to March 9, 1999, as set forth in Findings of Fact I.A, I.B, I.D, and I.E, constitutes "[c]ommission of an act that constitutes a misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate. Moreover, pursuant to Section 4731.99, Ohio Revised Code, as in effect prior to March 9, 1999, each violation of Section 4731.41, Ohio Revised Code, constitutes a misdemeanor offense.

7. The conduct of Dr. Adamson that occurred after March 9, 1999, as set forth in Findings of Fact I.A, I.B, I.D, and I.E, constitutes "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate. Moreover, pursuant to Section 4731.99(A), Ohio Revised Code, each violation of Section 4731.41, Ohio Revised Code, constitutes a felony offense.

8. Section 4729.51(C), Ohio Revised Code, as in effect on November 6, 1996, states, in part, as follows:

(1) Except as provided in division (C)(4) of this section, no person shall sell, at retail, dangerous drugs.

* * *

(4) Divisions (C)(1), (2), and (3) of this section do not apply to a registered wholesale distributor of dangerous drugs, a licensed terminal distributor of dangerous drugs, a practitioner, or a person who possesses, or possesses for sale or sells, at retail, a dangerous drug in accordance with Chapters 3719., 4715., 4729., 4731., and 4741. of the Revised Code.

* * *

R.C. 4729.51(C), effective November 6, 1996. [Note that Section 4729.51, Ohio Revised Code, has been amended several times since that date. However, none of these amendments substantively affect this matter.]

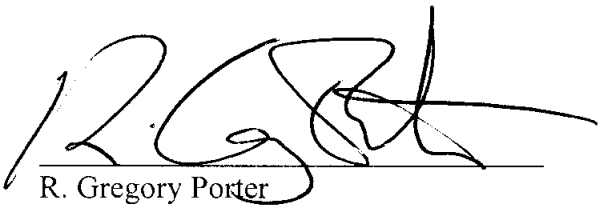
The evidence supports a conclusion that Ms. Adamson dispensed prescription medication, and authorized the calling in of prescription medication, for patients in the absence of any valid order to do so from a physician. Accordingly, the conduct of Dr. Adamson, as set forth in Findings of Fact I.B, I.D, and I.E, constitutes "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4729.51(C), Ohio Revised Code, Persons who may sell, purchase, distribute, or deliver dangerous drugs, as in effect during the all times relevant to this matter.

PROPOSED ORDER

It is hereby ORDERED that:

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

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



R. Gregory Porter
Attorney Hearing Examiner

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

EXCERPT FROM THE DRAFT MINUTES OF DECEMBER 11, 2002

REPORTS AND RECOMMENDATIONS

Dr. Somani announced that the Board would now consider the findings and orders appearing on the Board's agenda.

Dr. Somani 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: Wallace C. Adamson, M.D.; Robin Rae Adamson, P.A.; Brijesh Arya, M.D.; John A. Frenz, M.D.; Jitander N. Kalia, M.D.; Anthony W. Kitchen, M.D.; Joseph Robert Mannino, Jr., D.O.; Kenneth N. Michaelis, L.M.T.; Gary R. Rochon, M.D.; and Michael Carmen Staschak, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Mr. Browning	- aye
	Ms. Sloan	- aye
	Dr. Davidson	- aye
	Dr. Agresta	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Dr. Somani	- aye

Dr. Garg advised that he has not read the materials in the matters of Wallace Adamson, M.D., Robin Rae Adamson, P.A., and Jitander N. Kalia, M.D.

Dr. Somani asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye

Dr. Buchan	- aye
Mr. Browning	- aye
Ms. Sloan	- aye
Dr. Davidson	- aye
Dr. Agresta	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye
Dr. Somani	- aye

Dr. Somani noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Dr. Somani stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

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

WALLACE C. ADAMSON, M.D.

.....

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

Vote:

Mr. Albert	- abstain
Dr. Egner	- aye
Dr. Talmage	- aye
Dr. Bhati	- abstain
Dr. Buchan	- aye
Mr. Browning	- aye
Ms. Sloan	- aye
Dr. Davidson	- aye
Dr. Agresta	- aye
Dr. Garg	- abstain
Dr. Steinbergh	- aye

The motion carried.

VER/SWM

State Medical Board of Ohio

77 S. High Street, 17th Floor • Columbus, Ohio 43266-0315 • 614/ 466-3934 • Website: www.state.oh.us/med/

May 9, 2001

Wallace C. Adamson, M.D.
2202 Wingate Road
Delaware, OH 43015

Dear Doctor Adamson:

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

1. You entered into two supervision agreements with Robin Rae Hawn, P.A. Pursuant to these supervision agreements, effective on or about January 31, 1997, and February 14, 1997, respectively, you certified that you would supervise Ms. Hawn in accordance with both your and American Health Network of Ohio's Physician Assistant Utilization Plans ("Utilization Plans"), as approved by the Board. In part, the Utilization Plans required that established patients with new conditions be seen and personally evaluated by the supervising physician prior to the initiation of treatment.

   Contrary to the requirements of the Utilization Plans and R.C. Section 4731.21(D), you authorized Ms. Hawn to practice and/or you failed to see and personally evaluate the following established patients, who presented with new conditions, prior to the initiation of treatment for these new conditions by Ms. Hawn or Physician Assistants or Physician Assistant students under her supervision and Ms. Hawn and/or Physician Assistants and/or Physician Assistant students under her supervision examined, diagnosed and/or initiated treatment for these new conditions. Moreover, the following patients were not seen or personally evaluated by any other physician and Ms. Hawn failed to consult with, and/or your patient records fail to reflect any consultation with, you or any other supervising physician prior to the initiation of treatment of the patients' new conditions.

Mailed 5-9-01

a. The following established patients with new conditions received treatment from Ms. Hawn when you were out of town; therefore, you did not see and personally evaluate these patients prior to the initiation of treatment:

Patient	Date	New condition: Diagnosis: Treatment
5	07/30/99	Rash:tinea:Ketaconazole Rx
6	07/30/99	Anxious:Anxiety Disorder:Zoloft samples
12	07/26/99	Skin Abscess:Cellulitis:Drain Abscess and Keflex Rx
13	08/03/99	Rash on legs x 3 weeks:Ringworm:Oxistat
20	08/02/99	Acute Viral Pharyngitis:Tylenol (OTC)
21	08/03/99	GERD:Tagamet Rx
23	07/30/99	Right canal w/green exudiate:Amoxil and Cipro HC Otic Rxs
26	07/30/99	Probable Strep:Amoxil Rx
28	07/30/99	Cough and Runny Nose x 5 days:Humibid DM Rx
32	07/30/99	Sore throat earache x 3 weeks:Left Otitis Media:E-Mycin
35	08/02/99	C Strain and Fibromyalgia: Physical Therapy, Xenical and Flexeril Rxs
36	08/03/99	Atrophic vulvitis: Cipro Unipak Rx
39	07/26/99	Cough for 2-3 weeks:Pharyngitis:Humibid DM Rx
40	08/02/99	Plantar Fascitis:Naprosyn Rx.
42	08/02/99	Leg Laceration:Silvadine ointment with wrap, Keflex Rx
46	08/03/99	Conjunctivitis:Sulamyd Opthalmic Rx
50	08/02/99	Head Congestion:Viral URI:Entex LA Rx
51	08/02/99	Otitis Externa:Floxin Otic samples
56	08/02/99	Ankle Sprain:Ibuprofen

b. The following established patients with new conditions received treatment even though you failed to see and personally evaluate these patients prior to the initiation of treatment:

Patient	Date	New condition: Diagnosis: Treatment
7	10/30/98	Bronchitis:Amoxil
8	11/20/98	Viral meningitis,C-sprain:Flexeril Rx
8	09/10/99	Ankle injury:Tylenol,ice,elevate,exercise,x-ray
8	12/16/99	Pain right ear:R Otitis Media:Ceftin and Entex Rxs
9	11/09/98	Acute sinusitis:Amoxil,Robitussin DM and Sudafed Rxs
9	05/18/99	Bleeding 17 days:Yeast vulvitis:Suflucan Rx
9	08/18/99	Vision blurs,headache:Allergies:Zyrtec and Flonase samples

24	06/30/98	Skin tags, warts:Removed multiple skin tags with liquid nitrogen
24	08/20/98	Profuse sweating, fatigue:Fatigue,hyperhidrasis:Lab work, discontinue Paxil
24	09/15/98	Red spot on temple:Rash,costochondritis:Elocon cream Rx and Depo Provera Injection
25	01/12/98	Lungs hurt:Costochondritis: Tylenol
25	07/01/98	Something in R ankle snapped:Daypro Rx
25	03/09/99	Pregnant:Prenatal vitamins Rx
30	02/23/98	Cough off & on, dizzy spells:Sinusitis:Amoxil 500 Rx
30	04/29/98	Diarrhea,vomiting,cramps:Acute gastritis:Bentil Rx
30	02/23/99	Acute gastroenteritis:Immodium samples, Phenergan Rx
30	09/01/99	Sinusitis:Amoxil 500 & Phenergan Rxs
52	06/30/98	Skin tag:Skin tag: Removed skin tag
52	12/18/98	Sinusitis, pharyngitis:Z-Pak samples & Vicodin Rx
52	03/08/99	Lump left forearm:N2 treatment of nodule
52	09/10/99	Headache, nausea,shaky:URI:Phenergan Rx
57	06/12/98	Severe left hip pain, lift fell on pt: Darvocett Rx
57	08/06/98	Burning w/ urination, frequency:Trich:Flagyl and Diflucan Rxs
57	11/05/99	Circular rash in scalp:Paxil and Oxistat Rxs

2. You authorized and/or allowed Ms. Hawn to issue prescriptions for and/or dispense dangerous drugs to patients without your or any other physician's specific order as follows:

Patient	Date	Drug
5	07/30/99	Ketaconazole
6	07/30/99	Zoloft samples
11	08/03/99	Celebrex
11	08/03/99	Flonase samples
12	07/26/99	Keflex
13	08/03/99	Oxistat
14	08/02/99	Claritin
15	08/03/99	Z-pak
15	08/03/99	Pirxicam
16	07/30/99	Wellbutrin
17	03/02/98	Prozac
19	08/02/99	Prevacid samples
21	08/03/99	Tagamet
22	07/26/99	Augmentin samples
22	07/26/99	Bactrim DS
23	07/30/99	Amoxil

23	07/30/99	Cipro HC Otic
26	07/30/99	Amoxil
28	07/30/99	Humibid DM
31	08/02/99	Theophyllin
31	08/02/99	Prednisone
31	08/02/99	Sirax
31	08/02/99	Combivent
31	08/02/99	Zyban
32	07/30/99	E-Mycin
32	07/30/99	Premarin
33	08/03/99	Serevent
33	08/03/99	Ibuprofen
35	08/02/99	Xenical
35	08/02/99	Flexeril
35	08/02/99	Midrin
36	08/03/99	Cipro Unipak
36	08/03/99	Estratest NS
39	07/26/99	Humibid DM
39	07/30/99	Cechlor
39	07/30/99	Entex LA
40	08/02/99	Naprosyn
40	08/02/99	Glucotrol
40	08/02/99	Avandia
41	08/03/99	Zithromax
41	08/03/99	Anusol HC
42	08/02/99	Keflex
43	03/02/98	Cleocin
43	03/02/98	Premarin
43	03/02/98	Provera
43	08/03/99	Metrogel
44	08/02/99	Augmentin
46	08/03/99	Sulamyd Opthalmic
48	08/02/99	Medrol Dosepak
49	08/02/99	Zoloft samples
49	08/02/99	Medrol Dosepak
50	08/02/99	Entex LA
51	08/02/99	Floxin Otic samples
53	07/30/99	Prandin
53	08/02/99	Naprosyn
54	08/03/99	Isoptin
54	08/03/99	Diovan
54	08/03/99	Cardura
58	07/30/99	Amoxil

3. You failed to countersign patient chart entries reflecting medical orders signed or initialed by physician assistants under your supervision for Patients 1, 3, 7, 9, 12, 13, 15, 16, 17, 22, 24, 25, 27, 29, 30, 32, 34, 35, 37, 38, 39, 40, 41, 42, 44, 45, 47, 48, 49, 52, 53, 55, 56, 57, 58 and 59 on the following dates:

Patient	Date of Chart Entry	Patient	Date of Chart Entry
1	03/06/00	37	08/03/99
3	11/23/99	38	08/11/98
3	04/24/00	39	09/01/98
3	01/20/98	40	08/02/99
3	02/24/98	9	11/29/99
3	03/23/98	41	08/03/99
3	01/15/99	42	12/25/99
3	07/30/99	44	08/02/99
7	10/30/98	45	12/08/97
7	10/30/98	45	06/02/97
12	10/15/97	45	01/30/97
12	08/06/99	45	12/23/96
12	08/09/99	47	01/14/99
12	08/13/99	48	08/20/99
13	11/30/98	49	12/22/98
15	08/03/99	52	03/08/99
16	07/15/98	53	01/06/98
16	09/19/95	53	06/11/97
16	08/25/95	55	06/22/98
17	03/02/98	55	01/19/99
22	12/17/98	56	08/02/99
22	07/21/99	57	01/16/98
24	06/04/98	57	05/08/98
25	11/25/98	57	05/21/98
27	08/02/99	57	09/23/98
29	08/03/99	57	11/30/98
30	09/02/99	57	03/23/99
32	01/18/99	57	07/09/99
32	11/17/98	57	07/30/99
34	01/26/99	57	08/03/99
34	04/23/99	57	02/21/00
35	08/02/99	57	02/18/99
35	09/03/99	58	11/18/98
35	11/05/99	59	07/12/99

Moreover, you failed to review and countersign within 24 hours one or more patient chart entries reflecting medical orders signed or initialed by physician assistants under your supervision for Patients 2, 3, 4, 7, 9, 10, 11, 12, 13, 14, 16, 18, 20, 23, 24, 26, 28,30, 32, 38, 39, 43, 44, 45, 47, 49, 52, 53, 55, 57 and 58 on the following dates:

Patient	Date of Chart Entry	Patient	Date of Chart Entry
2	07/30/99	32	07/30/99
3	03/10/99	38	05/06/99
3	03/15/99	38	06/19/98
3	03/23/99	38	07/29/99
3	08/27/99	39	07/30/99
4	05/27/99	9	05/04/99
4	02/16/99	43	07/30/99
7	10/05/99	44	12/31/98
10	07/30/99	45	07/30/99
11	12/09/98	47	11/13/98
11	10/04/99	47	07/29/99
12	07/30/99	49	09/21/98
13	08/15/98	52	12/18/98
14	12/09/98	53	02/28/00
16	06/05/98	53	07/30/99
16	07/30/99	55	03/19/99
18	05/27/99	57	06/16/98
20	08/02/99	57	06/06/98
23	07/30/99	57	03/04/99
24	06/19/98	57	03/08/99
26	07/30/99	57	07/09/99
28	07/30/99	57	12/27/99
30	11/03/99	58	07/30/99

Your acts, conduct, and/or omissions that occurred prior to March 9, 1999, as alleged in paragraph (1) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Section 4730.02(E), Ohio Revised Code. Pursuant to Section 4730.99, Ohio Revised Code, violation of Section 4730.02, Ohio Revised Code, constitutes a misdemeanor offense.

Further, your acts, conduct, and/or omissions that occurred on or after March 9, 1999, as alleged in paragraph (1) above, individually and/or collectively, constitute "[c]ommission of an act in the course of practice that constitutes a misdemeanor in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, to wit: Section 4730.02(E), Ohio Revised Code. Pursuant to Section 4730.99, Ohio Revised Code, violation of Section 4730.02, Ohio Revised Code, constitutes a misdemeanor offense.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1), (2) and (3) above, individually and/or collectively, constitute "[f]ailure of a physician supervising a physician assistant to maintain supervision in accordance with the requirements of Chapter 4730. of the Revised Code and the rules adopted under that chapter," as that clause is used in Section 4731.22(B)(32), Ohio Revised Code, to wit: Section 4730.21(D), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-4-03(A) and (B), Ohio Administrative Code, as in effect prior to September 1, 2000.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-4-03(B) and (C), Ohio Administrative Code, as in effect prior to September 1, 2000.

Further, your acts, conduct, and/or omissions that occurred prior to March 9, 1999, as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a misdemeanor in this state regardless of the jurisdiction in which the act was committed, if the act was committed in the course of practice," as that clause is used in Section 4731.22(B)(12), Ohio Revised Code, as in effect prior to March 9, 1999, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code. Pursuant to Section 4731.99, Ohio Revised Code, as in effect prior to March 9, 1999, violation of Section 4731.41, Ohio Revised Code, constitutes a misdemeanor offense.

Further, your acts, conduct, and/or omissions that occurred after March 9, 1999, as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section

4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code. Pursuant to Section 4731.99(A), Ohio Revised Code, violation of Section 4731.41, Ohio Revised Code, constitutes a felony offense.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4729.51(C), Ohio Revised Code, Persons who may sell, purchase, distribute, or deliver dangerous drugs.

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

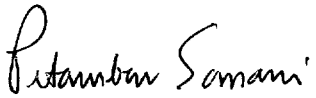
You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at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

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

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

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Pitambar Somani, M.D.
Acting Secretary

AGG/krt

Enclosures

CERTIFIED MAIL # 7000 0600 0024 5140 5604
RETURN RECEIPT REQUESTED

cc: Paul Coval, Esq.

CERTIFIED MAIL # 7000 0600 0024 5140 5611
RETURN RECEIPT REQUESTED

address: Vorys, Sater, Seymour and Pease
52 East Gay Street
Columbus, OH 43216-1008