

The Supreme Court of Ohio

FILED

OCT 27 2010

William W. Nucklos, M.D.

Case No. 2010-1404

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SUPREME COURT OF OHIO

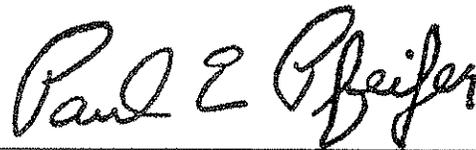
v.

ENTRY

State Medical Board of Ohio

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. 09AP406)



PAUL E. PFEIFER
Acting Chief Justice

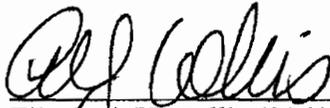
HEALTH & HUMAN
OCT 29 2010
SERVICES SECTION

NOTICE OF APPEAL
OF APPELLANT WILLIAM W. NUCKLOS, M.D.

Appellant William W. Nucklos, 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,

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

Respectfully submitted,



Elizabeth Y. Collis (0061961)(Counsel of Record)
Terri-Lynne Smiles (0034481)
Collis, Smiles & Collis, LLC
1650 Lake Shore Drive, Suite 225
Columbus, Ohio 43204
Tele: (614) 486-3909
Fax (614) 486-2129
E-mail: beth@collislaw.com
Counsel for Appellant
William W. Nucklos, M.D.

CERTIFICATE OF SERVICE

I certify that a true and accurate copy of the foregoing *Notice of Appeal* was served upon the following counsel of record by first class U.S. mail, postage prepaid, on this 11th day of August, 2010:

Karen Unver, Esq.
Office of the Ohio Attorney General
Health and Human Services Section
30 E. Broad Street, 26th Floor
Columbus, Ohio 43215-3400



Elizabeth Y. Collis

10X

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

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FRANKLIN CO. OHIO

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CLERK OF COURTS

William W. Nucklos, M.D.,

Appellant-Appellant

v.

State Medical Board of Ohio,

Appellee-Appellee

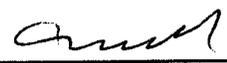
No. 09AP-406
(C.P.C. No. 08CVF08-12230)

(REGULAR CALENDAR)

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on June 29, 2010, appellant's assignments of error 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.

CONNOR, J., BROWN and McGRATH, JJ.

By 
Judge John A. Connor Duk

Barbara
Heffer

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

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CLERK OF COURTS

William W. Nucklos, M.D.,
Appellant-Appellant

v.

State Medical Board of Ohio,
Appellee-Appellee

No. 09AP-406
(C.P.C. No. 08CVF08-12230)
(REGULAR CALENDAR)

D E C I S I O N

Rendered on June 29, 2010

Collis, Smiles & Collis, LLC, Elizabeth Y. Collis and Terri-Lynne B. Smiles, for appellant.

Richard Cordray, Attorney General, Barbara J. Pfeiffer and Karen A. Unver, for appellee.

APPEAL from the Franklin County Court of Common Pleas

CONNOR, J.

{¶1} Appellant, William W. Nucklos, M.D. ("appellant"), appeals from a decision of the Franklin County Court of Common Pleas affirming an order of appellee, State Medical Board of Ohio ("the Board"), permanently revoking appellant's license to practice medicine and surgery. For the following reasons, we affirm.

{¶2} In a notice of summary suspension and opportunity for hearing dated October 10, 2007, the Board notified appellant that it had adopted an entry of order summarily suspending his certificate to practice medicine and surgery in Ohio, pursuant to R.C. 4731.22(G). The Board alleged that from March 2001 to October 2002, appellant

inappropriately prescribed controlled substances and/or dangerous drugs to 28 patients in a manner inconsistent with minimal standards of care and/or without a legitimate medical purpose. The notice cited conduct such as prescribing despite failure to order and/or document ordering appropriate consultations, failure to perform appropriate physical examinations, and failure to order and/or document ordering appropriate diagnostic testing. The notice further alleged appellant had violated R.C. 4731.22(B)(2), (B)(3), (B)(6), and (B)(20), along with Ohio Adm.Code 4731-21-02. Appellant was also advised that he was entitled to a hearing on this matter.¹

{¶3} A hearing was held before a hearing examiner for the Board on June 2 through June 6, 2008 and concluded on June 12, 2008. Appellant and the Board both provided expert testimony, but none of appellant's former patients testified. Appellant also invoked his Fifth Amendment right not to incriminate himself.

{¶4} Following the hearing, the hearing examiner issued a written report and recommendation, which was received by the Board on July 18, 2008, recommending that appellant's license be permanently revoked. On August 13, 2008, the Board issued an entry of order permanently revoking appellant's license to practice medicine and surgery in Ohio. Appellant then filed an appeal with the common pleas court, pursuant to R.C. 119.12. On March 31, 2009, the common pleas court affirmed the Board's order revoking

¹It should be noted that appellant's license was initially suspended in 2006 following a criminal trial that resulted in multiple convictions arising from the conduct at issue. However, those convictions were overturned on March 9, 2007. The State appealed that decision to the Supreme Court of Ohio. In the interim, on October 10, 2007, the Board dismissed the suspension predicated upon appellant's criminal convictions and, on that same date, issued a separate notice of summary suspension and opportunity for hearing, summarily suspending appellant's license based upon standard of care and prescribing violations. It is that October 2007 action which is the subject of this appeal. The Supreme Court of Ohio subsequently affirmed the decision overturning appellant's criminal convictions and the criminal matter was then remanded to the Clark County Court of Common Pleas for retrial. Although the retrial was pending at the time the instant appeal was filed, the criminal case has since been dismissed without prejudice.

appellant's license. In this timely appeal, appellant now asserts the following two assignments of error for our review:

Assignment of Error 1:

It is an abuse of discretion for the trial court to uphold a finding of permanent license revocation when the Medical Board relied upon exhibits that were not medical records and not reliable, probative or substantial evidence.

Assignment of Error 2:

It is an abuse of discretion for the trial court to uphold the Medical Board's permanent revocation Order when the Board was acting outside the express limitation of its authority under R.C. §4731.052, the intractable pain statute.

{¶5} In an administrative appeal, pursuant to R.C. 119.12, the trial court considers the entire record to determine whether a decision is supported by reliable, probative, and substantial evidence and is in accordance with the law. *Univ. of Cincinnati v. Conrad* (1980), 63 Ohio St.2d 108, 110-11. Therefore, the authority of a common pleas court in reviewing a decision of the medical board, which is an administrative agency, is limited to determining whether the board's order is supported by reliable, probative, and substantial evidence and is in accordance with law. *Korn v. Ohio State Med. Bd.* (1988), 61 Ohio App.3d 677. In applying this standard, the court must "give due deference to the administrative resolution of evidentiary conflicts." *Conrad* at 111.

{¶6} The Ohio Supreme Court has defined reliable, probative, and substantial evidence 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.

(Footnotes omitted.)

{¶7} On appeal to this court, the standard of review is more limited. Unlike the court of common pleas, a court of appeals does not determine the weight of the evidence. *Rossford Exempted Village School Dist. Bd. of Edn. v. State Bd. of Edn.* (1992), 63 Ohio St.3d 705, 707. In reviewing the court of common pleas determination that the board's order was supported by reliable, probative, and substantial evidence, this court's role is limited to determining whether the court of common pleas abused its discretion. *Roy v. Ohio State Med. Bd.* (1992), 80 Ohio App.3d 675, 680. Absent an abuse of discretion on the part of the trial court, a court of appeals cannot substitute its judgment for that of the board or the trial court. *Pons v. Ohio State Med. Bd.*, 66 Ohio St.3d 619, 621, 1993-Ohio-122. "The term 'abuse of discretion' connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary or unconscionable." *Blakemore v. Blakemore* (1983), 5 Ohio St.3d 217, 219, quoting *State v. Adams* (1980), 62 Ohio St.2d 151, 157. However, on the question of whether the board's order was in accordance with the law, this court's review is plenary. *McGee v. Ohio State Bd. of Psychology* (1993), 82 Ohio App.3d 301, 305, citing *Univ. Hosp., Univ. of Cincinnati College of Medicine v. State Emp. Relations Bd.* (1992), 63 Ohio St.3d 339, 343.

{¶8} In his first assignment of error, appellant asserts the Board improperly relied upon exhibits which were not medical records. Appellant repeatedly argues the exhibits submitted by the Board, specifically state's exhibit Nos. 1-28, are not his patients' actual medical records. He argues the use of these misleading exhibits, which were comprised of incomplete, altered medical records, as well as additional information such as pharmacy logs and police investigative reports, which appellant did not have at the time

he administered treatment, did not constitute reliable, probative, and substantial evidence upon which the Board could base its decision. Appellant further contends that because the Board's expert witness also relied exclusively upon these same exhibits in formulating his opinion, his testimony is flawed and does not constitute reliable, probative and substantial evidence upon which the Board could base its decision.

{¶9} Appellant contends the exhibits containing the purported medical records were missing documentation, such as the results of his patients' drug screens. He submits that when the records were seized from his practice, there were various documents which had not yet been filed, and that these unfiled documents were not contained in state's exhibit Nos. 1-28. Appellant claims he has not had access to his actual medical records since the day they were seized from his office in October 2002. Without access, he asserts he is unable to compare the exhibits to his actual medical records in order to prove each specific omission, addition, or alteration that exists and to prove that his patient records do in fact support and document the care he provided to his patients. Consequently, he further submits that this circumstance has improperly shifted the burden of proof to him to prove that his actual medical records properly support and document the care he provided.

{¶10} Appellee disputes appellant's assertion that its exhibits contain only parts of each patient's medical records and that there are additional records, such as drug screen results, which exist but were missing from the exhibits. The Board argues that such an assertion is pure conjecture because there is no testimony to support it. Appellee further argues that there was additional evidence considered by the Board beyond just state's exhibit Nos. 1-28 and the testimony of the Board's expert, such as appellant's testimony from the criminal trial. Additionally, the Board submits that the testimony of appellant's

former office manager, Tricia Woodruff, dispels any notion that the exhibits did not include the medical records of appellant's patients.

{¶11} We find appellant's argument to be without merit. If appellant had reason to doubt the authenticity of the medical records submitted by the Board in state's exhibit Nos. 1-28, appellant could have challenged those records using a variety of methods. Appellant could have questioned the authenticity of the records through the former office manager, Tricia Woodruff, or by subpoenaing the person who did the filing for appellant during the two-month time period after Ms. Woodruff left the office and before the records were seized. However, appellant offered no testimony from any witnesses to establish that certain drug screens were in fact scheduled or conducted. Additionally, appellant himself exercised his Fifth Amendment right not to incriminate himself and refused to answer even the most basic of questions, including whether or not there were additional materials. See *Baxter v. Palmigiano* (1976), 425 U.S. 308, 96 S.Ct. 1551 (the Fifth Amendment does not preclude adverse inferences from being drawn against parties to civil actions when they invoke the privilege and refuse to testify in response to probative evidence offered against them in a civil cause).

{¶12} Alternatively, appellant was also free to make a request for the issuance of a subpoena so that he could inspect the records that were originally seized from his office. The medical board is subject to the Administrative Procedure Act, R.C. Chapter 119, as a result of its licensing function. *Korn* at 686. "The Ohio State Medical Board's determination to suspend a physician's license is an adjudication and is, consequently, subject to R.C. 119.09, issuance of subpoenas, pursuant to R.C. 119.07." *Korn* at paragraph six of the syllabus.

{¶13} R.C. 119.09 provides, in relevant part:

For the purpose of conducting any adjudication hearing * * * the agency may, *and upon the request of any party receiving notice of the hearing as required by section 119.07 of the Revised Code shall, issue a subpoena for any witness or a subpoena duces tecum to compel the production of any books, records, or papers, directed to the sheriff of the county where such witness resides or is found, which shall be served and returned in the same manner as a subpoena in a criminal case is served and returned.* * * *

(Emphasis added.) See also Ohio Adm.Code 4731-13-13 ("Upon written request, the board shall issue subpoenas for purposes of hearing to compel the attendance and testimony of witnesses and production of books, records and papers. Each subpoena shall indicate on whose behalf the witness is required to testify."). Appellant did not exercise this option.

{¶14} Through the use of its exhibits, as well as the expert testimony of Theodore V. Parran, Jr., M.D. ("Dr. Parran") and the testimony of appellant in the criminal trial, the Board produced reliable, substantial and probative evidence. For example, as the trial court noted, Dr. Parran testified that in preparing for the criminal trial in 2006, he prepared an expert report based upon his review of 49 patient office charts, a pharmacy board generated prescription profile of the controlled drugs taken by those patients, and two undercover police investigation reports. However, the undercover reports were not included in his expert report, which cited violations involving 28 patients.

{¶15} He further testified that he also prepared an expert report for the Board, which was based upon the medical records of the 28 patients he had previously reviewed, along with his initial report prepared in the criminal case, and the transcript of his testimony in the criminal case. Thus, in addition to the pharmacy board generated prescription profiles and the police investigative documents, both of which Dr. Parran acknowledged were not part of appellant's original file but which were easily

distinguishable from medical records, he reviewed the original patient records at issue in preparing his first expert report, which he then later used to prepare his expert report for the Board.

{¶16} Additionally, Dr. Parran testified that despite occasional entries in patient records indicating that a drug screen should be scheduled at a future visit, he did not find evidence in the patients' files demonstrating that appellant had actually followed through with the drug screens. Put another way, Dr. Parran did not find drug screen results in the relevant patient files, nor did he find orders for those drug screens or even notes documenting any drug screen results, thereby leading to the conclusion that those drug screens were in fact never ordered, even if certain notes indicated an intention to do so in the future.

{¶17} We do not dispute that it is fundamental to administrative law and procedure that the party asserting the affirmative issues also bears the burden of proof. *Smith v. City of Columbus*, 10th Dist. No. 02AP-1219, 2003-Ohio-3303, ¶24, citing *Chiero v. Bur. of Motor Vehicles* (1977), 55 Ohio Misc. 22, 24. Yet, we disagree with appellant's contention that the burden of proof was improperly shifted to him to prove that the Board's allegations were false. Appellant cannot simply speculate or allege that the Board's records are inaccurate and that there are additional records somewhere out there which would support his position. Appellant failed to attempt to put on any actual evidence that would call into question the validity or reliability of the documents submitted by the Board. To the contrary, as the trial court noted, Ms. Woodruff identified her own handwriting on some of the records, as well as appellant's handwriting. Additionally, Ms. Woodruff was unable to verify appellant's assertion that a stack of unfiled documents had not made its way in to the patients' medical record files, since Ms. Woodruff left the office two months

before the seizure of the documents and could not testify as to whether or not the office was up to date in its filing at the time the records were seized.

{¶18} We find the trial court did not abuse its discretion in finding that the testimony and records referenced above constitute reliable, substantial and probative evidence. The trial court did not act unreasonably or arbitrarily in finding the records and testimony to be reliable for several reasons. First, the records were kept in the ordinary course of business. Second, Ms. Woodruff identified various records and also identified some of the records as containing her handwriting as well as appellant's handwriting. Additionally, the trial court was within its prerogative to find Dr. Parran to be a qualified expert, particularly given Dr. Parran's background in this area, and thus to find his testimony to be credible and afford it significant weight. Dr. Parran adequately explained his procedure for reviewing and identifying the records and distinguishing between the patient charts and the documents which were obtained after the records were seized from appellant's office, and he also testified he used the pharmacy logs simply to confirm appellant's prescribing history for each patient. We further find the common pleas court did not abuse its discretion in finding the records and the testimony to be probative and substantial, in that they addressed the issues in question, as well as the specific matters alleged in the notice served upon appellant.

{¶19} Accordingly, we overrule appellant's first assignment of error.

{¶20} In his second assignment of error, appellant asserts the Board is statutorily prohibited from disciplining a physician for prescribing pain medication for pain patients unless the requirements of R.C. 4731.052 are met. In essence, appellant argues the Board's authority to revoke appellant's license under R.C. 4731.22 is limited by R.C. 4731.052. Appellant argues the Board must prove that appellant violated *both* R.C.

4731.052 and the Board's intractable pain rules set forth under Ohio Adm.Code 4731-21 before it can impose discipline for prescribing controlled substances to intractable pain patients. Because the Board did not allege or find that appellant's treatment and care violated R.C. 4731.052, appellant submits the Board was without the authority to take disciplinary action and permanently revoke appellant's license. However, as the trial court noted, appellant has failed to provide sufficient legal authority to support this position.

{¶21} Chapter 4731 of the Revised Code vests the Board with broad authority to regulate the medical profession in Ohio and to discipline physicians whose conduct fails to conform to its regulations. *Griffin v. State Med. Bd. of Ohio*, 10th Dist. No. 09AP-276, 2009-Ohio-4849. R.C. 4731.22 authorizes the Board to discipline those within its licensing authority. *State of Ohio ex rel. Gelesh v. State Med. Bd. of Ohio*, 172 Ohio App.3d 365, 2007-Ohio-3328. Specifically, R.C. 4731.22(B) grants the Board the authority to revoke, suspend, limit, refuse to register, or reinstate a certificate to practice medicine, based upon one or more of the many reasons enumerated in that division. *Landefeld v. State Med. Bd. of Ohio* (June 15, 2000), 10th Dist. No. 99AP-612.

{¶22} R.C. 4731.052 and the rules set forth in Ohio Adm.Code 4731-21, codify the standard of care for physicians practicing pain management, as established by those physicians practicing such medicine prior to the enactment of the statute and the rules. *Dahlquist v. Ohio State Med. Bd.*, 10th Dist. No 04AP-811, 2005-Ohio-2298, ¶18. R.C. 4731.052 addresses a physician's authority to treat intractable pain using dangerous drugs. *Id.* R.C. 4731.052(B) directed the board to adopt rules to "establish standards and procedures to be followed by physicians in the diagnosis and treatment of intractable pain, including standards for managing intractable pain by prescribing, personally furnishing, or administering dangerous drugs in amounts or combinations that may not be

appropriate when treating other medical conditions." See *Dahlquist* and R.C. 4731.052(B). Ohio Adm.Code 4731-21 was then adopted in response to the enactment of R.C. 4731.052.

{¶23} Ohio Adm.Code 4731-21-02 sets forth rules for the utilization of prescription drugs for the treatment of intractable pain. Specifically, Ohio Adm.Code 4731-21-02(A) sets forth accepted and prevailing standards of care. Among others, these include requirements such as: conducting an initial evaluation that includes a relevant history; establishing and documenting a medical diagnosis indicating the presence of intractable pain; ordering an evaluation by one or more other practitioners who specialize in the treatment of the anatomic system or area of the body perceived as the source of pain prior to a diagnosis of intractable pain; and formulating and documenting an individualized treatment plan specifying the medical justification of the treatment via the utilization of prescription drugs on a protracted basis or in combinations or amounts that may be inappropriate for treating other medical conditions. A violation of a provision of any rule in Ohio Adm.Code 4731-21, such as one or more violations of Ohio Adm.Code 4731-21-02, constitutes a violation of the minimal standards applicable to the administration of drugs under R.C. 4731.22(B)(2), a violation of the provision against prescribing or administering drugs for other than legal and legitimate therapeutic purposes under R.C. 4731.22(B)(3), if done knowingly or recklessly, and a violation of the minimal standards of care of similar practitioners under similar circumstances set forth in R.C. 4731.22(B)(6). See Ohio Adm.Code 4731-21-05.

{¶24} Appellant argues R.C. 4731.052 prohibits the Board from basing an order on alleged violations of R.C. 4731.22 when the violations arise solely from the prescribing of controlled substances for chronic pain. Appellant relies upon R.C. 4731.052(D) to

support his argument that the Board was without the authority to take disciplinary action and permanently revoke his license. R.C. 4731.052(D) reads as follows:

A physician who treats intractable pain by managing it with dangerous drugs is not subject to disciplinary action by the board under section 4731.22 of the Revised Code solely because the physician treated the intractable pain with dangerous drugs. The physician is subject to disciplinary action only if the dangerous drugs are not prescribed, furnished, or administered in accordance with this section and the rules adopted under it.

{¶25} While R.C. 4731.052 provides specific standards and procedures for the diagnosis and treatment of intractable pain with dangerous drugs and, consequently, for pursuing disciplinary action against physicians who provide that type of treatment and fail to comply with those standards and procedures, R.C. 4731.052 does not prohibit the Board from pursuing disciplinary action under R.C. 4731.22 against physicians who fail to practice within minimal standards of care, fail to maintain minimal standards applicable to the selection or administration of drugs, or prescribe drugs for other than legal and legitimate purposes, or fail to comply with accepted and prevailing standards of care.

{¶26} In this case, the violations did not arise simply based upon the prescribing of controlled substances for chronic pain. Instead, many of the violations occurred because appellant's conduct generally fell below the minimal standards of care required of a physician. Examples include appellant's inappropriate or non-existent diagnoses and hopelessly incomplete and inadequate medical records, among numerous others.

{¶27} To illustrate, appellant was cited with a violation of R.C. 4731.22(B)(6). It states, in relevant part, that the Board shall revoke, suspend, or place a doctor on probation if his acts constitute a departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, regardless of whether or not there was actual injury to a patient. Appellant was also cited

with a violation of R.C. 4731.22(B)(2), which permits revocation of a certificate to practice medicine if a physician fails to maintain minimal standards applicable to the selection or administration of drugs or the failure to use acceptable scientific methods in the selection of drugs or other modalities for treatment. In addition, appellant was cited with a violation of R.C. 4731.22(B)(3), which authorizes the Board to revoke a physician's license for personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes. Finally, appellant was cited with a violation of R.C. 4731.22(B)(20), which provides that a licensed physician may be disciplined for violating any rule promulgated by the Board. Here, the rule cited was Ohio Adm.Code. 4731-21-02. The common pleas court found that all of these violations were properly supported by reliable, probative and substantial evidence, as discussed below.

{¶28} Dr. Parran testified that appellant failed to conform with the minimal standards applicable to the selection or administration of drugs and failed to conform to the minimal standards of care of similar practitioners, thereby violating R.C. 4731.22(B)(2) and (B)(6), respectively. Dr. Parran testified that appellant furnished, prescribed, or administered drugs for reasons other than legal and legitimate therapeutic purposes, in violation of R.C. 4731.22(B)(3), and violated R.C. 4731.22(B)(20) by violating Ohio Adm.Code 4731-21-02 regarding the utilization of prescription drugs for the treatment of intractable pain. Examples of appellant's non-conformity were numerous.

{¶29} According to the testimony of Dr. Parran, the medical histories taken by appellant were insufficient, as were the physical examinations. Appellant's patient records failed to show a work-up of any medical history, lacked laboratory testing, lacked records of prior treatment and failed to document impressions or a diagnosis in many cases. Additionally, the common pleas court cited to testimony and evidence establishing

that appellant: (1) inappropriately prescribed controlled substances in a manner below the minimal standard of care and without documenting a legitimate purpose, such as by prescribing without any diagnostic workup or evaluation, or adding more controlled substances or higher doses without documenting a supporting diagnosis or for no apparent reason when the patient reported doing well; (2) prescribed high doses or potentially fatal doses of controlled substances without verifying the patient's current level of medication or tolerance level; (3) gave early prescription refills; (4) continued to prescribe despite patients missing medicine checks and/or urine screens; (5) continued to prescribe without contacting other doctors despite notification that patients were seeing other doctors and receiving controlled substances; (6) failed to maintain minimal standards applicable to the selection or administration of drugs and failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment; (7) prescribed high doses of opiates to patients following gaps in treatment without regard for patient health and safety; and (8) failed to order appropriate consultations from an independent physician with respect to the patient's affected organ system as required under the intractable pain rules.

{¶30} Here, the Board's permanent revocation of appellant's license to practice was not based solely upon appellant's treatment of chronic pain patients using dangerous drugs. As noted above, the Board cited to and subsequently found numerous violations, many of which related to general minimal standards of care applicable to practitioners as a whole. We further note, as did the common pleas court, that, although appellant was not cited with a violation of R.C. 4731.052, he appears to assert the protections found in section (D), which he claims should shield him from any disciplinary action. However, like the common pleas court, we disagree. We make no finding with respect to violations of

R.C. 4731.052, which were not alleged. Yet, we fail to see how he can offer this shield here, as it seems apparent from various related facts contained within the record that, had he actually been cited with a violation of this statute, he would not be shielded from discipline because he failed to follow the steps which could possibly protect him, had the only allegation against him been treating chronic pain patients using dangerous drugs. However, as noted above, the violations asserted against him and subsequently proven did not include a violation of R.C. 4731.052 and encompassed much more than simply using dangerous drugs to treat chronic pain patients.

{¶31} Accordingly, we find the common pleas court did not abuse its discretion in finding that the Board's order was supported by reliable, probative and substantial evidence. Furthermore, we find said order is in accordance with law. Consequently, we overrule appellant's second assignment of error.

{¶32} Having overruled both of appellant's assignments of error, we affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

BROWN and McGRATH, JJ., concur.

**NOTICE OF APPEAL TO A COURT OF APPEALS
FROM A JUDGMENT OR APPEALABLE ORDER**

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

**William W. Nucklos, M.D.
1671 Heatherwae Loop
Powell, OH 43065**

Appellant

v.

**State Medical Board of Ohio
30 East Broad Street, 3rd Floor
Columbus, OH 43215-6127**

Appellee.

Case No.

CLERK OF COURTS

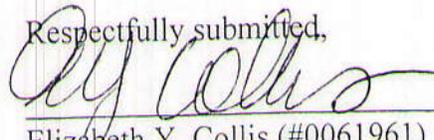
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COURT OF APPEALS
FRANKLIN CO. OHIO

NOTICE OF APPEAL

Notice is hereby given that William W. Nucklos, M.D. ("Appellant"), hereby appeals to the Court of Appeals, Tenth Appellate District of Franklin County, Ohio, from the Decision and Entry entered in the Franklin County Court of Common Pleas on March 31, 2009 (copy attached).

Respectfully submitted,



Elizabeth Y. Collis (#0061961)
Collis, Smiles & Collis, LLC
1650 Lake Shore Drive, Suite 225
Columbus, Ohio 43204
Telephone: (614) 486-3909
Facsimile: (614) 486-2129
E-mail: beth@collislaw.com
Counsel for Appellant,
William W. Nucklos, M.D.

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CLERK OF COURTS

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Notice of Appeal has been served via first class U.S. mail, postage prepaid, this 23rd day of April, 2009, upon:

Barbara Pfeiffer, Esq.
Assistant Attorney General
Office of the Ohio Attorney General
30 E. Broad Street, 26th Floor, HHS
Columbus, OH 43215

Counsel for Appellee, State Medical Board of Ohio


Elizabeth Y. Collis

COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

WILLIAM W. NUCKLOS, M.D. :
Appellant, : CASE NO. 08CVF-08-12230
-vs- : JUDGE NODINE MILLER
STATE MEDICAL BOARD OF OHIO, : (By Assignment)
Appellee. :

DECISION AND ENTRY AFFIRMING THE AUGUST 13, 2008 ORDER OF THE
STATE MEDICAL BOARD OF OHIO

Rendered this 31st day of March 2009

MILLER, JUDGE,

This matter comes before this Court upon an appeal pursuant to R.C. § 119.12 from an August 13, 2008 Order of the State Medical Board of Ohio (hereinafter the "Board"). The Board approved the Proposed Order of the Hearing Officer permanently revoking Appellant's license to practice medicine. See August 13, 2008 Entry of Order. The record certified by the Board can be summarized as follows:

On March 8, 2006 the Board issued to appellant a *Notice of Opportunity for Hearing and Notice of Immediate Suspension* proposing to take action against his Ohio medical license. This action was prompted by the fact that appellant had been found guilty of ten counts of illegal processing of drug documents and ten counts of trafficking in drugs by the Clark County Common Pleas court. The 2006 Immediate Suspension was in effect and suspended appellant from the practice of law in Ohio.

On March 9, 2007 the Second District Court of Appeals reversed the appellant's criminal conviction. Thus, the basis for the immediate suspension was no longer in effect and appellant requested to have his medical license reinstated. The Board lifted the 2006

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Immediate Suspension on October 10, 2007 and dismissed it. However, on that same day, the Board issued a new *Notice of Summary Suspension and Notice for Hearing*. Therefore, the allegations raised in the October 10, 2007 notice are the subject of this appeal.

The October 10, 2007 notice alleges that from March 1, 2001 to October 2002, appellant prescribed medications to twenty-eight (28) patients without a legitimate medical purpose in violation of R.C. 4731.22(B)(3). Specifically, the Board alleged that appellant's conduct constituted the following:

“[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as that language is used in Section 4731.22(B)(2), Ohio Revised Code.

“[s]elling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for treatment in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug,” as that language is used in Section 4731.22(B)(3), Ohio Revised Code.

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

“violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit Rule 4731-21-02, Ohio Administrative Code, Utilizing Prescription Drugs for the Treatment of Intractable Pain.

The Board advised appellant of his right to request a hearing and received his written request on November 2, 2007. The hearing on this matter was continued several times but was finally held on June 2, 2008 through June 6, 2008 and concluded on June 12, 2008. The appellant's motion in limine requesting that a “compilation” of information regarding Patients 1 through 28 be excluded was denied. The appellee introduced this evidence and both expert witnesses relied upon these exhibits in support of their respective positions in

this case. The appellant's motion to dismiss based on the fact that the Board failed to charge him with violating R.C. 4731.052 (the statute restricting the Board's ability to discipline physicians for the treatment of intractable pain) was never ruled upon.¹ Likewise, based on Fifth Amendment constitutional grounds, appellant filed a Motion to Quash the Subpoena Duces Tecum and Motion To Dismiss based on the Board's request to provide documentation regarding his education, training and experience. Appellant's motion was denied and he was required to produce the documents under the subpoena.

Hearing Examiner Gregory Porter issued his Report and Recommendation on August 13, 2008 recommending that the Board permanently revoke the appellant's Ohio medical license. On August 13, 2008, the Board voted to approve and adopt the Report and Recommendation and permanently revoked appellant's license to practice medicine in the State of Ohio. Thereafter, appellant filed a timely appeal.

STANDARD OF REVIEW

R.C. § 119.12 sets forth the standard of review a common pleas court must follow when reviewing an administrative appeal. R.C. 119.12 provides in pertinent part:

The court may affirm the order of the agency complained of in the appeal if it finds, upon consideration of the entire record and such additional evidence as the court has admitted, that the order is supported by reliable, probative and substantial evidence and is in accordance with law.

In *Our Place* the Ohio Supreme Court provided the following definition of reliable, probative and substantial evidence as:

(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 Comm. (1992), 63 Ohio St. 3d 570, 571.

¹ Clearly, that statute was not applicable based on the facts of this case.

Once the common pleas court has determined that the administrative agency's order is supported by reliable, probative and substantial evidence, the court must then determine whether the order is in accordance with law. See R.C. § 119.12. The reviewing court cannot substitute its judgment for the agency's decision where there is some evidence supporting the decision. See *Harris v. Lewis* (1982), 69 Ohio St. 2d 577, 579; see also *University of Cincinnati v. Conrad* (1980), 63 Ohio St. 2d 108.

Moreover, the common pleas court has no authority to modify a penalty that the agency was authorized to, and did impose, on the ground that the agency abused its discretion. When reviewing a Medical Board's order, courts must accord due deference to the Board's interpretation of the technical and ethical requirements of its profession. See *Coniglio v. State Med. Bd. of Ohio*, 2007 Ohio 5018.

LAW AND ARGUMENT

As background information, appellant received his medical degree from The Ohio State University College of Medicine in 1977. State's Exhibit 32A at 1625-1630. Upon completing his residency and other requirements, he opened a solo practice in Westerville, Ohio. He testified that he practiced physical medicine and rehabilitation in Westerville and Columbus for 17 years. The record also shows that appellant maintained an office from 2001 through October 2002 in Springfield, Ohio where he saw patients one day per week treating them for weight management and pain management. State's Exhibit 32A at 1631. Appellant acknowledged that he accepted only cash payment at his Springfield office.

State's Exhibit 32A at 1639-1641.

In February 2006, appellant was tried criminally in the Clark County Court of Common Pleas for allegations regarding his conduct in his Springfield office. Appellant was found guilty, but the jury verdict was later overturned on appeal. *State v. Nucklos*, 2007

Ohio App. LEXIS 958 (Ohio Ct. App., Clark County 2007); See Respondent's Exhibit DD; Tr. 239-241, 406-408. Recently, the Ohio Supreme Court affirmed the judgment of the court of appeals and the matter was remanded to the trial court.²

Dr. Theodore V. Parran, Jr., M.D. testified as an expert on behalf of the appellee in the related criminal matter and at the administrative hearing herein. At the administrative hearing, he gave testimony regarding his background and credentials. See State's Exhibit 30; Tr. 12-24. He testified that he treats patients who suffer from intractable pain and that he prescribes the appropriate controlled substances to treat them. Tr. 26-28. Dr. Parran testified that he assisted the Board in the drafting of the Ohio Administrative Code rules concerning the treatment of intractable pain. Tr. 19. Additionally, Dr. Parran testified that he authored an October 7, 2007 expert report, regarding appellant's conduct, for the Board. Tr. 39-40. He noted that in preparing that report, he reviewed copies of the medical records of Patients 1 through 28, a transcript of his testimony from the criminal trial, and a copy of an expert report that he had prepared for the criminal matter. Dr. Parran also testified that he reviewed the state laws regarding the prescribing of opiates. Tr. 39-40.

Dr. Parran defined intractable pain as pain that lasted longer than three months and could not be cured. He testified that treatment of such patients may entail the use of opiate or non-opiate medication, and typically also involves the use of interventions that are nonpharmacologic. Tr. 41-42. Dr. Parran testified that the steps that must be taken to provide proper care of patients with chronic intractable pain are as follows:

² The matter was remanded based upon the Ohio Supreme Court's holding that in order to convict a licensed health professional of trafficking in drugs under R.C. 2925.03(A), "the state bears the burden of proving beyond a reasonable doubt the inapplicability of the licensed-health-professional exception in R.C. 2925.03(B)(1) by submitting evidence that the licensed health professional violated statutes or regulations that define the standard of care for dispensing controlled substances." See *State v. Nucklos* Slip Opinion No. 2009-Ohio-792. Thus, the trial court erred when it instructed the jury that the licensed-health-professional exception under R.C. 2925.03(B)(1) was an affirmative defense.

A thorough history and physical examination

Verification or establishment of a clear diagnosis

Documentation of an adequate workup involving multiple steps

Assessment of functional capacity and impairment, and demonstration of impaired function

In Ohio, a consultation with a physician who specializes in treatment of the organ system or part of the body involved in the chronic intractable pain syndrome. The purpose of the consultation is to verify the presence or absence of the chronic intractable pain.

An individualized treatment plan that is adjusted over time based upon data obtained during ongoing monitoring of the patient.

Tr. 42-43; see also R.C. 4731.052.

Dr. Parran emphasized the need for patient information from the onset and stated that the more information that was available to the physician at the initial visit, the more accurate and confident the physician would be in prescribing appropriate medication and dosages. Tr. 45-46.

Dr. Parran testified that the medical records in this case are not the exact duplicates of the original medical records that he reviewed for the criminal case. He noted that State's Exhibits 1 through 28 each contain copies of the respective patient's chart. Summarily, Dr. Parran criticized appellant for failing to obtain or attempt to obtain records of prior medical treatment for Patients 1 through 28. He noted that this had been the case even for patients where appellant wrote in the initial history or physical examination "Obtain Medical Records." Dr. Parran testified that none of appellant's medical records for Patients 1 through 28 included a copy of a release signed by the patient giving the appellant permission to obtain the prior medical records. It was also Dr. Parran's belief that upon reviewing the files for Patients 1 through 28, he did not find any "prior medical records or studies or results of studies or results of consultations or notes from previous prescribing physicians."

Tr. 68-69. Dr. Parran testified that obtaining prior medical records is "very basic stuff" that are fundamentals which are taught to first and second year medical students. Tr. 63-65.

Dr. Parran also criticized appellant for failing to obtain a consultation with a physician who specializes in the organ or area of the body that underlies the patient's chronic pain complaint as required by the Board's rule. See R.C. 4731.052. He testified that the patient's record should reflect that the specialist was contacted, the date, the time of the scheduled appointment, the consultant's report and any follow-up with the consultant. Tr. 61-62.

Dr. Parran testified that it is inconsistent with the standard of care for a physician to simply tell a patient to see a consultant and expect the patient to follow up on their own, as what happened to several of appellant's patients in this case. Tr. 62. Dr. Parran testified that it is the usual approach when prescribing medication to a new chronic pain patient to verify from the patient interview and also some outside source, such as a pharmacy or previous prescribing physician, what medication and dose the patient was taking. Tr. 81. He stated that it was critical to have an accurate assessment of the patients' current tolerance to the respiratory depression effect of the opiates.

Additionally, Dr. Parran testified that the Board's rule concerning the treatment of intractable pain requires that, if a physician prescribes more than one medication at the same time to treat pain, the physician must document in the patient's record the medical necessity for utilizing more than one controlled substance. Tr. 265-266.

Dr. Kenneth G. Knott, M.D. testified as an expert on behalf of appellant. At the administrative hearing, he gave testimony regarding his background and credentials. See Respondent's Exhibit A. He testified that he has treated patients for chronic pain using controlled substances. He estimated that over the last two years, he has treated

approximately 15 percent of his patients with controlled substances. Tr. 620, 623. Dr. Knott testified that he last practiced in Ohio in 1989 and that he has never practiced under the Board's rules concerning the treatment of intractable pain. Tr. 610-612. He stated that he testified at appellant's criminal trial. State's Exhibit 33A; Tr. 824-825. He stated that prior to preparing his written report, he reviewed the medical records and other documents contained in State's Exhibits 1 through 28, the Board's rules concerning the treatment of intractable pain, and relevant sections of the Ohio Revised Code. Tr. 605-506. Dr. Knott's testimony regarding the definition of intractable pain was similar to Dr. Parran's testimony. However, Dr. Knott defined chronic pain as pain that lasted longer than six months. Tr. 632-633.

The record, evidence and testimony establishes as follows:

Patient 1

Patient 1 was a female born in 1963. She visited appellant on October 11, 2001. She presented a non-driver state identification. Appellant diagnosed lumbosacral radiculopathy at L4-5-6 and S1 with chronic pain syndrome. He prescribed OxyContin 20 mg #42 to be taken three times a day, Soma 350 mg #30 to be taken twice per day, Ambien 10 mg, quantity not documented, with instructions to take one at bedtime as needed, and an ointment. State's Exhibit 1 at 37. On a Patient Questionnaire that appears to have been filled out by Patient 1 for law enforcement purposes and included with her medical records, she indicated that she provided appellant with copies of her medical records from "Dr. Abraham" and "Dr. Andorfer." State's Exhibit 1 at 19, 23.

Dr. Parran testified that on the Pain Assessment Questionnaire that Patient 1 completed at her initial visit, she stated that she had not been taking any medication at that time. However, appellant recorded in his patient history "Medications," "Oxy-20." Dr.

Parran testified that was an inconsistency and must be reconciled in terms of safe and appropriate prescribing. State's Exhibit 8 at 8; Tr. at 68-87. Dr. Parran also testified that appellant's medical records for Patient 1 lacked documentation of a consultation with a specialist as required by the Board's rules. Moreover, he noted that there were no laboratory tests or diagnostic studies. Dr. Parran testified that appellant started Patient 1 on controlled substances at her first visit and that appellant continued to prescribe these controlled substances and increased the dosage over time. Dr. Parran noted that Xanax was added to her regiment at her third office visit with no supporting diagnosis documented. Finally, Dr. Parran testified that appellant's initial evaluation and ongoing treatment of Patient 1 was inconsistent with state law and the Board's rules concerning the long-term prescribing of opiates for the management of chronic intractable pain. Tr. 88-89.

Dr. Parran noted that the medications appellant prescribed for Patient 1 were all central nervous system depressants. He stated that the patient was being prescribed two sedative hypnotics, benzodiazepines and Soma and a sedating opiate all at the same time. Tr. 89-91. Dr. Parran noted that there was no documented assessment of addictive disease given the fact that Patient 1 was in her thirties and did not drive. Dr. Parran testified there is a concern regarding Patient 1's non-driver status since there is the possibility that she lost her license as a result of a DUI conviction(s). He explained why physicians are expected to use, as part of the usual standard of care in the community, a level of care to avoid the risk to life, liberty and safety of the patient and the patient's family if the patient has an addiction and the doctor concomitantly prescribes controlled drugs. Tr. 92-96. Dr. Parran noted that there is nothing in the record that documents the results of urine drug screens. Tr. 101.

On cross-examination Dr. Knott acknowledged the following:

There are no MRI or EMG results in the patient file

There are no records of prior medical treatment

There is no verification whether or when Patient 1 had actually been taking OxyContin 20 mg

There are no urine drug screen results

There is no documentation of physical therapy provided.

Patient 2

Patient 2 is a female born in 1974 who visited appellant on November 15, 2001. She presented non-driver identification. Appellant's impressions were lumbosacral sprain/strain and lumbar radiculopathy at L5-S1. He prescribed OxyContin 20 mg #30 with instructions to take one tablet every 12 hours, Soma #42, with instructions to take one tablet three times per day as needed, Lortab 10 mg with instructions to take one tablet twice per day as needed, and exercises. State's Exhibit 2 at 9.

Dr. Parran noted that appellant did not obtain any of Patient 2's prior medical records. He also testified that the patient history and physical examination were insufficient and that there was no evaluation as to why this twenty-six year old female did not drive. He stated that the OxyContin prescription could result in an overdose. Tr. 108-109. Even though appellant ordered an MRI in a subsequent visit, no results were ever documented. Moreover, the Ambien he prescribed was the strongest dose available. State's Exhibit 2 at 8; Tr. 109.

Dr. Knott testified that he does not regard a non-driver state identification card as a "red-flag." Tr. 663-664. He did acknowledge that insomnia can be a symptom of other conditions such as depression. Tr. 885-887. He also acknowledged that he would have started Patient 2 on a lower dose of OxyContin or some alternative treatment since she had not been on any medication at the time of the initial visit. Tr. 881-882. With regard to the gap in treatment of Patient 2 between December 13, 2001 and February 21, 2002, Dr. Knott

acknowledged that there were no notes in her medical file as to what she had done while she was off OxyContin. Dr. Knott stated that he would have asked the patient and documented the conversation in her file. State's Exhibit 2 at 29-31; Tr. 887-888.

Although appellant testified at the criminal trial that Patient 2 advised him that her prior medical records had been lost, he did not document this information in her medical record. Also not documented in the file was the reason Patient 2 was absent from his practice for over a month. Appellant admitted at his criminal trial that Patient 2 had been arrested as part of a drug ring. Once that matter came to his attention, appellant admitted that he did not refer her to an addiction specialist. State's Exhibit 32A at 1723-1727.

Patient 3

Patient 3 was a male born in 1965 and visited appellant on August 16, 2001. Appellant found decreased left grip strength and "leftwrist/Flexor/extensors." His impression was chronic pain syndrome. He prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, and OxyIr 5 mg #30 with instructions to take one tablet twice per day as needed. State's Exhibit 3 at 17.

Dr. Parran testified that there is no evidence that appellant obtained either prior medical records or obtained new studies, even though Patient 3 told him he had sustained three gunshot wounds in 1994. Dr. Parran also stated that there is no consult from a specializing physician. Moreover, there is a January 3, 2002 note documenting a call from a pharmacy "indicating that the patient was continuing to see other doctors" and was receiving

controlled substances from the other physicians. Tr. 117. Dr. Parran testified that on Patient 3's first visit appellant prescribed 90 milligrams of oxycodone which is the equivalent of 18

Percocet in one day. He stated that there was no verification whatsoever from any outside source that Patient 3 was on any preexisting opiates. Dr. Parran testified that simply relying

on the patient's word in this situation could have resulted in the patient's death and was inconsistent with reasonable care and concern for the life and safety of the patient. Tr. 120-121.

Dr. Knott acknowledged that appellant did not document a physical examination of the patient's left knee which had been included in the patient's complaints. State's Exhibit 3 at 17; Tr. 888-889. At the criminal trial, appellant was asked whether he obtained any records of prior medical treatment. He answered that "...I was treating him appropriately so after examining him and taking a history and seeing him for five months, the records wouldn't have been much value." State's Exhibit 32A at 1684-1685. Appellant acknowledged that he had been able to obtain records of other patients who had treated with Dr. Jenkins, but that he did not obtain, nor attempt obtain, records for Patient 3. State's Exhibit 32A at 1685-1686. Appellant testified that he would not have treated Patient 3 if he had been aware that Patient 3 had been seeing other physicians. However, he could not show anywhere in the record where he had tried to get prior medical records. See State's Exhibit 32A at 1686-1687. He also testified that it was unnecessary to refer Patient 3 to a specialist. State's Exhibit 32A at 1692-1694.

Patient 4

Patient 4 was a thirty something construction worker who was accompanied by his mother to his first visit with appellant on August 23, 2001. The name of Patient's 4's family doctor was noted at the initial visit. Dr. Parran criticized appellant for failing to obtain prior records and noted that there was no release form for these records that had been included in the chart for Patient 4. Although appellant noted that Patient 4 had been taking OxyContin 40 mg and Percocet, there was no verification of that information in the medical record.

Dr. Parran criticized appellant for failing to document a diagnosis; yet, appellant

prescribed OxyContin 40 mg #30 with instructions to take one tablet twice a day, Percocet 7.5 mg #42 with instructions to take one tablet three times per day as needed. State's Exhibit 4 at 25; Tr. 128. Dr. Parran testified that appellant had prescribed a dose of 95 mg of oxycodone per day. Without verifying that the patient had been taking such a dose previously, the dose prescribed by appellant could have proved fatal if the patient had no tolerance to opiate medication. Tr. 128. Dr. Parran also testified that there was no indication in the medical record as to why the OxyContin dosage was increased nor was there any documentation given for the addition of Xanax. State's Exhibit 4 at 3; Tr. 129-130.

Patient 4 reported that his medications were stolen on March 24, 2002. State's Exhibit 4 at 19. Appellant gave him early prescriptions. Tr. 130. Patient 4 reported having been treated for depression at Greenhill treatment facility. State's Exhibit 4 at 21. However, the medical record does not reflect that there was ever any request to obtain the records from Greenhill regarding Patient 4's depression. Dr. Parran noted that it is common that patients suffering with intractable pain also suffer from depression. Tr. 133.

Dr. Knott acknowledged that appellant did not document a physical examination of Patient 4's feet even though he complained of having the most intense pain in his lower back and feet. Dr. Knott acknowledged that there was no verification that Patient 4 had been on the same dosage as prescribed by appellant. Tr. 677-679.

Patient 5

Patient 5 was a female born in 1966 and first visited with appellant on July 26, 2001. The name of her previous physician was noted. Dr. Parran noted that her old medical records and pharmacy profiles were available but the record demonstrates that appellant never made any attempt to obtain them. Appellant prescribed OxyContin 20 mg #30 with

instructions to take one tablet twice per day, Maxidone #30 with instructions to take one tablet twice per day as needed. On her second visit, appellant increased the dose of OxyContin to three times a day. Tr. 139-140. The medical record indicates that Patient 5 reported taking OxyContin 20 mg three times per day and Soma but that she had no medications for one month prior. Tr. 136-137.

Following her second appointment on August 9, 2001, Patient 5 did not see appellant until November 29, 2001 because she had been in jail. The medical record did not mention why Patient 5 had been incarcerated. Dr. Parran testified that it was reckless for appellant to start Patient 5 back on OxyContin 20 mg three times a day, adding in quick release oxycodone (OxyIR), reestablishing Soma and adding Xanax. Dr. Parran testified that this behavior demonstrates a disregard for the health and safety and the life of the patient. Tr. 141-142. Dr. Parran testified that the medical records never reflected discussions with the patient concerning withdrawal symptoms or treatment for detoxification during periods of time when she should have run out of medication. Tr. 141-151. Dr. Parran stated that restarting Patient 5 on high doses of controlled substances following gaps in treatment had endangered her. Tr. 141-151. The medical records show that the patient reported that "all of her prescriptions flew out of the window of her car on her way home from Columbus." Dr. Parran stated that this is an indication of "fairly transparent sort of scamming-type behavior." State's Exhibit 5 at 5; Tr. 149. Dr. Parran also noted that on March 14, 2002 appellant increased the dosage of Patient 5's OxyContin to 40 mg with instructions to take one every 12 hours. On July 9, 2002 her dosage was increased to 40 mg three times a day with no reason noted in the medical records for the increase in the dosage. Tr. 145-146.

A progress note from February 28, 2002 indicates that the patient complained of left

knee pain. Appellant ordered "Obtain surg records [left] knee and refer to Ortho." However, Dr. Parran testified that there is no evidence that the records were obtained and no records that an orthopedic consultation took place. State's Exhibit 5 at 5; Tr. 153-154.

Dr. Knott testified that if a patient misses an appointment and is gone from his practice for a period of time and then returns, he would inquire as to the reason for the absence. Tr. 687. Dr. Knott also noted that if he needs records of prior medical treatment, he asks the patient to bring any records they have. If he needs more records, Dr. Knott testified that he has the patient sign a release and faxes the request for medical records to the previous treating physician. Tr. 689-690.

Patient 6

Patient 6 was a female born in 1978 and had her initial visit with appellant on September 13, 2001. The names of previous treating physicians were noted on her medical record as well as visits to the emergency room. Her last visit to a physician had occurred four months prior to seeing appellant and she reported to appellant that she was taking Vicodin and Tylox. Appellant prescribed OxyContin 20 mg #42 with instructions to take one tablet three times per day and Percocet 5 mg #30 with instructions to take one tablet three times per day as needed. State's Exhibit 6 at 27. On her next visit on September 27, 2001, appellant increased the dose of OxyContin to 40 mg twice per day. On October 25, 2001 appellant added Soma 350 mg #30 with instructions to take one tablet twice per day as needed. State's Exhibit 6 at 25. On December 6, 2001 the Percocet was discontinued, the dose of OxyContin was increased to 40 mg three times a day, and the dose of Soma was increased to three times per day. State's Exhibit 6 at 24.

Dr. Parran criticized appellant for prescribing Patient 6 70 milligrams of oxycodone per day on the first visit when she had reported that she was taking Vicodin and Tylox. He

stated that it could have been a fatal dose and is evidence of his disregard for the patient's safety. Tr. 160-161. Dr. Parran also testified that there were no reports in her medical record of the CT scan or MRI results. Tr. 158. In March 2002 Patient 6 reported to appellant that the medications allowed her to function and perform her activities of daily living. However, the oxycodone screening ordered at that visit had resulted in the patient being discharged from the practice. There was no explanation for the discharge. State's Exhibit 6 at 21; Tr. 159. Dr. Parran testified that the medical record for Patient 6 has "no old records, no studies, no consults, no workup, minimal history and physical, [and] no labs." Tr. 159.

Dr. Knott acknowledged that although Patient 6 complained of migraine headaches, appellant's documentation of her initial visit did not include a history, examination, or workup for migraine headaches. State's Exhibit 6 at 17; Tr. 898-899. Dr. Knott testified that he did not know why appellant failed to document why he had prescribed Percocet in addition to the OxyContin at Patient 6's first visit. Dr. Knott noted that Percocet normally would have been prescribed for breakthrough pain and acknowledged that appellant would have no way of knowing that at her initial visit. Dr. Knott testified that in his practice, he does not typically prescribe medication for breakthrough pain at a patient's initial visit. State's Exhibit 6 at 27; Tr. 900-901.

Patient 7

Patient 7 is a female born in 1958 and first visited appellant on August 16, 2001. On her Pain Assessment Questionnaire, she indicated that she had been taking OxyContin 20 mg and Soma. However, no indication of the current medication was noted on appellant's evaluation note. Appellant prescribed Lidoderm patches to be applied to Patient 7's lower back, OxyContin 20 #42 with instructions to take one tablet three times a day, Soma 350 mg

#30 with instructions to take one tablet twice per day, and Maxidone 10 mg #30 with instructions to take one tablet twice per day. State's Exhibit 7 at 41. Ms. Woodruff, appellant's office assistant, testified that Patient 7 died in a house fire. Tr. 469-470.

In his written report, Dr. Parran criticizes appellant for failing to obtain records of her prior medical treatment and for having performed an "awful H&P"³ at Patient 7's first visit. State's Exhibit 31. Dr. Parran stated that the 42 year old patient had reported back pain from a previous injury. Even though she told appellant at her initial visit that she was not on any medication, he nonetheless prescribed 60 mg of oxycondone per day.

Dr. Parran testified that the history and physical examination were inconsistent with an initial visit of chronic pain. He stated that there were "[N]o old records, no studies, no workup ordered." State's Exhibit 7 at 85; Tr. 163.

Dr. Parran testified that at Patient 7's second visit on August 30, 2001 appellant found "Pain adequately controlled." But nonetheless, he added OxyIr 5 mg with instructions to take one tablet twice per day as needed. State's Exhibit 7 at 83; Tr. 163. Dr. Parran noted that appellant prescribed additional controlled medications to Patient 7's regiment during the course of her treatment without documenting any legitimate purpose. For example, at Patient 7's October 11, visit she reported occasional breakthrough pain and appellant found that pain control was adequate. Nevertheless, appellant added Percocet and Xanax to her medications. State's Exhibit 7 at 81; Tr. 162-164.

Patient 8

Patient 8 was a female born in 1968 and first visited the appellant on August 16, 2001.⁴ She reported suffering from low back pain and migraine headaches following a rape that occurred in 2000. She said that she had been taking OxyContin 40 mg and Vicodin.

³ Ostensibly referring to a history and physical examination.

⁴ This exhibit contains medical records from individuals other than Patient 8. State's Exhibit 8.

Appellant prescribed Lidoderm patches, OxyContin 40 mg #30 with instructions to take one tablet twice per day, OxyIR 5 mg #30 with instructions to take one capsule twice per day as needed, and to exercise. State's Exhibit 8 at 49.

Dr. Parran testified that Patient 8's medical record contained no old records or requests for old records, no studies, and clearly demonstrated an insufficient initial history and physical examination. State's Exhibit 8 at 49; Tr. 165. Dr. Parran testified that appellant prescribed the equivalent of 90 milligrams of oxycodone per day from the first visit with no verification that she actually was on that medication. He stated that it could have been a lethal dose if Patient 8 had not actually been taking that medication. Tr. 165-166.

Additionally, during appellant's treatment of Patient 8, medications such as Xanax and Soma were added without any documentation. State's Exhibit 8 at 46-47; Tr. 166-167. In February of 2002, the Xanax dose was doubled without any explanation. Patient 8 missed a medication check and a urine drug screen in March 2002, but appellant continued to prescribe her medications. Patient 8 reported in May 2002 that her medicines were stolen while she was in jail, but this was never verified by appellant. She was gone from the practice for a while in the summer of 2002 and appellant continued to prescribe for her through October 14, 2002. Thus, with the incarcerations, the stolen medicines, the missing medication checks and Patient 8's failure to get a urine drug screen, appellant failed to do any evaluation and/or a workup, and just kept prescribing the medication. Tr. 167-168.

On cross-examination, Dr. Knott disagreed that it was necessary for appellant to obtain diagnostic testing or evaluations prior to prescribing Ambien for Patient 8.

Patient 9

Patient 9 was a male born in 1967. He presented non-driver identification at his initial visit. He claimed to have been taking OxyContin 80 mg three times per day, Soma eight times per day, and Percocet eight times per day. Appellant prescribed OxyContin 20 mg [quantity illegible] with instructions to take one tablet three times per day, Ambien 10 mg with instructions to take one tablet at bedtime as needed and Soma 350 mg with instructions to take one tablet three times per day. Appellant noted in the medical record "Obtain old medical records." State's Exhibit 9 at 9, 20, 41-43.

Dr. Parran noted that Patient 9 was another adult non-driver. He stated that there was no release form signed by Patient 9 to obtain his prior medical records nor was there evidence of any attempt that appellant tried to obtain them. Tr. 169-170. Dr. Parran testified that appellant did not perform or order any studies, workup or consults for Patient 9. Dr. Parran noted that the dosing claimed by Patient 9 was inconsistent with prescribing. Tr. 170. Dr. Parran also noted that a urine drug screen for oxycodone was ordered in April 2002 but there were no results noted in his chart. Likewise appellant failed to document the reason he increased Patient 9's dose of OxyContin or why Percocet was added in August 2002 since Patient 9 reported at that visit that his pain control was sufficient and he presented no new complaints. Tr. 170-171. Finally, appellant never verified that the patient had been taking the level of medication he claimed, but prescribed a dose that would at least be harmful to the patient's health and potentially fatal. Dr. Parran characterized appellant's prescribing as "not consistent with doctoring" and "unsafe." Tr. 171.

Dr. Knott testified that he does not regard a non-driver adult as a red flag. Tr. 714.

However, he did acknowledge that appellant failed to document a workup for Patient 9's complaint of head pain, nor did he document any impressions or diagnoses for the patient.

Dr. Knott further acknowledged that appellant did not document any workup concerning the history of Patient 9's drug and alcohol use. Tr. 914-915.

Patient 10

Patient 10 was a female born in 1960. Her first visit with appellant was August 2, 2001 and she presented a non-driver state identification. She claimed to have been taking OxyContin 40 mg and Vicodin. Appellant noted in her medical record that Patient 10 was not taking any medication currently, "none at present, last meds were June." Appellant prescribed exercises, OxyContin 40 mg #30 with instructions to take one tablet twice per day, and Ambien 10 mg #10 with instructions to take one tablet at bedtime as needed. State's Exhibit 10 at 23, 37.

In his written report, Dr. Parran criticized appellant for, among other things, continuing to treat Patient 10 with controlled substances despite Patient 10 having failed twice to follow his orders to undergo a urine drug screen. State's Exhibit 31. Dr. Parran testified that appellant failed to obtain previous medical records, perform or order any workup or order a consult, and prescribed OxyContin 40 mg at Patient 10's first visit without verifying that she had been taking that level of medication. Tr. 171-172. The medical record indicates that on October 4, 2002, Patient 10 had been an inmate in the Clark County jail. However, on her visit to appellant on October 16, 2002, there is no reference to that event. Dr. Parran criticized appellant for failing to inquire why Patient 10 had been jailed. Tr. 171-173.

Patient 11

Patient 11 was a male born in 1970 and complained of injuries sustained in 1997 and 1999. He also presented that he was a non-driver. The Pain Assessment Questionnaire indicates that Patient 11 had been taking OxyContin 40 mg and oxycodone 5 mg. Appellant

noted that Patient 11 had not had any meds in three weeks. Appellant prescribed OxyContin 40 mg [no quantity noted] with instructions to take one tablet twice per day and OxyIR [quantity not noted] with instructions to take one capsule twice per day. State Exhibit 11 at 23-25, 77.

Dr. Parran criticized appellant for failing to find out why Patient 11 was a non-driver. He criticized appellant for failing to obtain previous medical records or perform or order studies. He also testified that appellant's history and physical examination of Patient 11 was very scant. Tr. 175-176. He criticized appellant for prescribing 90 mg of oxycodone per day without evidence that Patient 11 had been taking such medications and testified that the dose could have killed the patient had he not been previously exposed to opiates. Tr. 176-177. Dr. Parran noted that on July 11, 2002, Patient 11 had been referred to consult with another physician and that there is no evidence in the record of any follow up or that it ever happened. State's Exhibit 11 at 7; Tr. 177.

Patient 12

At his first visit on December 27, 2001, Patient 12, a male born in 1960, presented a temporary Ohio driver's license. He claimed he had been taking OxyContin 40 mg, Percocet, and Soma. Appellant prescribed OxyContin 20 mg #30 with instructions to take one tablet every 12 hours, Percocet 5 mg #30 with instructions to take one tablet twice a day and Soma 350 mg #30 with instructions to take one tablet twice per day. State's Exhibit 12 at 23, 49.

Dr. Parran testified that appellant failed to obtain records of previous medical treatment. He also stated that appellant increased the medications on multiple occasions without any documentation. Two progress notes dated March 21 and April 4, 2002 indicate that urine drug screens had been ordered or completed but there were no results documented

in the medical record. Tr. 178-179. Dr. Parran also testified that a 41 year old man with a temporary driver's license "is totally aberrant." Tr. 179. Moreover, Dr. Parran testified there had been no studies, no workup, and no verification that Patient 12 had taken the medications he claimed to have taken. Tr. 179.

Patient 13

Appellant prescribed a controlled substance diet medication for Patient 13 who was obese. Dr. Parran testified that appellant failed to follow Ohio law with regard to both the diet medication and the opiate medication that he prescribed for her. Dr. Parran testified that appellant prescribed the controlled substance anorectics for a period longer than the three-month maximum mandated by the Board's rules. Moreover, Dr. Parran testified that appellant continued to prescribe the controlled substance anorectics despite the fact that Patient 13 gained weight during this time. Tr. 180-182.

Patient 14

Patient 14 was a female born in 1964. She saw appellant for an initial visit on August 9, 2001. There is a conflict that appellant wrote in her medical record: he notes that Patient 14 had been taking OxyContin 20 mg and Soma. However, in a different location in the same note it states "Injection & Oxy 0 & Soma." Appellant prescribed OxyContin 40 mg #30 with instructions to take one tablet every 12 hours, and Soma 350 mg #30 with instructions to take one tablet twice per day. Appellant also prescribed abdominal exercises. State's Exhibit 14 at 87.

Dr. Parran criticized appellant's treatment of Patient 14 as follows: he stated that the history and physical examination was inadequate. He also noted that Patient 14 had been treated for pain for three years, indicating that previous medical records were available. However, there was no evidence that appellant made any attempt to obtain Patient 14's

previous medical records. There was no documentation of a workup or consults. Dr. Parran noted that appellant never verified that Patient had been taking OxyContin 40 mg and Soma as she had claimed.

Dr. Parran criticized appellant for prescribing 80 mg of oxycodone per day at the initial visit without verifying that she had been taking that dosage level. Dr. Parran also testified to the medications that appellant added to Patient 14's treatment and stated that they were not appropriate for a person who is on OxyContin 40 milligrams twice a day. He stated that without an evaluation it just did not make any clinical sense. Tr. 182-185.

The medical records for Patient 14 include an authorization to release and a request for information from McKinley Hall in Springfield, Ohio. The request is dated July 17, 2002. However, the fax information at the top of the page indicates that it had not been faxed to appellant until July 26, 2002. Dr. Parran testified that no further prescriptions for controlled substances appear to have been issued by appellant after July 26, 2002.

Regarding the conflict in the medical record, Dr. Knott testified that he would have ascertained which amount of the OxyContin was correct. Further, he acknowledged that appellant failed to do this. State's Exhibit 19; Tr. 929-930.

Patient 15

Dr. Parran testified that Patient 15 was a 35 year-old woman and was a non-driver. He testified that the previous physician, whom she had not seen since six months earlier, prescribed hydrocodone 7.5 mg and Valium. Dr. Parran stated that appellant started her on OxyContin 20 mg with instructions to take one tablet every 12 hours, and Lortab 10 mg with instructions to take one tablet three times per day as needed. Furthermore, Dr. Parran testified that appellant prescribed 70 mg of opiate even though Patient 15 reported that she had not seen a doctor in six to seven months. Dr. Parran stated that this could have resulted

in an overdose, and that she should have been placed on a lower dose or started on a non-opiate medication.

Dr. Parran testified that appellant increased Patient 15's OxyContin to 20 mg three times per day and added Xanax. On January 3, 2002 appellant gave Patient 15 a refill of Xanax based upon her statement that she "lost her script." Dr. Parran stated that in his opinion prescribing opiates and Benzodiazepines to Patient 15 "was just inconsistent with the usual course of medical practice and with the State statutes regarding the management of chronic intractable pain." Tr. 189-190.

Dr. Knott noted that Patient 15 had been in three car accidents. Tr. 743. He noted that there was no information indicating whether Patient 15 was on any medication immediately preceding her visit to appellant. Tr. 745-746.

Patient 16

Patient 16 is a female born in 1962. She first visited appellant on September 27, 2001. At that time, Patient 16 completed a Pain Assessment Questionnaire and wrote that the location of the most intense pain was in her "pancreas." State's Exhibit 16 at 19. In his note concerning Patient 16's initial visit, appellant did not mention the pancreas but instead recorded "back pain" and his impression of right sciatica and myofascial pain. State's Exhibit 39. There was a conflict with appellant's notes; he states that Patient 16 had reported taking OxyContin 40 mg but elsewhere in the same note states "no meds at this time." Appellant prescribed OxyContin 20 mg #30 with instructions to take one every 12 hours, and Lortab 10 mg #30 with instructions to take one tablet twice per day as needed. State's Exhibit 16 at 39.

Dr. Parran testified that Patient 16 was 38 years old and had chronic pancreatitis, secondary to chronic alcoholism. The fact that this patient had chronic pancreatitis

secondary to the alcoholism indicates a more severe alcoholism than the average alcoholic. Dr. Parran further testified that appellant did not obtain any records of prior medical treatment nor did he pursue a workup, consultation or a chemical dependency evaluation. Dr. Parran noted that although Patient 16 had not been taking any medication, appellant started her on the equivalent of 60 milligrams of high potency opiates per day. He stated that this was inconsistent with the usual course of medical practice. He also noted that Soma was added on February 14, 2002.

Dr. Parran testified that Patient 16 had a flare-up of her pancreatitis pain on January 31, 2002 but that appellant did not evaluate Patient 16 to determine if she had still been drinking. State's Exhibit 16 at 31; Tr. 192-193. Dr. Parran testified that a history of alcoholism is a contraindication to the scheduled drugs that appellant prescribed to Patient 16. Dr. Parran noted that although Patient 16 missed a medication check on March 7, 2002, appellant still prescribed her regimen of medications to her on March 14, 2002. On March 21, 2002, Patient 16 missed another medication check and when it was learned that she was seeing multiple doctors, she was dismissed from the practice. State Exhibit 16 at 29-31; Tr. 193-194.

Patients 17 through 22

Dr. Parran testified that Patients 17 through 22 all shared the same surname and appeared to be related to one another. They all were in their late thirties to early forties and three of the five did not have a driver's license. Dr. Parran testified that it was difficult to tell from the medical records whether these people were related to one another and how they were related. Tr. 196-197. He further testified that appellant was inconsistent with the standard of care since he was taking care of multiple people from the same family and his records were not clear as to how these people were related to one another. Tr. 196-197. Dr.

Parran stated that Patient 17 and Patient 21 appear to be married to one another. Tr. 322-324.

Patient 17

Dr. Parran testified that the medical records for Patient 17 demonstrate that patient is a non-driver and that he had been discharged from another physician's practice "due to stolen meds and a failed medication check." Nevertheless, appellant prescribed OxyContin 40 mg twice per day and prescribed Tylox two weeks later. Tr. 203. Dr. Parran testified that appellant's medical records for Patient 17 did not include any prior records of treatment, no workup and no consultations. He also stated that there was an inadequate history and physical examination and that the "prescribing was inconsistent with the standard of care and was inconsistent with the statutes regarding the prescribing of chronic opiates for chronic pain." Tr. 203.

Dr. Knott noted that Patient 17 had been discharged from his previous physician for missing medication checks. Tr. 755. He acknowledged that there was no alcohol or drug history which was documented at Patient 17's initial visit. He further acknowledged that he would consider that to be important information with this patient. Tr. 937.

Patient 18

Patient 18 is a male born in 1959. He first visited the appellant on July 26, 2001. He stated that he had previously been prescribed OxyContin 40 mg, Lortab 10 mg and Valium 10 mg. Appellant's initial visit report states that Patient 18 received Xanax and OxyII BID from a Dr. Cole. Appellant's notes also indicate that Patient 18 had not been taking any medication for six weeks. The notes also indicate that Patient 18 had surgery in February 2000 and was diagnosed with colon cancer. Appellant diagnosed lower back pain and prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day,

Lortab 10 mg #30 with instructions to take one tablet at bedtime as needed. He also discussed meditation, diet and supplements with the patient.

Dr. Parran noted that on August 23, 2001, despite Patient 18 reporting that he had no problems and that his medications were working well, appellant added Valium 10 milligrams three times a day for no apparent reason. Patient 18 had an abnormal medication check on January 31, 2002 and in March and April 2002 failed to get the urine screens that were ordered. In May 2002 Patient 18 missed a medication check and was dismissed from the practice. However, within days he was reinstated.

Dr. Parran noted that there were no hospital records, discharge summary or other evidence in the medical record that supported Patient 18's claim. Additionally, Patient 18 missed another medication check in June 2002 and as a consequence his medicines were decreased to Percocet and Xanax. The OxyContin was not prescribed. But, by the next month, July 2002, appellant prescribed OxyContin, Percocet and Xanax. Dr. Parran noted that despite Patient 18 demonstrating wildly out-of-control behavior over a several month period of time, appellant continued prescribing controlled substances despite the evidence of deterioration on the part of the patient. Tr. 201-203.

Dr. Knott noted that Patient 18 was discharged from the practice for missing a med check pending explanation. He testified that another med check was scheduled for May 23, 2002 which Patient 18 also missed. He was discharged from the practice again. However, appellant continued to see Patient 18 and prescribed controlled substances for him on seven subsequent visits through August 26, 2002, after which Patient 18 missed another med check and was discharged. State's Exhibit 18 at 27-33.

Patient 19

Patient 19 was a male born in 1960. He presented a non-driver state identification on his first visit on August 30, 2001. He left blank the space for listing his current medications. However, appellant's notes for that date state that Patient 19 had been taking OxyContin. On the other side of the same page it states "Currently on Fioricet [two tablets] for migraine and Valium 10 mg one tablet three times per day." No further comments concerning Patient 19's different pain reports or medications were documented. Appellant diagnosed cervical sprain/strain, facet joint injury, and lumbosacral sprain/strain "[with] neuro deficit. He prescribed OxyContin 40 mg #30 with instructions to take one tablet every 12 hours, Oxy IR 5 mg [no quantity documented] with instructions to take one capsule twice per day as needed, and Zonegran 100 mg 328 with instructions to take one capsule at bedtime. State's Exhibit 19 at 11015, 65.

Dr. Parran testified that Patient 19 was a non-driver and on February 28, 2002 went to jail for six weeks. Tr. 201-202. At that time, appellant provided Patient 19's public defender with prescriptions for OxyContin 40 mg #30 with instructions to take one tablet three times per day, and Ambien 10 mg #10 with instructions to take one tablet at bedtime as needed. State's Exhibit 19 at 57. The next progress note following February 28, 2002 is April 11, 2002. At that visit appellant prescribed the same medication and dosages he had prescribed on February 28, 2002. State's Exhibit 19 at 57.

Patient 20

Patient 20 first visited appellant on July 19, 2001. Appellant noted that the patient came to see him for a pain management evaluation and that he was not seeing any physicians at that time. The notes indicate that Patient 19 was released from jail on July 14th, 2001. Appellant indicated as subjective information, "Meds-OxyContin 20-Soma-

Valium.” Appellant prescribed OxyContin 20 mg with instructions to take one tablet twice per day, and Zanaflex 4 mg [no quantity noted] with instructions to take one tablet twice per day as needed. State’s Exhibit 20 at 75.

A note dated November 15, 2001 states that Nationwide Insurance called wanting a copy of Patient 20’s medical records along with another individual’s. The note further states that “[T]hey are both turning in bills for treatment here for an automobile accident. Nationwide thinks they are trying to ‘pull something with the bills’ I see no notes of us treating them for the car accident 10/12/01. I will send the records on 11/30/01. Tricia.” State’s Exhibit 20 at 39.

Dr. Parran testified that Patient 20 was another non-driver who presented to appellant’s office having just been released from jail indicating he was not on any medications. The record shows that appellant made no effort to obtain prior medical records, do a workup or order a consultation. Tr. 204. Dr. Parran noted that following the January 3, 2002 visit when appellant prescribed meds to Patient 20, appellant did not see Patient 20 again until September 11, 2002. Appellant did not document any reason for the extended absence. Nevertheless, appellant restarted the patient on OxyContin 20mg twice per day. Dr. Parran noted that the dose was an unsafe amount. Tr. 204-205.

Patient 21

Patient 21 was a female born in 1960. When she visited appellant for the first time on August 9, 2001 she weighed 85 pounds. She reported a 1997 injury and stated that she was taking several non-controlled substance medications and OxyContin 20 mg three times per day. Dr. Parran testified that appellant doubled her OxyContin dose on the second visit and added Valium. However, the medical record indicates that Patient 21 continued to receive the same OxyContin prescription she received on her initial visit through the last

visit recorded on October 15, 2002. Tr. 199-200.

Patient 22

Patient 22 is a male born in 1962. His first appointment with the appellant was July 19, 2001. He reported a 1988 injury wherein he fractured 3 vertebrae and reported having had spinal fusion surgery in 1992. He stated that he was not currently seeing a doctor. Appellant diagnosed chronic L4-L5 radiculopathy with chronic pain syndrome. Appellant prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, Maxidone #60 with instructions to take one tablet every six hours (the pharmacy was out of Maxidone and filled the prescription with Lortab 10 mg) and Zanafles 2 mg #42 with instructions to take one tablet three times per day.

Dr. Parran noted that Patient 22 was a non-driver and denied alcohol or drug use.

Tr. 777-778

Patient 23

Patient 23, initials J.D.R., was a male born in 1959 who first visited appellant on July 26, 2001. He presented a non-driver state identification. He named two prior physicians and noted that he was not taking any medications at the time of the initial visit. Appellant prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, Maxidone tablets #30 with instructions to take one tablet twice per day as needed, and Ambien 10 mg with instructions to take one tablet at bedtime as needed. State's Exhibit 23 at 21, 29. A note dated October 3, 2001 states "Spoke [with] Chris and Dr. Andorfer [Patient 23] is stating that his brother is using his name to come to our office and get meds. Faxed over the [patient's] signature to Dr. Andorfer's office it matched [Patient's 23's]. We will no longer see or treat the patient per Dr. Nucklos." State's Exhibit 23 at 44.

Another initial visit form in State's Exhibit 23 is dated November 8, 2001. This

form is in regard to the visit of a patient with the initials "D.R." with the same last name, date of birth and Social Security number as Patient 23. Appellant prescribed OxyContin 40 mg #30 with instructions to take one tablet every 12 hours, Soma 350 mg with instructions to take one tablet three times per day as needed, and Xanax 0.5 mg #30 with instructions to take one tablet twice per day. State's Exhibit 23 at 17-19; Tr. 206.

A November 15, 2001 note states that Patient 23 visited appellant on November 8, 2001 posing as another individual. The date of the notification is difficult to read but it states either "1/15 or 11/18." State's Exhibit 23 at 27. The next note is dated December 20, 2001. Appellant prescribed OxyContin 40 mg#30 with instructions to take one tablet every 12 hours, Lortab 10 mg #30 with instructions to take one tablet twice per day, and Xanax 1.0 mg #42 with instructions to take one tablet three times per day. State's Exhibit 23 at 33-34. Appellant continued to see Patient 23 on a regular basis and prescribed controlled substances at each visit. State's Exhibit 23 at 33-34.

Dr. Parran noted that Patient 23 presented with a non-driver state identification card. He stated that appellant prescribed OxyContin 80 mg twice per day, Maxidone and Ambien at the first visit without obtaining prior medical records of treatment, and did not complete or order any workups or consultations. Appellant noted in the medical record that Patient 23 was seeing different doctors to obtain controlled substances. Appellant was aware that Patient 23 returned to his office posing as another person. Once that ruse was discovered, appellant reinstated Patient 23 and prescribed OxyContin, Lortab and Xanax. Dr. Parran noted that there was no diagnosis recorded for the Xanax prescription. The medical records indicated that appellant continued to see Patient 23 on a regular basis through October 9, 2002 and prescribed controlled substances at each visit. State's Exhibit 23 at 33-44; Tr. 207-209.

Dr. Parran testified that “[H]ere is person who was a non-driver with clear-cut-out-of-control chemical dependency behavior throughout his time, and continued to receive controlled substances in a manner which is inconceivable and inconsistent with the usual course of medical practice and for other than a medical purpose.” Tr. 209.

Dr. Knott testified that on cross-examination that Patient 23 had exhibited drug seeking behaviors and that he would have obtained more information concerning this patient. Tr. 961-964.

Patient 24

Patient 24 presented a non-driver state identification card at his first visit to appellant on January 17, 2002. It had been two years previous when he last saw his treating physician. He reported that he was not taking any medication. Nevertheless, appellant prescribed OxyContin 20 mg #30 with instructions to take one tablet every 12 hours and Soma 350 mg #30 with instructions to take one tablet twice per day. State’s Exhibit 24 at 23; Tr. 215. On his second visit on January 31, 2002 the notes indicate that appellant ordered x-rays and an MRI.

Dr. Parran testified that there are no reports of x-rays or MRIs and that there are no workups or consultations. The progress notes indicate that on May 30, 2002, Patient 24 was in jail but there in no mention of the reason for his incarceration. Dr. Parran testified that appellant continued prescribing for appellant through October 2002. State’s Exhibit 24 at 19; Tr. 215-216. Dr. Parran also noted that the medical record mentions Patient 24 reporting blackouts without any further information in the medical record about what is meant by blackouts. Dr. Parran testified that this is inconsistent “with the usual and minimal standard of care to just write that in the chart and not document more about what might be going on.” State’s Exhibit 24 at 17-23; Tr. 216-217.

Dr. Parran testified on cross-examination that the medical records indicate that appellant's office sent Patient 24's medication to the jail on May 30, 2002. However, Dr. Parran stated that it would have been appropriate for appellant to document in the medical record why the patient was in jail, what the charges were about, and why the patient was a non-driver. Tr. 328-330.

Dr. Knott testified that the medical records indicate that Patient 24 was experiencing blackouts and that a March 28, 2002 note states that the patient reported that he scheduled tests for his blackouts. However, the note for the next visit does not follow up to say whether Patient 24 had followed through with the testing. State's Exhibit 24 at 21; Tr. 790-791. Dr. Knott testified that regarding Patient 24's blackouts, that "[W]ell, I think a CT scan would be indicated, an MRI or a neurological consult, just to-just to see if there's some sort of lesion causing this, or if he's having TIAs, mini strokes." Tr. 792-793.

Patient 25

Dr. Parran testified that Patient 25 had two initial office visits. The first occurred on October 25, 2001 for weight management. The other occurred on December 20, 2001 for pain management. On his Pain Assessment Questionnaire dated December 20, 2001, Patient 25 indicated that his pain began following a motor vehicle accident two years previously. He indicated that he was not taking any medication. Appellant prescribed OxyContin 20 mg #30 with instructions to take one tablet every 12 hours, Vicodin HP 10 mg #30 with instructions to take one tablet twice per day, and Soma 350 mg #30 with instructions to take one tablet twice per day. Dr. Parran testified that appellant continued to prescribe OxyContin and Vicodin on the basis of a diagnosis of a lumbosacral strain, sprain, and contusion, for 10 months without any diagnostic workup or evaluation. State's Exhibit 25 at 3, 13-17, 26-35; Tr. 218-219.

In addition Dr. Parran testified that prescribing 60 mg of high potency opiate daily at the first visit put the patient's health, and potentially his life, at risk. Dr. Parran also noted that at Patient 25's first visit on October 25, 2001, there was no mention of any pain complaint or opiate medication. However, when December 20, 2001 rolls around, the patient suddenly reports that he is on OxyContin, Vicodin and Soma. Tr. 220.

Patient 26

Patient 26 was a 34 year-old woman who visited appellant on August 16, 2001 for the first time. She complained of a five year history of migraine headaches and low back pain related to scoliosis. She reported having had a previous treating physician. She further reported that her current medications were OxyContin 40 mg and Soma. State's Exhibit 26; Tr. 222-223.

Dr. Parran testified that there was no indication in her medical records when she last saw her treating physician, there were no old records from that doctor, no request for prior medical records and no documentation of any workup or consultation. Nevertheless the evidence shows that appellant prescribed OxyContin 40 mg twice per day and Soma at the first visit without any verification of the patient's current level of medication. Dr. Parran stated, "That's dangerous."

Dr. Parran testified that the medications were increased over time and OxyIR and Xanax were added. On January 31, 2002 Patient 26 failed a medication check, yet appellant continued to prescribe for her. On March 7, 2002 the patient reported good pain control and difficulty sleeping. Appellant increased her OxyContin to 40 mg three times per day despite her report of good pain control. State's Exhibit 26 at 40, 77, 85-89; Tr. 222-224.

Dr. Parran testified that "it's my opinion that the prescribing was inconsistent with the usual course of medical practice and inconsistent with State Medical Board rules

regarding chronic opiates for chronic pain.” Tr. 224. Dr. Parran testified that a patient who fails a med check is not taking the medication as prescribed and that it is a violation of the treatment contract. Tr. 225-227.

Patient 27

Patient 27 is a female born in 1963 who first visited appellant on September 27, 2001. She identified her previous treating physician as Dr. Jenkins and stated that she had been taking OxyContin 40 mg and Soma. Appellant prescribed OxyContin 40 mg #30 with instructions to take one tablet every 12 hours, Lortab 10 mg #30 with instructions to take one tablet twice per day as needed, and Soma 350 mg #30 with instructions to take one tablet per day as needed. State’s Exhibit 29; Tr. 227-228.

Dr. Parran criticized appellant since he had not obtained any prior medical records, never bothered to request any, failed to do any workup or studies, and did not order a consult. Dr. Parran also criticized appellant for having prescribed the equivalent of 100 mg per day of high potency opiate without verifying that Patient 27 had been taking those medications. Tr. 228-229. On November 18, 2001, appellant added Xanax 0.5 mg three times per day based on his note that “anxiety persists.” However, Dr. Parran testified that appellant never made a diagnosis of anxiety disorder nor was there any evaluation done. Dr. Parran testified that the minimal standards of care require “an assessment of an anxiety disorder and a reason to start Xanax on top of Percocet and OxyContin.”

On December 20, 2001, Patient 27 reported good pain control with decreased anxiety. Nevertheless, appellant doubled the patient’s dosage of Xanax. Dr. Parran testified that “[T]here’s just no evidence of a legitimate medical purpose for that change.” It was Dr. Parran’s opinion that there was inadequate evidence for a legitimate medical purpose to start the Xanax on 11-8-01 and no evidence for the doubling of the Xanax in December.

State's Exhibit 27 at 26-27; Tr. 228-230. Dr. Parran testified that appellant's treatment of Patient 27 had been inconsistent with the Board rules concerning long-term prescribing of opiates for chronic intractable pain. Tr. 229.

Patient 28

Patient 28 first visited appellant on July 19, 2001. She reported that she used OxyContin and Tylox. Appellant prescribed OxyContin 80 mg #30 with instructions to take one tablet twice per day, and Lortab 10 mg #30 with instructions to take as needed.

Dr. Parran testified that the medication appellant prescribed to Patient 28 would kill her if she had not already been taking that level of medication. He also stated that there is no evidence that appellant attempted to verify the patient's current medications. State's Exhibit 28 at 9; Tr. 233. Moreover, Dr. Parran testified that appellant did not do any workup, consultation, nor did he have records of Patient 28's prior medical treatment.

A note following the August 16, 2001 progress note states as follows:

Pharmacist @ Whit-Lagonda Ave-called stated that [Patient 28] just had OxyContin 20mg #60 filled 8-15-01 per Dr. Shah's office. Pharmacy filled her script today then noticed it. Seeing Dr. Shah at Northpark medicine. Told Dr. Nucklos stated we'd speak to her on her next visit re: above.

State's Exhibit 28 at 9.

The record indicates that Patient 28 told appellant that Dr. Shah discharged her and that she discarded the remaining OxyContin that were given to her by Dr. Shah. State's Exhibit 28 at 9. A progress report note dated August 30, 2001 indicates that Patient 28 reported having breakthrough pain periodically. Appellant prescribed OxyContin 80 mg #30 with instructions to take one tablet every 12 hours, and OxyIR 5 mg [no quantity noted] with instructions to take one tablet per day as needed for breakthrough pain. State's Exhibit 28 at 10.

Dr. Parran testified that appellant never contacted Dr. Shah's office and stated

"[A]gain this is unbelievable." Tr. 233-234. He further stated that appellant started prescribing Xanax to Patient 28 on September 13, 2001 for anxiety without any further documentation. State's Exhibit 28 at 10; Tr. 234. Dr. Parran also noted that appellant was given an early prescription even though Patient 28 has violated the pain management agreement. State's Exhibit 28 at 11; Tr. 234.

On July 18, 2002 the record demonstrates that the Ohio Department of Job and Family Services sent a letter to appellant advising him that Patient 28 had been receiving controlled substances inappropriately and asked him to complete a Drug Utilization Review Physician Response form. State's Exhibit 28 at 23-37. Dr. Parran testified that the drug utilization form sent to appellant advised him that Patient 28 had been receiving controlled substances from multiple physicians, just as the pharmacy had reported to him earlier. Again, Dr. Parran testified appellant did no workup, no documentation of the legitimate medical purpose, and no documentation of the previous prescribing. Appellant's response to Patient 28's clearly aberrant behavior was to continue prescribing controlled meds to her. Tr. 235. Since this was in contrast to the agreement that was in the chart, Dr. Parran found appellant's behavior to be "inconsistent with the standard of care in the community and inconsistent with the State Medical Board rules regarding the chronic prescribing of opiates for intractable pain syndromes."

Dr. Knott testified that, for a first time patient, the dosages that appellant prescribed to Patient 28 "might be...a little excessive." Tr. 811-813. Dr. Knott testified that there is no way for a physician to know that a patient is seeing multiple physicians until that information comes to you from a third party. Dr. Knott stated that it is a "judgment call" to continue seeing a patient that a pharmacist has informed you is receiving medications from another physician but that he "would have been leery of this patient." Tr. 815.

During his testimony at the criminal trial, appellant acknowledged that there was nothing in Patient 28's medical record concerning the medication she had been taking prior to her initial visit, other than her self report. He also acknowledged that he did not ask Patient 28 about her alcohol or substance abuse history. State's Exhibit 32A at 1674-1677. Appellant also testified that at the time he treated Patients 2, 3 and 28, he had not been aware of the Board's rules concerning the treatment of intractable pain. He further testified that he since has become familiar with those rules and applied them in his practice. State's Exhibit 32A at 1678.

With regard to the note concerning the call from the pharmacist in Patient 28's chart, appellant testified that he could not recall if he had seen the note prior to treating Patient 28 on August 30, 2001. State's Exhibit 32A at 1703-1704. On November 8, 2001, appellant prescribed OxyContin 80 mg with instructions to take one tablet every 12 hours, Tylox #30 with instructions to take one capsule twice per day as needed and Xanax 1 0 mg #90 with instructions to take one tablet three times per day. State's Exhibit 28 at 12. One week later, on November 15, 2001, appellant prescribed OxyContin 80 mg #30 with instructions to take one tablet every 12 hours, Tylox #30 with instructions to take one capsule twice per day as needed, and "Cont Xanax." State's Exhibit 28 at 13.

In his written report, Dr. Parran made the following statement with regard to each patient in this case:

It is my opinion to a reasonable degree of medical certainty that in the care of this patient, ~~Dr. Nucklos did not maintain minimal standards applicable to the~~ selection or administration of drugs, and failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment. In addition Dr. Nucklos' care of this patient did constitute prescribing controlled drugs for other than legal and legitimate therapeutic purposes. ~~Therefore, it appears that to within a~~ reasonable degree of medical certainty, Dr. Nucklos violated Section 4731.22(B)(2), Section 4731.22(B)(3), and Section 4731.22(B)(6) of the Ohio Revised Code. State Exhibit 31.

Dr. Parran reiterated and gave these same opinions in his testimony before the Hearing Examiner. Tr. 235-237. Dr. Parran testified that he was contacted by the Springfield Police Department in late 2004 regarding appellant's conduct and was asked to review some material. He testified that for his review in the criminal case, he had been provided with transcripts of tapes obtained by two undercover visits to appellant's office and was provided with medical records. He noted that each of those records contained a Pharmacy Board controlled substance profile of all the prescriptions that they had been able to find during an approximately 2 year time period. Dr. Parran noted that the medical records of all 28 patients included in the Board's case had been included in the original medical records that he reviewed for the criminal case. He noted that appellant's criminal trial took place in 2006. Tr. 239-241.

Appellant undertook the care of Patients 1 through 28 from a time period beginning in March 2001 through about October 2002. Upon review, the evidence overwhelmingly supports a finding that appellant inappropriately prescribed controlled substances and/or dangerous drugs to Patients 1 through 28 in a manner that was below the minimal standards of care. More importantly, the evidence demonstrates that appellant prescribed controlled substances without a legitimate medical purpose. This conduct includes prescribing controlled substances and other dangerous drugs even when he failed to order or document, and/or that he failed to order the appropriate consultations in each patient's case. This also takes into consideration appellant's failure to perform and/or document appropriate physical examinations, and his failure to order, and/or document, that he ordered the appropriate diagnostic tests in each respective patient's case.

Accordingly, there is reliable, substantial and probative evidence to conclude that appellant violated R.C. 4731.22(B)(2), R.C. 4731,22(B)(3), R.C. 4731.22(B)(6), R.C. 4731(B)(20) and O.A.C. 4731-21-02.

APPELLANT'S ARGUMENTS

Although appellant does not set forth specific assignments of error as such, appellant asserts several arguments. First, appellant asserts that the Board's Order is not supported by reliable, probative and substantial evidence and is not in accordance with law. Secondly, appellant asserts that the Board lacks authority to discipline him absent a violation of R.C. 4731.052. Appellant also asserts that the Board erred as a matter of law by repeatedly denying appellant's requests for continuances. Furthermore, appellant asserts that the Board erred as a matter of law by denying appellant's subpoena duces tecum and motion to dismiss thus, requiring him to provide "testimony" in violation of his Fifth Amendment right against self incrimination.

A. Appellant argues that the Board lacks authority to discipline him absent a violation of R.C. 4731.052.

R.C. 4731.052(C) provides:

When a treating physician diagnoses an individual as having intractable pain, the physician may treat the pain by managing it with dangerous drugs in amounts or combinations that may not be appropriate when treating other medical conditions. **The physician's diagnosis shall be made after having the individual evaluated by one or more other physicians who specialize in the treatment of the area, system, or organ of the body perceived as the source of the pain.** The physician shall maintain a record of all of the following:

- ~~(1) Medical history and physical examination of the individual;~~
- (2) The diagnosis of intractable pain, including signs, symptoms and causes;
- (3) The plan of treatment proposed, the patient's response to the treatment, and any modification to the plan of treatment;
- ~~(4) The dates on which dangerous drugs were prescribed, furnished, or administered, the name and address of the individual to or for whom the dangerous drugs were prescribed, dispensed, or administered, and the amounts and dosage forms for the dangerous drugs prescribed, furnished, or administered;~~

- (5) A copy of the report made by the physician or the physician to whom referral for evaluation was made under this division.

Based on a review of the evidence, appellant did not come close to complying with R.C. 4731.052 or O.A.C. 4731-21-02 and thus, this statute would not apply under appellant's circumstances. In order to be within the parameters of R.C. 4731.052, appellant must have complied with each and every one of the steps necessary in order to have properly diagnosed and then treated an individual with chronic intractable pain. Appellant himself admitted that there was a time when he was treating patients and was not aware of this statute. State's Exhibit 32A at 1678. The evidence is overwhelming that appellant did not comply with this statute and therefore cannot seek its protections.

The statutory scheme in R.C. Chapter 4731 et seq. authorizes the Board to engage in rulemaking and conduct adjudicatory proceedings, among other purposes. The Board's disciplinary authority is established in R.C. 4731.22. Appellant's assertion that the Board could discipline him pursuant to one statute only, R.C. 4731.052, is illogical and contrary to the statutory scheme. Moreover, appellant has not provided to this court any legal basis for this assertion.

The factual allegations before this court pertain to various aspects of appellant's diagnosis and medical treatment of Patients 1 through 28. Appellant never diagnosed chronic intractable pain in any of these patients as set forth in R.C. 4731.052. The record is replete with examples of appellant falling below the minimal standard of conduct, such as ~~his inappropriate (or non-existent) diagnosis and treatment of these patients, his~~ inappropriate prescribing of controlled substances and/or dangerous drugs in dangerous ~~amounts without any verification of the patient's past dosage, his sloppy, conflicting and~~ incomplete medical records and notes, and his failure to obtain prior medical records, and obtain or document testing, workups and consultations on these patients. Again, these are

just examples of a few, among many other infractions, that were proven at the hearing.

The Board is authorized by R.C. 4731.22 to discipline appellant for these various aspects of providing inadequate patient care since appellant's conduct fell below the level of minimal standards of patient care. The evidence overwhelmingly proves, among other things, that appellant failed to maintain minimal standards applicable to the selection and/or prescribing of drugs, and that he failed to document and maintain thorough medical records for these patients. Appellant asserts that as a physician treating intractable chronic pain he could have only been disciplined pursuant to R.C. 4731.052.

However, the medical records that appellant generated regarding Patients 1 through 28 are inadequate and below the minimum standards. Thus, there is no *premise* that these patients truly had a diagnosis of chronic intractable pain since appellant did not record or support by documents or verification or otherwise, that any of these patients truly had a diagnosis of chronic intractable pain.⁵ See R.C. 4731.052 and O. A.C. 4731-21-02.

From his perspective, appellant may have been treating these patients for intractable chronic pain; however, the inadequate and poorly kept medical records in this case do not support this unrecorded and unsubstantiated diagnosis. There is little or scant evidence which verifies and documents that Patients 1 through 28 were diagnosed properly with chronic intractable pain. To the contrary, the evidence demonstrated that many or all of these patients exhibited drug seeking behaviors and that appellant was an enabler who furnished drugs for other than a legitimate therapeutic purpose.

Clearly, the Board properly disciplined the appellant for violating R.C. 4731.22(B)(2), R.C. 4731,22(B)(3), R.C. 4731.22(B)(6), R.C. 4731(B)(20) and O.A.C.

⁵ The only patient wherein appellant noted a diagnosis of "chronic pain syndrome" is set forth in the medical records of Patient 22. However, there is no basis, verification or documents supporting this diagnosis. Thus, it is the conclusion of this court that the diagnosis for Patient 22 was never substantiated pursuant to R.C. 4731.052 and O. A.C. 4731-21-02

4731-21-02 since the record is replete with evidence that supports these charges.

B. Appellant asserts that exhibits/documents regarding Patients 1 through 28 were not properly admitted.

First and foremost, it was appellant's decision and choice to testify at his criminal trial.⁶ Thus, it was appellant's prerogative not to assert his Fifth Amendment right in that instance and the record demonstrates that he waived his Fifth Amendment right. Moreover, the February 2006 criminal trial had concluded at the time that the administrative hearing finally went forward on June 2, 2008, after several continuances that were requested by the appellant.

Appellant asserts that State's Exhibits 1 through 28 are not true and adequate copies of his medical records since they contain printouts from the State Board of Pharmacy or a law enforcement agency showing all prescriptions filled by the patient from all prescribers.⁷ Appellant additionally argues that some exhibits contain questionnaires and statements from patients regarding appellant and their use of prescriptions. At least one record includes a "Miranda waiver." The additional information contained in Exhibits 1 through 28 show that some of these patients were obtaining multiple prescriptions from multiple providers and that at least one patient was diverting the medication from its intended purpose. Appellant also asserts that these exhibits were "compiled" from appellant's records and were altered and were not complete. Additionally, appellant asserts that these exhibits are inadmissible hearsay.

~~The record shows that at the hearing, appellant did not raise any objection to the~~

⁶ Appellant testified on his behalf in the February 2006 criminal trial which took place in Clark County. See State's Exhibit 32A. As to the Subpoena Duces Tecum, the record shows that the appellant was required to respond to the production of his board certification information and that he failed to produce any documents. Likewise, since appellant only accepted cash payment, there were no billing records for his Springfield medical office.

⁷ Appellant asserts that State's Exhibits 1 through 28 are a "compilation" of medical records. However, appellant's assertion/definition of "compilation" does not comport with Evid. R. 1006.

admission of State's Exhibits 1 through 28.⁸ The record also shows that, in preparation for his testimony in the criminal trial, the expert for appellee, Dr. Parran, reviewed charts from appellant's office, along with prescription profiles generated by the Pharmacy Board and transcripts from two undercover visits, among other things. Tr. 38, 239. Dr. Parran confirmed the prescribing history of appellant by comparing the information from these several documents. In preparing for the hearing in the matter herein, Dr. Parran testified that he reviewed the medical records of the 28 patients he had reviewed previously for the criminal trial, and also reviewed his testimony in the criminal trial. He articulated and explained his procedure to sort out the medical and non-medical records such as the pharmacy prescription profiles etc. Tr. 243-248.

Likewise, Dr. Knott, appellant's expert witness relied on State's Exhibits 1 through 28 throughout his testimony and referred to them as the basis of his opinion that appellant met the standard of care in providing medical services to Patients 1 through 28. Moreover, Ms. Woodruff, appellant's office manager, also referred to State's Exhibits 1 through 28 throughout her testimony, identified her own handwriting, and never challenged the authenticity of these exhibits which were kept in the normal course of business in appellant's Springfield office. Tr. 528-529.

This court will note that the traditional rules of evidence are relaxed in administrative hearings. See *Haley v. Ohio State Dental Board* (1982), 7 Ohio App. 3d 1; see also O.A.C. 4731-13-25. Clearly, both experts in this case, Dr. Parran and Dr. Knott, were capable of distinguishing the respective patient's medical record, as noted by appellant, from other documents such as a prescription profile or a law enforcement record as indicated by their testimony.

⁸ The record shows that the Hearing Examiner conducted a hearing on May 29, 2008 on appellant's Motion in Limine seeking to exclude State's Exhibits 1 through 28. The Motion in Limine was denied.

Moreover, expert medical testimony is not mandatory in a medical disciplinary proceeding where the issue is whether a physician's conduct falls below a reasonable standard of medical care. See *Arlen v. State Medical Board of Ohio* (1980), 61 Ohio St. 2d 168; see also *Reed v. State Medical Board of Ohio* (2005), 162 Ohio App. 3d 429. Thus, the Board in this case did not have to rely on the experts' testimony since it was perfectly capable of determining on its own whether appellant fell below a reasonable standard of patient medical care.

In this case, Dr. Parran was well qualified to testify regarding the standard of care issues before the Board. He is Board certified in internal medicine with a subspecialty in addiction medicine. He treats patients in a clinical setting who may or may not have addiction issues. He was a member of the state taskforce that developed the Board's rules concerning intractable pain. Thus, his testimony was relevant regarding the standard of care for similarly situated practitioners in the medical community. Appellant's expert, Dr. Knott, had not practiced in Ohio since 1989 and had never practiced under the Board's rules concerning the treatment of intractable pain. Tr. 610-612. Thus, there was a succinct basis for the Board to rely on the credibility of Dr. Parran over the testimony of Dr. Knott, as it did in this case.

Even when assuming that the exhibits in question are inadmissible hearsay, upon review, it was permissible for the Board to rely on evidence that may have been based on hearsay. Statements or other evidence that may constitute inadmissible hearsay are permitted in administrative proceedings where the rules of evidence are relaxed. See *Simon v. Lake Geauga Printing Co.*, (1982), 69 Ohio St.2d 41, 44. However, discretion to consider hearsay evidence cannot be exercised in an arbitrary manner. See *Fox v. Parma Community Gen. Hosp.*, 160 Ohio App.3d 409 quoting *Menon v. Stouder Mem. Hosp.* (Feb. 21, 1997),

1997 Ohio LEXIS 567. This court concludes as a matter of law and after a thorough review of the record, that the Hearing Examiner did not admit hearsay evidence arbitrarily.

C. Appellant asserts that the Board erred in denying its requests for continuances.

O.A.C. 4731-13-06(D) sets forth the rule governing continuances in adjudicatory hearings:

No continuance of an adjudicatory hearing under division (G) or (I) of section 4731.22 of the Revised Code shall be granted without the written agreement of the respondent or the respondent's attorney or attorneys and of the board through its secretary and supervising member.

After the Board issued its Notice of Opportunity to appellant on October 10, 2007, agreed in writing to a sixty day continuance of the hearing that was set for November 16, 2007. The hearing was rescheduled to Monday, January 28, 2008. The record shows that on Friday, January 25, 2008 appellant obtained an *ex parte* temporary restraining order prohibiting the Board from conducting its hearing on January 28, 2008. The temporary restraining order ended by operation of law and the Board re-set the hearing for June 2, 2008. Clearly, given these facts, the Board did not err as a matter of law. The third motion for a continuance was filed by appellant on May 15, 2008. This court notes that as a matter of law, the Board was within its discretion to deny appellant's third attempt to delay the administrative proceedings.

It is important to note that this Court did not consider the underlying criminal conviction in making its decision. Thus, the decision to affirm the Board's August 13, 2008

Order was not based on appellant's criminal matter since the Ohio Supreme Court remanded that case to the trial court and thus, the matter is unresolved and still pending. See

State v. Nucklos, Slip Opinion No. 2009-Ohio-792. The decision reached by this court only considered the overwhelming evidence of the other aspects of this case.

The Board's primary mission is to protect the public against unscrupulous medical practices. The Board is comprised of twelve members: nine physicians and three non-physician public members. Each board member is appointed by the Governor and serves a five-year term. Thus, a majority of the Board's members are experts in their own right since they are doctors and already possess the specialized knowledge needed to determine the acceptable standard of general medical practice. See *Arlen v. The State Medical Board of Ohio* (1980), 61 Ohio St. 2d 168; see also *In re Williams* (1991), 60 Ohio St. 3d 85, 87.⁹

This court concludes that a majority of the Board members themselves possess the expertise necessary to determine if the appellant fell below the minimum standards of practice and all other matters regarding appellant's conduct that were before the Board. Accordingly, this Court concludes that there was reliable, probative and substantial evidence that appellant had a fair and impartial hearing, and that the hearing was conducted in accordance with law.

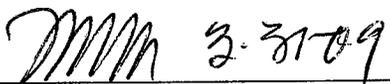
This court concludes that the conduct of appellant, as set forth in the Hearing Examiner's Findings of Fact and Conclusions of Law and as supported by the record, supports that there is reliable, probative and substantive evidence that appellant violated R.C. 4731.22(B)(2), R.C. 4731.22(B)(3), R.C. 4731.22(B)(6), R.C. 4731(B)(20) and O.A.C. 4731-21-02. Therefore, appellant's arguments are not well-taken and are hereby **OVERRULED.**

⁹ The Medical Board is comprised of twelve members: nine physicians and three non-physician public members. Each Board member is appointed by the Governor and serves a five-year term.

DECISION

Based on the foregoing, and upon a review of the record, this court concludes that there is reliable, probative and substantial evidence supporting the August 13, 2008 Order of the State Medical Board of Ohio. Moreover, this court concludes that the Board's Order is in accordance with law. The Board's August 13, 2008 Order is hereby **AFFIRMED**.

It is so ordered.



Judge Nodine Miller

Copies to:

Elizabeth Collis, Esq.
Terri-Lynne Smiles, Esq.
Collis, Smiles & Collis
1650 Lake Shore Drive, Suite 225
Columbus, Ohio 43204
Counsel for Appellant

Richard Cordray, Esq.
Barbara Pfeiffer, Esq.
Karen Unver, Esq.
Office of the Attorney General
Health and Human Services Section
State Office Tower
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3400
Counsel for Appellee

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

William W. Nucklos, M.D.,	:	
Appellant-Appellant,	:	
v.	:	No. 08AP-510 (C.P.C. No. 07CVF10-14544)
State Medical Board of Ohio,	:	(REGULAR CALENDAR)
Appellee-Appellee.	:	

O P I N I O N

Rendered on November 4, 2008

Dinsmore & Shohl, LLP, Eric J. Plinke and Janice E. Casanova, for appellant.

Nancy H. Rogers, Attorney General, Barbara J. Pfeiffer and Karen A. Unver, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

T. BRYANT, J.

{¶1} Appellant, William W. Nucklos, M.D., appeals from a judgment of the Franklin County Court of Common Pleas which dismissed his appeal seeking reversal of a summary suspension of his medical license by appellee, State Medical Board of Ohio ("Board"). For the following reasons, we dismiss this appeal as moot.

{¶2} By order dated October 10, 2007, the Board, pursuant to R.C. 4731.22(G), summarily suspended appellant's license to practice medicine based upon the

recommendation of the Board's secretary and supervising member that there existed clear and convincing evidence that appellant violated R.C. 4731.22(B)(6) and that his continued practice presented a danger of immediate and serious harm to the public. On October 25, 2007, appellant appealed the Board's October 10, 2007 order to the common pleas court pursuant to R.C. 119.12. On November 2, 2007, appellant requested an administrative hearing before the Board.

{¶3} On November 9, 2007, the Board filed a motion to dismiss the appeal for lack of jurisdiction. In particular, the Board argued that appellant commenced the appeal without statutory authority to do so, failed to exhaust his administrative remedies, failed to set forth the grounds for his appeal, and pursued an appeal which was premature because the order appealed from was not a final appealable order. By decision and entry filed May 16, 2008, the common pleas court sustained the Board's motion to dismiss, finding that appellant had no legal right to seek redress of the summary suspension under R.C. 119.12 where the appeal is filed prior to the summary suspension hearing.

{¶4} Appellant appeals from the trial court's May 16, 2008 decision and entry, advancing a single assignment of error, as follows:

FIRST ASSIGNMENT OF ERROR: THE TRIAL COURT ERRED IN ITS MAY 16, 2008 ENTRY DISMISSING DR. NUCKLOS' ADMINISTRATIVE APPEAL AND FINDING THAT DR. NUCKLOS HAD NO LEGAL RIGHT TO APPEAL THE SUMMARY SUSPENSION UNDER THE PROVISIONS OF ORC 119.12.

{¶5} Initially, we must address an issue that was raised by the panel at oral argument—whether this appeal is moot. In *Ridgeway v. State Med. Bd. of Ohio*, Franklin App. No. 06AP-1197, 2007-Ohio-5657, a physician opined by letter to the Board that Dr.

Ridgeway suffered from alcoholism. In response to the letter, Dr. Ridgeway filed a complaint against the Board seeking injunctive and declaratory relief to prevent the Board from summarily suspending his medical license based upon the physician's opinion.

{¶6} The trial court denied Dr. Ridgeway a temporary restraining order and summarily suspended Dr. Ridgeway's medical license. Dr. Ridgeway appealed the suspension to the common pleas court and simultaneously requested an administrative hearing on the matter. Upon the Board's motion, the trial court consolidated Dr. Ridgeway's injunctive and declaratory action with his appeal of the summary suspension. Despite his contention that disciplinary action against his license was unwarranted, the Board issued a final administrative order that, in part, required Dr. Ridgeway to obtain alcohol treatment and suspended his medical license for three months.

{¶7} Dr. Ridgeway appealed the Board's final administrative order to the trial court. The Board notified the trial court assigned to the consolidated actions of the appeal of the final administrative order and asserted that Dr. Ridgeway's appeal of the final administrative order rendered the consolidated actions moot. The trial court agreed and issued a decision and judgment entry dismissing the consolidated actions.

{¶8} On appeal, Dr. Ridgeway asserted, inter alia, that the trial court erred by dismissing the appeal of the summary suspension on the basis of mootness. This court disagreed. At the outset, this court engaged in a general discussion regarding the doctrine of mootness, noting that "[a]ctions are moot when ' they involve no actual genuine, live controversy, the decision of which can definitely affect existing legal relations." ' " *Ridgeway*, at ¶11, quoting *Lingo v. Ohio Cent. RR., Inc.*, Franklin App. No. 05AP-206, 2006-Ohio-2268, at ¶20, quoting *Grove City v. Clark*, Franklin App. No. 01AP-

1369, 2002-Ohio-4549, at ¶11. We further noted that "Ohio courts have long recognized that a court should not entertain jurisdiction over cases that are not actual controversies." *Id.*, citing *Tschantz v. Ferguson* (1991), 57 Ohio St.3d 131, 133, and *State ex rel. Eliza Jennings, Inc. v. Noble* (1990), 49 Ohio St.3d 71, 74.

{¶9} This court applied the mootness doctrine to Dr. Ridgeway's appeal seeking reversal of the summary suspension. Quoting R.C. 4731.22(G), which provides, in part, that "[a]ny summary suspension * * * shall remain in effect * * * until a final adjudicative order issued by the board pursuant to this section and Chapter 119 of the Revised Code becomes effective," we noted that the Board had issued a final adjudicative order in the matter. We concluded that Dr. Ridgeway's license "was no longer under summary suspension and his attempts to contest the summary suspension are moot." *Ridgeway*, at ¶12, citing *Vogelsong v. Ohio State Bd. of Pharmacy* (1997), 123 Ohio App.3d 260, 267, and *Angerman v. State Med. Bd. of Ohio* (Feb. 27, 1990), Franklin App. No. 89AP-896.

{¶10} We also disagreed with Dr. Ridgeway's contention that his consolidated actions should be excepted from the mootness doctrine because they presented issues capable of repetition yet evading review. We noted that "[a]lthough an action may be moot, a court may still resolve it if: '(1) the challenged action is too short in its duration to be fully litigated before its cessation or expiration, and (2) there is a reasonable expectation that the same complaining party will be subject to the same action again.'" *Ridgeway*, at ¶13, quoting *State ex rel. Calvary v. Upper Arlington* (2000), 89 Ohio St.3d 229, 231. Applying *Calvary*, we found that even if Dr. Ridgeway had demonstrated that a summary suspension does not exist long enough to review it, he failed to present any evidence establishing that he expected the Board to issue a summary suspension against

his license again. Accordingly, we concluded that Dr. Ridgeway's consolidated actions were moot and affirmed the trial court's judgment.

{¶11} In this case, counsel for both parties acknowledged at oral argument that the Board issued a final adjudicative order in this matter on August 13, 2008¹ and that appellant's appeal of that order is pending in the common pleas court. Appellant argued that *Ridgeway* is inapplicable to the instant case because the two cases are procedurally distinguishable. In particular, appellant noted that in *Ridgeway*, the Board entered the final adjudicative order before the case reached the common pleas court; accordingly, the summary suspension was already nullified by the time the common pleas court dismissed the appeal as moot. In contrast, the adjudicative order here was entered after the common pleas court rendered its judgment; accordingly, the summary suspension was still valid at the time the common pleas court reviewed it. Appellant urges that we remand the case to the common pleas court to determine the mootness issue.

{¶12} Appellant's attempt to distinguish *Ridgeway* is unavailing. Pursuant to R.C. 4731.22(G), entry of the Board's final adjudicative order dissolves the summary suspension order. This is true no matter when in the litigation process the Board issues the order. "When circumstances prevent an appellate court from granting relief in a case, the mootness doctrine precludes consideration of those issues." *Schwab v. Lattimore*, 166 Ohio App.3d 12, 2006-Ohio-1372, at ¶10, citing *In re Bailey*, Hamilton App. No. C-040014, 2005-Ohio-3039, at ¶9. Thus, because the Board has issued a final adjudicative order in this case, appellant's attempt to contest the summary suspension order is moot.

¹ As noted, appellant, on November 2, 2007, requested an administrative hearing before the Board. The Board set the matter for hearing within the 15-day period mandated by R.C. 4731.22(G). However, as a result of appellant's legal maneuvering, the Board did not hold a hearing until early June 2008.

{¶13} Further, appellant has failed to present this court with any reason to except his appeal of the summary suspension from the mootness doctrine. Appellant has not established that the issue in this case is capable of repetition yet evades review. As in *Ridgeway*, appellant contends the summary suspension is too short in its duration to be fully litigated. However, he has not presented any evidence establishing that he expects that he will again be subject to a summary suspension of his medical license. Accordingly, this appeal is moot, and we decline to reach the merits of appellant's only assignment of error.

{¶14} For the foregoing reasons, appellant's assignment of error is overruled and this appeal is dismissed.

Appeal dismissed.

KLATT and TYACK, JJ., concur.

T. BRYANT, J., retired of the Third Appellate District,
assigned to active duty under authority of Section 6(C), Article
IV, Ohio Constitution.

IN THE COURT OF COMMON PLEAS,
FRANKLIN COUNTY, OHIO

STATE MEDICAL BOARD
OF OHIO

2008 AUG 25 P 3: 35

WILLIAM W. NUCKLOS, M.D.
1671 Heatherwae Loop
Powell, Ohio 43065

2008 AUG 29 P 12: 33

08 CV F 8 122 30

Appellant,

Case No. _____

v.

Judge _____

STATE MEDICAL BOARD OF OHIO
30 East Broad Street, 3rd Floor
Columbus, OH 43215-6127,

Appellee.

FILED
COMMON PLEAS COURT
FRANKLIN CO. OHIO
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CLERK OF COURTS

NOTICE OF APPEAL

William W. Nucklos, M.D. ("Appellant"), pursuant to Ohio Revised Code Section 119.12, hereby appeals the final decision of the State Medical Board of Ohio ("Appellee"), which permanently revoked Appellant's license to practice as a physician in the State of Ohio in Appellee's *Entry of Order*, issued on August 13, 2008 and mailed to Appellant on August 15, 2008, a copy of which is attached hereto as Exhibit "A" (the "Appellee Entry of Order").

The decision of Appellee is not supported by reliable, probative, and substantial evidence and is not in accordance with law. Specifically, the State failed to show by reliable, probative and substantial evidence that Dr. Nucklos' practice failed to conform to minimal standards of care of similar practitioners, pursuant to R.C. 4731.22(B)(6), or that Dr. Nucklos sold, gave away or personally furnished drugs for other than legal or legitimate therapeutic purposes in violation of R.C. 4731.22(B)(3). To prove its case, the

State did not rely upon a review of Dr. Nucklos' medical records, but instead based its decision to revoke his license after reviewing an incomplete *compilation* of documents, some of which were seized from his office and some of which were from other sources, unavailable to Dr Nucklos. The records that the State relied upon were incomplete, contained inaccuracies, and also included investigative information that was never a part of the original medical records. The expert witness who testified on behalf of the State was also not provided with copies of Dr. Nucklos' medical records to review, but was merely presented with the *compiled* documents to review. Based on the fact that the decision of the State to revoke Dr. Nucklos' license was based on unreliable evidence, the decision must be reversed.

The State failed to prove its case by reliable, probative and substantial evidence by relying upon the expert testimony of Dr. Theodore Parran¹, who is not a physical medicine and rehabilitation specialist and should never have been qualified by the State to provide testimony against Dr. Nucklos in this case.

In addition, the State failed to charge Dr. Nucklos with violating R.C. 4731.052, which is the Medical Board statute that governs the treatment of patients with intractable pain. This statute was drafted by the legislature to protect physicians who treat patients with intractable pain, and specifically prohibits disciplinary actions unless a physician has violated this statute. In this instant case though, the State did not even charge Dr. Nucklos with violating R.C. 4731.052, therefore the decision of Appellee to revoke Appellant's medical license is contrary to law.

¹ While Dr. Parran is a physician licensed to practice medicine in the State of Ohio, his education, training and experience is in the area of addiction medicine. Dr. Parran is not qualified to provide testimony regarding the treatment of patients with intractable pain by a physician who has been educated and trained in physician medicine and rehabilitation.

STATE MEDICAL BOARD
OF OHIO
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Finally, the State erred as a matter of law by failing to grant a request to continue the administrative hearing date. Pursuant to O.A.C. 4731-13-06, Appellee has the authority to continue a hearing as long as reasonable case and proper diligence is presented and as long as no harm to the public would result. At the time the continuance was requested, Dr. Nucklos' license to practice medicine was under summary suspension by the State, therefore the continuance would not have caused any harm to the public. A continuance of the hearing was requested to allow counsel to adequately prepare for a hearing that was scheduled to last five days. By failing to allow for the continuance, the decision of the Appellee is contrary to law and should be reversed.

Therefore, the decision of Appellee to permanently revoke Dr. Nucklos' medical license should be reversed by this Court.

Respectfully submitted,



Elizabeth Y. Collis, LLC (#0061961)
Collis, Smiles & Collis, LLC
1650 Lake Shore Drive, Suite 225
Columbus, Ohio 43204
Tele: (614) 486-3909
Fax: (614) 486-2129
Email: beth@collislaw.com

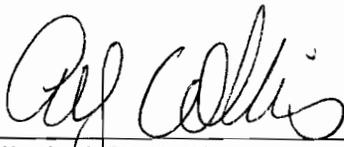
Counsel for Appellant
William W. Nucklos, M.D.

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2008 AUG 29 P 12:35

STATE MEDICAL BOARD
OF OHIO
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CERTIFICATE OF SERVICE

I certify that this *Notice of Appeal* was served this 25th day of August, 2008, via hand delivery upon Appellee, Ohio State Medical Board, 30 E. Broad Street, 3rd Floor, Columbus, Ohio 43215, and via first class mail, postage prepaid, upon counsel for Appellee, Barbara Pfeiffer, Esq. and Karen Unver, Esq., Assistant Attorneys General, Office of the Ohio Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215.



Elizabeth Y. Collis

STATE MEDICAL BOARD
OF OHIO
2008 AUG 29 P 12: 35

STATE MEDICAL BOARD
OF OHIO
2008 AUG 25 P 3: 30

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.
Executive Director



(614) 466-3934
med.ohio.gov

August 13, 2008

William W. Nucklos, M.D.
1671 Heatherwae Loop
Powell, OH 43065

RE: Case No. 07-CRF-004

Dear Doctor Nucklos:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 13, 2008, 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 an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with 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

A handwritten signature in black ink, appearing to read "Lance A. Talmage M.D.", is written over the typed name.

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3934 3487 3085
RETURN RECEIPT REQUESTED

CC: Elizabeth Y. Collis, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3934 3487 3092

Mailed 8-15-08

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 August 13, 2008, 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 William W. Nucklos, M.D., Case No. 07-CRF-004, as it appears in the Journal of the State Medical Board of Ohio.

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



Lance A. Talmage, M.D.
Secretary

(SEAL)

August 13, 2008

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

* CASE NO. 07-CRF-004

WILLIAM W. NUCKLOS, M.D.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on August 13, 2008.

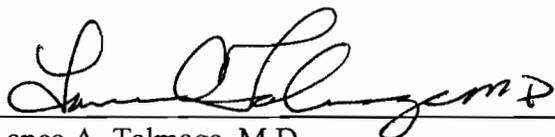
Upon the Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the 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 William W. Nucklos, 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.

(SEAL)


Lance A. Talmage, M.D.
Secretary

August 13, 2008
Date

2008 JUL 18 A 10: 35

**REPORT AND RECOMMENDATION
IN THE MATTER OF WILLIAM W. NUCKLOS, M.D.
Case No. 07-CRF-004**

The Matter of William W. Nucklos, M.D., was heard by R. Gregory Porter, Hearing Examiner for the State Medical Board of Ohio, on June 2 through 6, and June 12, 2008.

INTRODUCTION

Basis for Hearing

In a Notice of Summary Suspension and Opportunity for Hearing dated October 10, 2007, the State Medical Board of Ohio [Board] notified William W. Nucklos, M.D., that, pursuant to Section 4731.22(G), Ohio Revised Code, the Board had adopted an Entry of Order summarily suspending Dr. Nucklos' certificate to practice allopathic medicine and surgery in Ohio. The Board further advised that continued practice would be considered practicing without a certificate, in violation of Section 4731.43, Ohio Revised Code. Moreover, the Board notified Dr. Nucklos that it intended to determine whether or not to take disciplinary action against his certificate based on allegations concerning his prescribing of controlled substances for twenty-eight patients in 2001 and 2002.

The Board alleged that Dr. Nucklos' conduct constitutes the following:

- “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as that language is used in Section 4731.22(B)(2), Ohio Revised Code.
- “[s]elling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for treatment in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug,” as that language is used in Section 4731.22(B)(3), Ohio Revised Code.
- “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that language is used in Section 4731.22(B)(6), Ohio Revised Code.
- “violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board,” as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit:

Rule 4731-21-02, Ohio Administrative Code, Utilizing Prescription Drugs for the Treatment of Intractable Pain.

The Board advised Dr. Nucklos of his right to request a hearing, and received his written request for hearing on November 2, 2007. (State’s Exhibits 34A, 34B)

Appearances

Nancy Hardin Rogers, Attorney General, and Barbara J. Pfeiffer and Karen A. Unver, Assistant Attorneys General, for the State.

Elizabeth Y. Collis, Esq., and Terri-Lynne B. Smiles, Esq., for the Respondent.

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EVIDENCE EXAMINED

Testimony Heard

Presented by the State

Theodore V. Parran, Jr., M.D.
William W. Nucklos, M.D.
Rebecca J. Marshall, Esq.

Presented by the Respondent

Tricia Woodruff
Ken G. Knott, M.D.

Exhibits Examined

Presented by the State

State’s Exhibits 1 through 28: Patient Records for Patients 1 through 28 (sealed to protect confidentiality).

State’s Exhibit 29: Excluded, but proffer accepted.

State’s Exhibit 29A: Redacted copy of State’s Exhibit 29, the transcript of the testimony of Theodore V. Parran, Jr., M.D., from the February 2006 criminal trial of Dr. Nucklos.

State's Exhibit 30: Curriculum vitae of Dr. Parran.

State's Exhibits 31 through 33: Excluded, but proffers accepted.

State's Exhibit 31A: Redacted copy of State's Exhibit 31 consisting of a copy of the October 7, 2007, expert report of Dr. Parran, with attached redacted copy of the transcript of Dr. Parran's testimony from Dr. Nucklos' criminal trial.

State's Exhibits 32A and 33A: Redacted copies of State's Exhibits 32 and 33, consisting of the criminal trial testimony of Dr. Nucklos and Kenneth G. Knott, M.D., respectively.

State's Exhibit 34A through 34D: Procedural exhibits, including notice of opportunity for hearing.

State's Exhibits 35 and 35A: Patient keys (sealed to protect confidentiality).

State's Exhibit 36: Drawing showing the layout of Dr. Nucklos' offices.

Presented by the Respondent

Respondent's Exhibit A: Curriculum vitae of Dr. Knott.

Respondent's Exhibit B: Copy of the April 11, 2008, expert report of Dr. Knott.

Respondent's Exhibits C through E, G through H, J, L through V, and X through BB: Letters of support for Dr. Nucklos.

Respondent's Exhibits I and W: Letters of support for Dr. Nucklos from Dr. Nucklos' patients (sealed to protect patient confidentiality).

Respondent's Exhibit DD: Copies of documents maintained by the Board regarding Dr. Nucklos, including the following: Decision and Entry, *Nucklos v. State Medical Board*, Franklin Common Pleas No. 07-CVF-10-14544 (May 13, 2008); Order, *Nucklos, supra* (Jan. 25, 2008); multiple Board Orders in 2006 and 2007; and pages regarding Dr. Nucklos from the Ohio eLicense Center (downloaded June 3, 2008).

Board Exhibits

Board Exhibit A: Transcript of Prehearing Conference held May 29, 2008.

Board Exhibit B: State's motion regarding redactions filed June 18, 2008.

Board Exhibit C: Entry filed June 20, 2008, granting State's motion regarding redactions.

Board Exhibit D: Unredacted pages from the Hearing Transcript. See Procedural Matters 2, below.

PROCEDURAL MATTERS

1. After the last day of hearing on June 12, 2008, the hearing record was held open for the purpose of addressing issues regarding redaction of certain exhibits. On June 18, 2008, the Hearing Examiner conferred with the parties, and made certain rulings regarding redactions. The State subsequently filed a motion requesting the Hearing Examiner to admit redacted copies of certain exhibits pursuant to the parties' stipulation. The Hearing Examiner granted the motion in an Entry dated June 20, 2008, and the record closed on that date. (Bd. Exs. B, C)
2. A portion of the Hearing Transcript, from line 2 of page 273 through line 13 of 274, has been redacted per the Hearing Examiner's ruling at page 274, lines 14 through 16. The unredacted pages were marked Board Exhibit D and held as a proffer.
3. Upon reviewing State's Exhibits 29A, 32A, and 33A, the Hearing Examiner made additional redactions of patient identifying information:
 - State's Exhibit 29A at page 733, line 20 (the same redaction was made to the transcript attached to State's Exhibit 31);
 - State's Exhibit 32A at page 1666, line 23; page 1715, line 10; page 1737, line 22; page 1752, line 10; and page 1773, line 16; and
 - State's Exhibit 33A at page 986, lines 7-8.

SUMMARY OF THE EVIDENCE

All exhibits and transcripts of testimony were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

Background Information

William W. Nucklos, M.D.

1. William W. Nucklos, M.D., obtained his medical degree in 1977 from The Ohio State University [OSU] College of Medicine. Previous to that, in 1973, Dr. Nucklos had obtained a Master's degree in psychology from OSU. Following medical school, Dr. Nucklos did research concerning patient rehabilitation from knee surgery at OSU for the Weshler's Foundation. Dr. Nucklos then participated in a general medicine residency

at Barberton's Citizen Hospital in Barberton Ohio, and then returned to OSU where he participated in a three-year residency in physical medicine and rehabilitation. (State's Exhibit [St. Ex.] 32A at 1625-1630)

After finishing his residency, Dr. Nucklos opened a solo practice in Westerville, Ohio, where he practiced physical medicine and rehabilitation "as one of the areas" of his practice. Dr. Nucklos testified that he had practiced physical medicine and rehabilitation in Westerville and Columbus for 17 years. From 2001 through around October 2002, Dr. Nucklos maintained an office in Springfield Ohio, where he saw patients one day per week. (St. Ex. 32A at 1631)

2. In February 2006, Dr. Nucklos was tried criminally in the Clark County [Ohio] Court of Common Pleas for allegations that concerned his practice in Springfield. Dr. Nucklos was found to be guilty; however, the guilty verdict was later overturned on appeal. (Respondent's Exhibit [Resp. Ex.] DD; Hearing Transcript [Tr.] at 239-241, 406-408)

Theodore V. Parran, Jr., M.D.

3. Theodore V. Parran, Jr., M.D., testified as an expert on behalf of the State. Dr. Parran obtained his medical degree in 1982 from the Case Western Reserve University School of Medicine [CWRU] in Cleveland, Ohio. From 1982 through 1985, Dr. Parran participated in an internship and residency in internal medicine at Baltimore City Hospital, Johns Hopkins University School of Medicine, in Baltimore, Maryland. From 1985 through 1986, Dr. Parran was Chief Medical Resident in that program. Dr. Parran was certified by the American Board of Internal Medicine in 1986, and was certified in Addiction Medicine by the American Society of Addiction Medicine in 1994. From 1994 through 1988, Dr. Parran was licensed to practice medicine in Maryland, and from 1988 through the present, he has been licensed to practice medicine in Ohio. (St. Ex. 30; Tr. at 12-13)

Since his residency, Dr. Parran has held faculty appointments at Johns Hopkins University and CWRU. (St. Ex. 30)

4. Dr. Parran testified that, during the time he served as Chief Medical Resident at Baltimore City Hospital, he had spent approximately 50 percent of his time working in the field of addiction medicine. Since that time, Dr. Parran has continued to focus part of his professional activity in that field. (Tr. at 14-15)
5. Currently, Dr. Parran's practice includes: (a) an Addiction Medicine Consultant at University Hospitals of Cleveland; (b) Medical Director of the Office of Continuing Medical Education at Case Western Reserve University School of Medicine; (c) Medical Director of the Veterans Addiction Recovery Center at the Lewis Stokes – Cleveland VAMC; (d) Associate Medical Director of Rosary Hall at Saint Vincent Charity Hospital and Health Center; (e) Medical Director of the Cleveland Treatment Center's Methadone Maintenance Center; (f) Addiction Consultant to University Hospitals Chronic Pain

Management Center; (g) Medical Director of the Detoxification Unit at Huron Hospital; (h) Addiction and Medical Consultant at Windsor Hospital; (i) Medical Director of the Harbor Light Detoxification Unit of the Salvation Army; and (j) Associate Medical Director of the Stella Maris Detoxification Center. (St. Ex. 30)

6. Dr. Parran testified that he spends about one-third of his time teaching. (Tr. at 22)

Dr. Parran further testified that, in his clinical work, approximately two-thirds to three-quarters of his work concerns patients with addictive disease. The remaining one quarter to one third “is purely internal medicine, primary care, either consultation work, you know, managing medical issues, along with maybe a psychiatrist or whatever, or internal medicine outpatient work.” Dr. Parran added that he “easily spend[s] 40 hours a week seeing patients.” (Tr. at 23-24)

Moreover, Dr. Parran testified that he treats patients who suffer from intractable pain, and that he utilizes controlled substances to treat them. Dr. Parran further testified that most, but not all, have addiction issues. Others were referred to him because their physicians had been uncomfortable treating them or they had asked for another physician to manage their pain treatment. Dr. Parran testified that he currently sees about 50 patients for intractable pain who do not have addiction issues. (Tr. at 26-28)

7. Dr. Parran testified that he had assisted the Board in the drafting of the Ohio Administrative Code rules concerning the treatment of intractable pain. (Tr. at 19)
8. Dr. Parran testified that he had provided testimony on behalf of the State during a 2006 criminal trial of Dr. Nucklos. (Tr. at 36-37)
9. Dr. Parran testified that he had authored an expert report regarding Dr. Nucklos for the Board, which is dated October 7, 2007. Dr. Parran noted that, in preparing that report, he had reviewed copies of medical records of Patients 1 through 28, a transcript of his own testimony from the criminal trial, and a copy of an expert report that he had prepared for the criminal matter. Dr. Parran also reviewed State laws concerning the prescribing of opioids. (Tr. at 39-40)

Kenneth G. Knott, M.D.

10. Kenneth G. Knott, M.D., testified as an expert on behalf of Dr. Nucklos. Dr. Knott obtained his medical degree in 1976 from the University of Tennessee Center for the Health Sciences in Memphis, Tennessee. From January to June 1977, Dr. Knott participated in a rotating internship at Good Samaritan Hospital in Phoenix, Arizona. From July 1977 to June 1978, he participated in a residency program in physical medicine and rehabilitation at that same institution. From July 1978 to June 1980, Dr. Knott participated in a residency in physical medicine and rehabilitation at OSU. Dr. Knott was board-certified in physical medicine and rehabilitation in May 1985. He holds an active medical

license in Georgia, and inactive medical licenses in Tennessee, Arizona, and Ohio. Dr. Knott's Ohio license expired in December 1990. (Resp. Ex. A; Tr. at 599-600)

From 1978 to 1987, Dr. Knott was a Clinical Instructor in the Department of Physical Medicine and Rehabilitation at OSU. From 1979 to the present, Dr. Knott has been a specialty examining physician for the Ohio Industrial Commission. Further, from 1980 through 1988, Dr. Knott was engaged in the private practice of physical medicine and rehabilitation at St. Anthony Medical Center in Columbus, Ohio. From October 1987 to January 1995, Dr. Knott was involved in the private practice of physical medicine and rehabilitation at Executive Medical of Georgia, Inc., in Marietta, Georgia. Beginning in January 1994 through the present, Dr. Knott has been a reviewing physician for the Georgia State Composite Board of Medical Examiners. In addition, beginning in January 1995 through the present, Dr. Knott has been the medical director of Health Horizons, Inc., in Marietta. Finally, from April 1999 to June 2007, Dr. Knott was the medical director of Renew Youth in Marietta. (Resp. Ex. A)

11. Dr. Knott testified that, in addition to his work experience noted in his curriculum vitae, he has also been the medical director at ProHBO in Marietta. Dr. Knott further testified that "ProHBO is the administration of hyperbaric oxygen treatment." When asked why he had not listed that in his curriculum vitae, Dr. Knott testified that it had been omitted for "[n]o particular reason." Dr. Knott testified that hyperbaric oxygen treatment "is given to people with a condition called the bends. * * * It's a diving condition called nitrogen narcosis. That's only one of the many indications. But that's the type of treatment that it is. It's in a pressurized tank with 100% oxygen." (Tr. at 614-617)
12. Dr. Knott acknowledged that he has not conducted any reviews for the Georgia State Composite Board of Medical Examiners for the past 10 years. (Tr. at 619)
13. Dr. Knott testified that, in his private practice, he sees patients "with a multitude of neurological, musculoskeletal-type injuries. I also see people with collagen vascular diseases, degenerative diseases of neurological origin, such as Lou Gehrig's disease, polio, strokes, head injuries, spinal cord injuries, and chronic pain problems." Dr. Knott further testified that he holds privileges at Kennestone Hospital in Marietta. (Tr. at 600-601)

Dr. Knott estimated that he sees 20 to 30 patients on a daily basis. (Tr. at 625)

14. Dr. Knott testified that physical medicine and rehabilitation is a specialty recognized by the American Board of Medical Specialties [ABMS]. Dr. Knott further testified that physical medicine and rehabilitation is a unique specialty and is actually two specialties in one. Dr. Knott stated that physical medicine involves utilizing a number of agents to affect a cure or provide relief, such as physical therapy modalities. Moreover, Dr. Knott testified that it is the only specialty recognized by ABMS "that has any training whatsoever in the use and application and understanding of physical medicine modalities: such things as exercise prescriptions; range of motion exercises; ultrasound; iontophoresis[;] * * * [l]aser applications; injection techniques; invasional techniques like epidurals, nerve blocks,

ligamentous injections, [and] trigger point injections. So it is a myriad of things we use physically to affect the care or provide relief.” (Tr. at 602-604)

Dr. Knott testified that the rehabilitation side of the specialty involves the treatment of catastrophic diseases or conditions. Dr. Knott further testified, “we take off where the traditional medical community stops.” Moreover, Dr. Knott testified:

We see some acute care patients, but most of ours are chronic care patients; such thing as spinal cord injuries, strokes, head injury, collagen vascular diseases such as rheumatoid arthritis, lupus, neurological conditions like multiple sclerosis, ALS, and you see all the muscular dystrophy patients, and cerebral palsy patients.

(Tr. at 604)

15. Dr. Knott testified that he has treated patients for chronic pain using controlled substances, and estimated that, over the last two years, he has treated approximately 15 percent of his patients with controlled substances. (Tr. at 602, 623)
16. Dr. Knott noted that Georgia does not have intractable pain rules such as Ohio’s. Dr. Knott further testified that he last practiced in Ohio in about 1989, and has never practiced under the Board rules concerning the treatment of intractable pain. (Tr. at 610-612)
17. Dr. Knott testified on Dr. Nucklos’ behalf at Dr. Nucklos’ criminal trial. Dr. Knott further testified that he testified at the criminal trial and at the Board hearing on a volunteer basis and was not been paid for his testimony. (St. Ex. 33A; Tr. at 824-825)
18. Dr. Knott testified that, prior to preparing his written report, he had reviewed the medical records and other documents contained in State’s Exhibits 1 through 28, the Board rules concerning the treatment of intractable pain, and relevant sections of the Ohio Revised Code. (Tr. at 605-606)
19. Dr. Knott testified that he knows Dr. Nucklos, and that he has known Dr. Nucklos for about 30 years. Dr. Knott testified that he first met Dr. Nucklos when they were both in the physical medicine and rehabilitation residency program at OSU. Dr. Knott noted that he was one year ahead of Dr. Nucklos in that program. (Tr. at 631-632)

Dr. Knott further testified that he and Dr. Nucklos are friends and that they have kept in touch during the past 30 years. Dr. Knott testified that he talks with Dr. Nucklos on probably a monthly basis. (Tr. at 825)

20. At Dr. Nucklos’ criminal trial in February 2006, Dr. Knott testified that Dr. Nucklos had purchased Dr. Knott’s medical practice in the 1990s. (St. Ex. 33A at 976)

Dr. Nucklos' Office in Springfield, Ohio

Testimony of Dr. Nucklos from the Criminal Trial

21. As stated earlier, Dr. Nucklos had practiced physical medicine and rehabilitation in Westerville and Columbus for 17 years. (St. Ex. 32A at 1631)
22. At his criminal trial, Dr. Nucklos testified about his Springfield, Ohio, office. Dr. Nucklos testified that, in 1997, he had met a fellow physician named Dr. Carl Jenkins at a continuing medical education conference. Dr. Jenkins practiced in Springfield, Ohio, where he provided treatment to bariatric medicine, acupuncture, and Workers' Compensation patients. Dr. Nucklos testified that he had previously heard about Dr. Jenkins in medical school, where he had been told, "'You really ought to meet him because you all have a lot of the same types of ideas as relates to being on the cutting edge of—of medicine.' That is, being willing to try new things and endeavor to help people." (St. Ex. 32A at 1632) After that meeting, Dr. Nucklos stayed in touch with Dr. Jenkins and they periodically exchanged ideas concerning medical care until Dr. Jenkins' death in around 2000. (St. Ex. 32A at 1632-1633)

Dr. Nucklos testified that when he had learned of Dr. Jenkins death he contacted Dr. Jenkins' widow and asked her about Dr. Jenkins medical practice. Ms. Jenkins put Dr. Nucklos in touch with, among others, Tricia Woodruff, the former office manager of Dr. Jenkins. Dr. Nucklos contacted Ms. Woodruff concerning reviving Dr. Jenkins weight management practice. Ms. Woodruff was interested and set about looking for office space in Springfield. After office space was located and the office was set up, Dr. Nucklos began seeing patients once per week for weight management. (St. Ex. 32A at 1634-1639)

23. Dr. Nucklos acknowledged that he had accepted only cash as payment at his Springfield office. When asked why, Dr. Nucklos answered that, first, most insurance would not pay for weight management, "and so we decided that to eliminate bookkeeping and red tape, we would accept cash. And actually it was no different in our Columbus office other than the fact that we accepted Worker's Comp and Medicare in the Columbus office." When asked how his cash-only policy had been communicated to patients, Dr. Nucklos indicated that his patients had been advised "out front" of that policy and the cost of his services. Dr. Nucklos further testified that, "some time after we got started," Ms. Woodruff made signs and posted them on the wall. (St. Ex. 32A at 1639-1641)
24. When asked when he had started acquiring pain management patients, Dr. Nucklos indicated that, in weight management, "you can only treat a person for 12 weeks and pretty soon you run out of individuals unless you're being very aggressive at your advertising. [New paragraph] Of course, we weren't aggressive at that; but we were steadily getting more requests for muscle, nerve, bone problems, which is the cornerstone of what physical medicine and rehabilitation specialists do. [New paragraph] We were getting request after request for that, and it sort of had a life of its own." (St. Ex. 32A at 1641-1642)

Testimony of Tricia Woodruff

25. Tricia Woodruff testified at hearing on behalf of Dr. Nucklos. Ms. Woodruff testified that she had been employed by Dr. Nucklos in his Springfield office during the period at issue in this matter. Prior to that, beginning in 1999 or 2000, she had been employed as the office manager for Dr. Jenkins in Springfield. She explained that Dr. Jenkins had a general practice but specialized in workers' compensation cases and weight management. Ms. Woodruff testified that she had worked for Dr. Jenkins for almost one year, until his death, after which she continued working for the practice for several weeks, distributing patient records, providing referrals to doctors who were taking new patients, and tying up loose ends of billing. (Tr. at 437-439, 484-485)
26. Ms. Woodruff testified that she had met Dr. Nucklos in February 2001, about five months after Dr. Jenkins died. She said that Dr. Nucklos had been interested in buying the practice and that she had met him through Dr. Jenkins' widow. (Tr. at 439-440)
27. Ms. Woodruff explained that the proposed purchase of the practice by Dr. Nucklos had "fallen through," but there was still a demand from patients, so he had decided to find a new location and open a practice. Ms. Woodruff helped Dr. Nucklos set up the office. She testified that many patients heard about Dr. Nucklos when they picked up their medical records from Dr. Jenkins' office and, in addition, Dr. Nucklos placed advertisements in newspapers. (Tr. at 439-442, 484-488)
28. Ms. Woodruff stated that Dr. Nucklos saw patients in the Springfield office only one day per week. She explained that the office was closed the rest of the week, and no other business used the office. (Tr. at 482-489, 502-503)
29. Ms. Woodruff testified that, although the Springfield office had begun as a weight management practice, the practice changed after a few months, and Dr. Nucklos began to see patients for pain management. When asked why the practice had changed, she responded that she was not sure, but that Dr. Nucklos had specialized in physical medicine and rehabilitation in Columbus, and she thought that "people got wind of that and knew that he could help them in the Springfield office." Nonetheless, the Springfield office continued to be open only one day per week. (Tr. at 443-444)
30. With regard to office procedures, Ms. Woodruff stated that Dr. Nucklos had taught her to interview new patients on the telephone, to learn whether they wanted to see him for pain management or weight management, whether they had been in a car accident, what kind of pain they had, whether they had seen physicians in the past, and whether they had any medical records. She stated that, once she knew the reason for the visit, she would schedule patients for an appointment and explain how the first visit would go. She testified that she had asked patients to bring any medical records, especially MRIs and CT scans. Ms. Woodruff stated that she did not make written notes of these interviews although she would sometimes write, next to the patient's name in the appointment book, the reason for the visit. (Tr. at 445-446, 491)

31. Ms. Woodruff stated that, on subsequent visits, after the patients signed in, she took their blood pressure, weight and pulse, if needed. She explained that Dr. Nucklos would tell her if he wanted the pulse or BP taken on every visit. (Tr. at 450-452, 464)
32. Ms. Woodruff testified that patients were sometimes ordered to have a urine screen. She stated that Dr. Nucklos would write a note on the prescription pad for the drug screen to be done at Mercy Reach, a drug and alcohol-dependency counseling center in Springfield. She testified that the lab report would come back within seven days, and she put the report into the patient's file so that Dr. Nucklos could review it on the next visit. She noted, however, that she was not always current with her filing, and she could not say that all urine-screen reports were filed in the patients' files. She further stated that there were times that she did not place a drug-screen result in the file because "the chart wouldn't happen to be there" or if Dr. Nucklos "happened to be standing there with me as I was going through the mail," and in those instances she would hand the lab report to him. (Tr. at 456-458, 460, 469, 515-516)

Ms. Woodruff testified that she had also performed medication checks when ordered to do so. Patients would be told to come to the office and bring their prescription bottles with them. She would ensure that the name on the prescription bottle matched the patient's name, and that the number of pills in each bottle corresponded to what the patient should have. She would then advise Dr. Nucklos of the results of the medication check and any discrepancy. (Tr. at 455-456, 512-514)

33. Ms. Woodruff testified that she had worked for Dr. Nucklos until August 2002, at which time she resigned due to health reasons. She stated that, after she left, Mrs. Nucklos and an office assistant worked in the office, which closed shortly thereafter in October 2002. She stated that, when she went on medical leave, she had communicated to others that filing needed to be done. Nevertheless, she is unaware if the filing was completed. (Tr. at 459-461, 503, 517)
34. Ms. Woodruff described Dr. Nucklos as "very caring and very sincere" with his patients. She stated: "He always treated every patient individually, not just as, you know, a patient number." She explained that he "got to know the patients" and "really cared about them." (Tr. at 474-475)
35. Ms. Woodruff recalled that the total number of patient files in Dr. Nucklos' Springfield office had been between 100 and 250. (Tr. at 539-540)

Pain Management in General

Testimony of Dr. Parran and Dr. Knott

36. Dr. Parran defined intractable pain as chronic pain (pain that has lasted longer than three months) that cannot be cured. Dr. Parran testified that the treatment of such patients may

entail the use of opiate or non-opiate medication, and typically also involves the use of interventions that are nonpharmacologic. (Tr. at 41-42)

Dr. Knott's testimony on this issue was similar, although he defined chronic pain as pain lasting longer than six months. (Tr. at 632-633)

Rule 4731-21-02, Ohio Administrative Code

37. Effective November 11, 2008, the Board promulgated Rule 4731-21-02, Ohio Administrative Code, which, along with other rules within Chapter 4731-21, places certain requirements upon practitioners who treat patients for intractable pain. Rule 4731-21-02 states as follows:

Utilizing prescription drugs for the treatment of intractable pain.

(A) When utilizing any prescription drug for the treatment of intractable pain on a protracted basis or when managing intractable pain with prescription drugs in amounts or combinations that may not be appropriate when treating other medical conditions, a practitioner shall comply with accepted and prevailing standards of care which shall include, but not be limited to, the following:

(1) An initial evaluation of the patient shall be conducted and documented in the patient's record that includes a relevant history, including complete medical, pain, alcohol and substance abuse histories; an assessment of the impact of pain on the patient's physical and psychological functions; a review of previous diagnostic studies and previously utilized therapies; an assessment of coexisting illnesses, diseases or conditions; and an appropriate physical examination;

(2) A medical diagnosis shall be established and documented in the patient's medical record that indicates not only the presence of intractable pain but also the signs, symptoms, and causes and, if determinable, the nature of the underlying disease and pain mechanism;

(3) An individualized treatment plan shall be formulated and documented in the patient's medical record. The treatment plan shall specify the medical justification of the treatment of intractable pain by utilizing prescription drugs on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions, the intended role of prescription drug therapy within the overall plan, and, when applicable, documentation that other medically reasonable treatments for relief of the patient's intractable pain have been offered or attempted without adequate or reasonable success. The prescription drug therapy shall be tailored to the individual medical needs of each patient. The practitioner shall document the patient's response to treatment and, as necessary, modify the treatment plan;

(4)(a) The practitioner's diagnosis of intractable pain shall be made after having the patient evaluated by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain. For purposes of this rule, a practitioner "specializes" if the practitioner limits the whole or part of his or her practice, and is qualified by advanced training or experience to so limit his or her practice, to the particular anatomic area, system, or organ of the body perceived as the source of the pain. The evaluation shall include review of all available medical records of prior treatment of the intractable pain or the condition underlying the intractable pain; a thorough history and physical examination; and testing as required by accepted and prevailing standards of care. The practitioner shall maintain a copy of any report made by any practitioner to whom referral for evaluation was made under this paragraph. A practitioner shall not provide an evaluation under this paragraph if that practitioner would be prohibited by sections 4731.65 to 4731.69 of the Revised Code or any other rule adopted by the board from providing a designated health service upon referral by the treating practitioner; and

(4)(b) The practitioner shall not be required to obtain such an evaluation, if the practitioner obtains a copy of medical records or a detailed written summary thereof showing that the patient has been evaluated and treated within a reasonable period of time by one or more other practitioners who specialize in the treatment of the anatomic area, system, or organ of the body perceived as the source of the pain and the treating practitioner is satisfied that he or she can rely on that evaluation for purposes of meeting the further requirements of this chapter of the Administrative Code. The practitioner shall obtain and review all available medical records or detailed written summaries thereof of prior treatment of the intractable pain or the condition underlying the intractable pain. The practitioner shall maintain a copy of any record or report of any practitioner on which the practitioner relied for purposes of meeting the requirements under this paragraph; and

(5) The practitioner shall ensure and document in the patient's record that the patient or other individual who has the authority to provide consent to treatment on behalf of that patient gives consent to treatment after being informed of the benefits and risks of receiving prescription drug therapy on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions, and after being informed of available treatment alternatives.

(B) Upon completion and satisfaction of the conditions prescribed in paragraph (A) of this rule, and upon a practitioner's judgment that the continued utilization of prescription drugs is medically warranted for the treatment of intractable pain, a practitioner may utilize prescription drugs on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions,

provided that the practitioner continues to adhere to accepted and prevailing standards of care which shall include, but not be limited to, the following:

(1) Patients shall be seen by the practitioner at appropriate periodic intervals to assess the efficacy of treatment, assure that prescription drug therapy remains indicated, evaluate the patient's progress toward treatment objectives and note any adverse drug effects. During each visit, attention shall be given to changes in the patient's ability to function or to the patient's quality of life as a result of prescription drug usage, as well as indications of possible addiction, drug abuse or diversion. Compliance with this paragraph of the rule shall be documented in the patient's medical record;

(2) Some patients with intractable pain may be at risk of developing increasing prescription drug consumption without improvement in functional status. Subjective reports by the patient should be supported by objective data. Objective measures in the patient's condition are determined by an ongoing assessment of the patient's functional status, including the ability to engage in work or other gainful activities, the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient. Compliance with this paragraph of the rule shall be documented in the patient's medical record;

(3) Based on evidence or behavioral indications of addiction or drug abuse, the practitioner may obtain a drug screen on the patient. It is within the practitioner's discretion to decide the nature of the screen and which type of drug(s) to be screened. If the practitioner obtains a drug screen for the reasons described in this paragraph, the practitioner shall document the results of the drug screen in the patient's medical record. If the patient refuses to consent to a drug screen ordered by the practitioner, the practitioner shall make a referral as provided in paragraph (C) of this rule;

(4) The practitioner shall document in the patient's medical record the medical necessity for utilizing more than one controlled substance in the management of a patient's intractable pain; and

(5) The practitioner shall document in the patient's medical record the name and address of the patient to or for whom the prescription drugs were prescribed, dispensed, or administered, the dates on which prescription drugs were prescribed, dispensed, or administered, and the amounts and dosage forms of the prescription drugs prescribed, dispensed, or administered, including refills.

(C) If the practitioner believes or has reason to believe that the patient is suffering from addiction or drug abuse, the practitioner shall immediately consult with an addiction medicine or other substance abuse specialist. For purposes of this rule, "addiction medicine or substance abuse specialist" means a physician who is

qualified by advanced formal training in addiction medicine or other substance abuse specialty, and includes a medical doctor or doctor of osteopathic medicine who is certified by a specialty examining board to so limit the whole or part of his or her practice. Prescription drug therapy may be continued consistent with the recommendations of the consultation, including, if the consulting addiction medicine or other substance abuse specialist recommends that it is necessary, prompt referral to an addiction medicine or other substance abuse specialist for physical examination and evaluation of the patient and a review of the referring practitioner's medical records of the patient. The practitioner shall document the recommendations of the consultation in the patient's record. The practitioner shall continue to actively monitor the patient for signs and symptoms of addiction, drug abuse or diversion. The practitioner shall maintain a copy of any written report made by any practitioner to whom referral for evaluation was made under this paragraph.

(Ohio Adm.Code 4731-21-02)

Further Testimony of Dr. Parran

38. Dr. Parran testified concerning the steps that he believes must be taken to provide proper care of patients with chronic intractable pain:

- A through history and physical examination.
- Verification or establishment of a clear diagnosis.
- Documentation of an adequate workup. Dr. Parran noted that this involves multiple steps.
- Assessment of functional capacity and impairment, and demonstration of impaired function.
- In Ohio, a consultation with a physician who specializes in treatment of the organ system or part of the body involved in the chronic intractable pain syndrome. The purpose of the consultation is to verify the presence or absence of the chronic intractable pain.
- An individualized treatment plan that is adjusted over time based upon data obtained during ongoing monitoring of the patient.

(Tr. at 42-43)

Dr. Parran further testified that chronic intractable pain "is a complicated clinical scenario." Among other things, it involves an extensive patient evaluation and developing or obtaining "a large amount of background information; prior medical records, prior studies, contacting pharmacies to find out how the patient's prescribing history has been, verification of the patient's adherence to previous treatment recommendations. All of that is part of the initial patient evaluation, really the initial database." Dr. Parran added that that information should be gathered at or before the patient's first visit, and noted that office staff can make arrangements for much of this information to be obtained before the

patient's first visit. Dr. Parran noted that, if this material is not available at the first appointment, it is "standard practice in order to obtain those very shortly within the time of the first appointment." (Tr. at 44-45)

Dr. Parran testified that, without having obtained the information described above, it becomes more difficult for a physician to prescribe medication and controlled substances to the patient. Moreover, Dr. Parran testified that, the more information that is available to the physician at the outset of treatment, "the more appropriate prescribing can be early on in the patient management course." (Tr. at 45-46)

39. When asked whether a lack of prior history and treatment records of a patient meant that the physician could not prescribe controlled substances at the first visit, Dr. Parran replied:

Not necessarily. The reality of clinical practice, and actually the reality of the rules that were put together, indicates that there is a period of time where—where physicians are expected to gather a database. And that period of time has been identified as 12 weeks or—or three months in Ohio.

(Tr. at 46)

Dr. Parran explained that some physicians' offices are appointment-only and schedule patient visits well in advance. Other physicians' practices accept walk-in patients. Dr. Parran testified that there is leeway for physicians in the latter group to obtain the necessary information subsequent to a patient's first visit; however, the data must be obtained. (Tr. at 46-47)

Dr. Nucklos' Testimony from the Present Hearing

40. Dr. Nucklos was called by the State to testify during the hearing on this matter. Based upon the advice of counsel, Dr. Nucklos invoked his Fifth Amendment privilege against self-incrimination for all of the substantive questions he was asked. (Tr. at 351-395)

However, Dr. Nucklos testified during his February 2006 criminal trial, and a redacted copy of the transcript of his testimony was admitted to the hearing record. (St. Ex. 32A)

State's Exhibits 1 through 28

41. State's Exhibits 1 through 28 contain Dr. Nucklos' medical records for Patients 1 through 28.
42. Dr. Parran testified that the medical records in this case are not exact duplicates of the original medical records that he had reviewed years ago for the criminal case. Dr. Parran noted that State's Exhibits 1 through 28 each contain copies of the patient's chart. In addition, the exhibits contain documents that would not have been included in Dr. Nucklos' original medical records. For example, Dr. Parran referred to State's Exhibit 2, which appears to contain copies of a police questionnaire completed by Patient 2 regarding this

matter. Dr. Parran testified that that would not have been part of Dr. Nucklos' medical record for that patient. (St. Ex. 2 at 17-23; Tr. at 294-298)

Dr. Parran also was referred to State's Exhibit 3, which contains a Pharmacy Board profile that lists prescriptions filled by Patient 3. Dr. Parran testified that it is very unlikely that the profile had been included in Dr. Nucklos' original medical records. Furthermore, Dr. Parran testified that another page in State's Exhibit 3 appears to be referring to the patient being informed of his rights by a detective. (St. Ex. 3 at 21, 23, 27; Tr. at 298-300)

Moreover, Dr. Parran noted that, in State's Exhibit 6, there are three slightly different versions of Dr. Nucklos' progress note for March 25, 2002. Dr. Parran testified that he does not know why the copies differ, or which is Dr. Nucklos' original note. (St. Ex. 6 at 21, 39, 70; Tr. at 301-303)¹

Dr. Nucklos' Treatment of Patients 1 through 28 – In General

Testimony of Dr. Parran

43. Dr. Parran criticized Dr. Nucklos for failing to obtain or attempt to obtain records of prior medical treatment for Patients 1 through 28. Dr. Parran added that this had been the cases even for patients where Dr. Nucklos' initial history or physical examination stated "Obtain Medical Records." Moreover, Dr. Parran testified that none of Dr. Nucklos' medical records for Patients 1 through 28 included a copy of a release signed by the patient to obtain old medical records. In addition, Dr. Parran testified: "I believe [in] not a single record did I find prior medical records or studies or results of studies or results of consultations or notes from previous prescribing physicians. It's—It's possible that there were one or two, but I believe there were none." (Tr. at 68-69)

Dr. Parran testified that obtaining prior medical records is "very basic stuff" that is taught to first- and second-year medical students. Dr. Parran testified that, if the physician plans to treat a patient for a long period of time, he or she is expected to obtain prior medical records. (Tr. at 63-65)

Dr. Parran testified that a physician is *not* absolved from this requirement by continuing to treat a patient for a long period of time without obtaining prior medical records. (Tr. at 65-66)

44. Dr. Parran further criticized Dr. Nucklos for failing to obtain a consultation with a physician who specializes in the organ or area of the body that underlies the patient's chronic pain complaint, as is required by the Board's rule. He testified that the medical

¹ Note: The Hearing Examiner did not consider any document in State's Exhibits 1 through 28 unless the Hearing Examiner felt comfortable that the document had been part of Dr. Nucklos' original medical records. The documents considered include Pain Assessment Questionnaires, Dr. Nucklos' handwritten progress notes, copies of patient identification cards, and occasionally other notes and correspondence that were dated within the time period during which Dr. Nucklos treated the patient.

record should include documentation that the specialist had been contacted, the date and time of the scheduled appointment, the consultant's report, and any follow-up with the consultant. (Tr. at 61-62)

Dr. Parran testified that it is inconsistent with the standard of care for a physician to simply tell a patient to see a consultant and expect the patient to follow up, as had happened with some of Dr. Nucklos' patients. Dr. Parran testified that someone from the physician's office should assist the patient with scheduling the appointment and the physician should follow up to obtain the results. (Tr. at 62)

45. Moreover, Dr. Parran testified that, when starting out with a new patient, the physician must balance patient safety with patient comfort. Dr. Parran further testified that patient safety comes first, and trumps patient comfort. Dr. Parran testified that that is an ethical principal of practicing medicine: first, do no harm; then provide comfort whenever possible; finally, cure if you can. (Tr. at 80-81)

Dr. Parran testified that chronic pain patients have had their conditions for some time; therefore, "it's not urgent to fix them right away if fixing them right away might put them at risk." (Tr. at 81)

46. Dr. Parran testified that the usual approach to prescribing to a new chronic pain patient is to verify by patient interview and also from some outside source—a pharmacy or previous prescriber—what medication and dose the patient has been taking, and that the patient has currently been taking that medication and dose. (Tr. at 81)

Dr. Parran testified that verifying from an outside source is important because pain patients over time develop a tolerance to the pain relieving effects of opiate medications *and* tolerance to the respiratory depression effect as well. Dr. Parran further testified that "the way opiates kill people is by causing them to stop breathing and die." (Tr. at 81-82) Moreover, Dr. Parran testified:

And so when prescribing narcotics, opiates to patients, it's critical to have an accurate assessment of their current tolerance to the respiratory depression effect of the opiates. Because if you don't, you run the risk of starting them on a dose of opiates which is, in reality, substantially higher than what they've been on recently.

And they, even if they take it as directed, run the risk of overdose, respiratory depression, showing up in an emergency room, having 911 calls to the house, heaven forbid, death; but potentially respiratory depression and brain damage or even death.

* * * So that's why, when it comes to initiating opiate prescribing in a given physician's practice and when the physician starts prescribing for the first

time him- or herself, that's new prescribing, you need to verify both with the patient and with another source what dose they've been on.

Otherwise, it's important to start on the lowest dose and gradually increase it so that you're putting patient safety first; and then a reasonable degree of concern for patient comfort as a second, a close second, but still only second.

(Tr. at 82-83)

47. Dr. Parran testified that OxyContin is "a very potent Schedule II prescription opiate." Dr. Parran testified that it contains oxycodone in a time-release formula that is usually prescribed to be taken every 12 hours. (Tr. at 97-98)

Dr. Parran testified that OxyIR is an immediate release form of oxycodone. (Tr. at 98)

48. Dr. Parran testified that OxyContin sells on the street for one dollar per milligram: a tablet of OxyContin 20 mg would sell for \$20, and a tablet of OxyContin 80 mg would sell for \$80. Dr. Parran further testified that OxyContin sells for much less at the pharmacy. A one month supply of OxyContin 80 mg #60 [4800 mg total] costs about \$360 at the pharmacy. (Tr. at 79-80)

Dr. Parran testified that OxyContin is available in doses of 10, 20, 40, and 80 mg. (Tr. at 80)

49. Dr. Parran testified that the Board's rule concerning the treatment of intractable pain requires that, if a physician prescribes more than one medication at the same time to treat pain, the physician must document in the patient record the medical necessity for utilizing more than one controlled substance. (Tr. at 265-266)

Patient 1

50. Patient 1, a female born in 1963, first visited Dr. Nucklos on October 11, 2001. She presented with non-driver State identification. The medical records for Patient 1's initial visit indicate that she had complained of low back pain that referred to her left leg. Patient 1 reported that she had injured her back lifting. Dr. Nucklos diagnosed lumbosacral radiculopathy at L4-5-6 and S1 with chronic pain syndrome. He prescribed OxyContin 20 mg #42 to be taken three times per day, Soma 350 mg #30 to be taken twice per day, Ambien 10 mg, quantity not documented, with instructions to take one at bedtime as needed, and an ointment. (St. Ex. 1 at 37)

On a Patient Questionnaire that appears to have been filled out by Patient 1 for law enforcement purposes and included along with Dr. Nucklos' medical record for Patient 1, Patient 1 indicated that she had provided Dr. Nucklos with copies of her medical records from "Dr. Abraham" and "Dr. Andorfer." (St. Ex. 1 at 19, 23)

51. At Patient 1's second visit, October 25, 2001, Dr. Nucklos discontinued Ambien and added OxyIR 5 mg #30 with instructions to take one tablet twice per day as needed. Dr. Nucklos renewed the OxyContin and Soma prescriptions. (St. Ex. 1 at 36)
52. At Patient 1's third visit, November 8, 2001, Dr. Nucklos continued the prescriptions for OxyContin, Soma, and OxyIR and added a prescription for Xanax 0.5 mg #42 with instructions to take one tablet three times per day. The patient's only complaint that day was increased low back pain, and Dr. Nucklos' only assessment was occasional breakthrough pain. (St. Ex. 1 at 36)
53. Dr. Nucklos continued seeing Patient 1 on a regular basis and prescribed at nearly every visit OxyContin (which increased to 40 mg twice per day starting May 23, 2002), OxyIR, Soma (which was briefly discontinued), and Xanax, through October 9, 2002. (St. Ex. 1 at 25-35)

Testimony of Dr. Parran

54. On a Pain Assessment Questionnaire that Patient 1 completed at her initial visit, Patient 1 wrote that she had not been taking any medication at that time; however, Dr. Nucklos recorded in his patient history notes for "Medications," "Oxy - 20." Dr. Parran testified, "That's an inconsistency in [the] initial database that must be reconciled in terms of safe and appropriate prescribing." (St. Ex. 8 at 8, 37; Tr. at 68-87) (Emphasis in original)

Dr. Parran further testified that Dr. Nucklos' medical records for Patient 1 lacked documentation of a consultation with a specialist as required by the Board's rules. Moreover, there were no laboratory tests or diagnostic studies. Dr. Parran further testified that, because previous studies were not obtained, "one would expect new studies to be ordered, but they weren't." In addition, Dr. Parran testified that Patient 1 was started on controlled substances at her first visit, and that "controlled substance prescribing was continued and increased over time." Furthermore, Dr. Parran testified that Xanax, a benzodiazepine, was added at the third office visit with no supporting diagnosis documented. Finally, Dr. Parran testified that Dr. Nucklos' initial evaluation and ongoing treatment of Patient 1 was inconsistent with State law and the Board's rules concerning the long-term prescribing of opiates for the management of chronic intractable pain. (Tr. at 88-89)

55. Dr. Parran testified that the medications Dr. Nucklos prescribed to Patient 1 are all central nervous system depressants. Dr. Parran testified that OxyContin is an opiate, Xanax is a benzodiazepine, and Soma, although noncontrolled, is a barbiturate. Dr. Parran noted that Soma "potentiates the sedative effect of opiates, and potentiates the sedative effects of benzodiazepines." Dr. Parran further testified that "this patient was being prescribed, basically, two sedative hypnotics, benzodiazepines and Soma, and a sedating opiate all at the same time." (Tr. at 89-91)

56. Dr. Parran testified that Patient 1 had been in her 30s at her initial visit on October 11, 2001, and she had non-driver State identification. However, Dr. Parran testified that there had been no documented assessment of addictive disease. (St. Ex. 1 at 11; St. Ex. 31; Tr. at 88)

Dr. Parran testified that there is concern with regard to Patient 1's non-driver status due to the possibility that Patient 1 had lost her license as a result of DUI convictions. Dr. Parran explained:

[T]he hallmark of addiction or chemical dependency is—is intermittent, inconsistent but repetitive loss of control over the use of euphoria-producing substances.

Now, these euphoria-producing substances are illicit substances and licit substances. So intermittent, inconsistent repetitive loss of control over the use of these euphoria-producing substances that results in repetitive adverse consequences in a person's life.

And that's why physicians, you know, when asking a person about drinking problems, will ask about things like a blackout, an amnesic event from drinking. That's where a person plans to drink to a certain point and then drinks to such a level that their brain actually doesn't lay down short-term memory.

That's why things like DUIs are such strong predictors of having the disease of addiction, because people who plan to drink to a certain level of intoxication and do it, exactly what they plan, also plan to have a designated driver. Whereas people with addiction, alcoholism, who plan to drink to a certain level and then lose control and drink way past it, are the ones who begin to attract things like DUIs, et cetera, et cetera.

That's why this kind of clinical data in the chart is so critical for a physician to recognize and then follow-up on.

When I said that these euphoria-producing substances are licit and illicit, there's four categories of euphoria-producing substances. And it winds up being fairly important for this case for me to briefly describe what these categories are.

So one category is the opioids. There are illicit opioids; heroin, or buying prescription drugs on the street, buying legal pharmaceutical opiates but from illegal sources. Those are illicit opioids. And then there's licit opioids; prescribed opiate analgesics. So those are the opioids. That's one class of euphoria-producing substances.

The second general class of euphoria-producing substances are the sedative hypnotics, which I briefly mentioned already. There are three sort of groups of medicine in this class of * * * sedative hypnotics. There's benzodiazepines; and for the purposes of this case, mostly Xanax. There are barbiturates; for the purpose of this case, mostly Soma or Fiorinal or Fioricet. And then alcohol is the sort of third group of sedative hypnotics.

There also are some sleeping pills that fall into the category of controlled drugs, sedative hypnotics. And this case has some use of a sleeping pill called Ambien, which is still just another sedative hypnotic. So those are all in the same class.

And then the third—the third major classes of euphoria-producing substances are the stimulants. And the illicit stimulants are methamphetamine and crack cocaine. The illicit and licit stimulants are cocaine, because you can write prescriptions actually for it, you can get it legally or illegally; and many of the diet pills, the controlled stimulant diet pills; and many of the medications used to treat hyperactivity, things like Ritalin or whatever. There's some diet pill prescribing in this case, but not very much.

Finally, the last class of these euphoria-producing substances is sort of a—sort of a wastebasket group and that includes things like phencyclidine, PCP, marijuana, and—and a bunch of other hallucinogen-type medicines which really don't—don't relate to this case at all.

But these are the four classes of substances which are euphoria-producing substances. And if a person has addictive disease, they have a brain which has—if you know a person has addictive disease, you know they have a brain which, if it is exposed to these substances, is going to have an intermittent, inconsistent, repetitive loss of control over the use of these substances, frequently resulting in adverse consequences.

And the adverse consequences tend to be legal problems, financial problems, marital problems, domestic violence problems, child abuse and neglect problems, loss of job problems, accidental overdose problems. That's the kind of pain and suffering that people with addiction accumulate as a consequence of their out-of-control behavior with their addiction, some of which includes death.

* * * And that's why physicians are expected to have a higher level of care prior to long-term prescribing of controlled drugs because, by definition, all controlled drug prescription[s] are [for] euphoria-producing substances. And, therefore, every controlled drug that's prescribed falls into one of these classes of drugs.

And that's why physicians are expected to use, as part of the usual standard of care in the community, and as far as the State Medical Board rules regarding longitudinal opiates in chronic—in intractable pain, that's why physicians are expected to have this level of care; because of the attendant increased risk to the life, liberty, and safety of the patient and the patient's family if they have addiction and you concomitantly prescribe controlled drugs.

(Tr. at 92-96)

In addition, Dr. Parran testified that, if Patient 1 had lost her driver's license due to alcohol abuse, her continued consumption of alcohol would multiply the effects of the prescribed medications. Furthermore, Dr. Parran testified that each of those medications multiplies the other's effects rather than just adding to it. Alcohol would further multiply the effects of the medications. Furthermore, Dr. Parran testified:

[T]he risk of accidental overdose and—and fatality, or accidental overdose and a motor vehicular accident, or accidental overdose and falling down the steps and breaking your neck, whatever it happens to be, goes up exponentially as these drugs are layered on top of each other, especially in a patient who has any history of chemical dependency.

(Tr. 91-92)

57. Dr. Parran testified that urine drug screens had been ordered “a couple times” on Patient 1; however, there is nothing in the record that documents the results of urine drug screens.
(Tr. at 98-99)

Dr. Parran testified that urine drug screens are used to document that the patient is actually taking the medication that is being prescribed. If a patient is being prescribed medication and the medication is not found in the patient's system, that could indicate that the patient is diverting the medication. Another reason to perform urine drug screens is to ensure that the patient is not taking other substances that are not being prescribed, such as alcohol, cocaine, or methadone. Dr. Parran noted that it is not uncommon for patients who are on a methadone maintenance program to see pain management physicians to try to obtain additional medication which they then divert. (Tr. at 98-100)

Dr. Parran testified that abnormal findings on a urine drug screen require an alteration in the treatment plan. (Tr. at 101)

Dr. Knott's Written Report

58. In his written report, Dr. Knott opined as follows:

[Patient 1] [w]as diagnosed initially with chronic lumbosacral radiculopathy at the L4-5 levels resulting in chronic pain syndrome and, after obtaining

appropriate consent was treated medically. The examination and treatment are well documented and I do not observe deviations from the standards of care as alleged in this chart. No violations of R.C. §§ 4731.22(B)(2)(3) or (6) noted.

(Resp. Ex. B)

Testimony of Dr. Knott

59. Dr. Knott described the findings that Dr. Nucklos recorded from his initial visit with Patient 1:

It goes into a general assessment of the patient. Indicates that she's in moderately severe distress. No list with the station. The station is the posture. Spurling's maneuver was negative. Straight-leg raising maneuver was negative. Braggard's reinforcement test was negative.

There is an absent ankle jerk and—I'm sorry—tenderness to palpation noted over the right—or the bilateral SI joints and the thoracic spine midline and the bilateral piriformis muscles.

(St. Ex. 1 at 37; Tr. at 655) Dr. Knott further testified that Dr. Nucklos diagnosed Patient 1 with lumbosacral radiculopathy at L4-L5.² (Tr. at 656)

60. With regard to the medications prescribed to Patient 1, Dr. Knott testified:

[It may be necessary to prescribe more than one controlled substance because controlled] substances have a limited half-life. And you may have to cover the period where there's not coverage with another medication.

Also, if you're treating muscle tightness, it's—it's not treated as well with analgesic medication. You may have to introduce another type of medication, another class of medication; in this case, like Soma. Soma is a muscle relaxant-type medication.

Also, if the patient is having difficulty sleeping. Sleep is very important for — for these problems. Lack of sleep always makes the problems worse. In this case, * * * she was given Ambien for at bedtime.

(Tr. at 656-657)

61. On cross-examination, Dr. Knott acknowledged the following:

² Note that the medical record indicates that Dr. Nucklos diagnosed lumbosacral radiculopathy at L4-5-6 and S1 with chronic pain syndrome. (St. Ex. 1 at 37)

- There are no MRI or EMG results in the patient file;
- There are no records of prior medical treatment;
- There is no verification whether or when Patient 1 had actually been taking OxyContin 20 mg;
- There are no urine drug screen results;
- There is no documentation of physical therapy provided;

(Tr. at 870-872)

Patient 2

62. Patient 2, a female born in 1974, first visited Dr. Nucklos' office on November 15, 2001. She presented with non-driver identification. On her Pain Assessment Questionnaire, Patient 2 indicated that she had pain in her right hip and lower back, and suffered from severe headaches. She reported her pain at that time to be 8 on a scale of 1 to 10. Patient 2 wrote that she had first noticed pain in 1996 and that it "gradually buil[t] up." She further indicated that she was taking no medication at that time. (St. Ex. 2 at 3-4, 13)

In his notes for Patient 2's initial visit, Dr. Nucklos noted that Patient 2 had lower back pain, right hip pain, and right leg pain resulting from a motor vehicle accident. He noted that Patient 2 was last treated by a physician one year earlier, and that Patient 2 could not remember her physician's name. He further indicated that Patient 2 had visited the ER 10 to 15 times during the past year. Moreover, he noted, "Obtain Medical Records." Furthermore, Dr. Nucklos indicated that Patient 2 smoked one half of a pack of cigarettes per day, and "ETOH." Dr. Nucklos impressions were lumbosacral sprain/strain and lumbar radiculopathy at L5-S1. Dr. Nucklos prescribed OxyContin 20 mg #30 with instructions to take one tablet every 12 hours, Soma #42, with instructions to take one tablet three times per day as needed, Lortab 10 mg with instructions to take one tablet twice per day as needed, and exercises. (St. Ex. 2 at 9) (Emphasis in original)

Testimony of Dr. Parran

63. Dr. Parran noted that, although Patient 2 was 26 years old when she first saw Dr. Nucklos, she had presented with non-driver State identification. Dr. Parran further testified that Dr. Nucklos obtained none of her previous medical records. Moreover Dr. Parran testified that the history and physical examination were insufficient, and that there was no evaluation of the reason why Patient 2 did not drive. (Tr. at 107-108)

Dr. Parran testified concerning Dr. Nucklos' prescription at Patient 2's initial visit for OxyContin 20 mg twice per day: "This actually could result in an overdose situation in a patient. Going from zero to 40 mg of oxycodone a day, could, if taken as directed, within the first 24 to 48 hours, result in accidental overdose in and of itself." (Tr. at 108-109)

In addition, Dr. Parran testified that, during subsequent visits, Dr. Nucklos had ordered an MRI scan, but no results were documented in the record. Further, Dr. Parran noted that Dr. Nucklos ordered a urine drug screen, but no results were documented in the record. Moreover, Dr. Parran testified that the patient had complained of difficulty sleeping and, although there is no further history or evaluation concerning that issue, Dr. Nucklos prescribed Ambien 10 mg, the strongest dose of Ambien available. (St. Ex. 2 at 8; Tr. at 109)

64. Dr. Parran noted that, in the addiction medicine part of his practice, it is commonplace that patients are non-drivers because they have had DUI convictions. However, Dr. Parran testified that, in other areas of his practice dealing with patients “without a history of chemical dependency, it is unheard of. You just don’t see patients in their 20s, 30s and 40s in regular medical practice who are non-drivers, who have State ID cards. You just don’t see them * * * unless there’s chemical dependency.” (Tr. at 111-112)

Testimony of Dr. Knott

65. Dr. Knott testified that Patient 2 had been injured in a motor vehicle accident and sustained injuries that caused lower back pain, and pain in the right hip and right leg. (Tr. at 661)

Dr. Knott further described the physical examination Dr. Nucklos performed on Patient 2:

A complete neurological and orthopedic examination, starting with a generalized assessment, then going through station, gait, Spurling’s, straight-leg raise, Braggard’s reinforcement, deep tendon reflex, manual muscle testing, and sensation to the light touch and pinprick.

(Tr. at 661)

Dr. Knott stated that Dr. Nucklos diagnosed lumbosacral sprain and strain, and a secondary diagnosis of lumbar radiculopathy at L4-L5-S1. (Tr. at 661-662)

Dr. Knott testified that Dr. Nucklos’ treatment plan consisted of a flexibility and progressive resistive exercise program and medication. Dr. Knott characterized the initial dosage of medication as “a very low dose.” (Tr. at 662-663)

66. Dr. Knott does not regard non-driver State identification card as a “red flag.” (Tr. at 663-664)
67. Dr. Knott testified that, at Patient 2’s third visit on December 13, 2001, Dr. Nucklos had added Ambien 10 mg to Patient 2’s treatment regimen. Dr. Knott testified that that had been added based upon Dr. Nucklos’ assessment of insomnia. (Tr. at 664)

68. Dr. Knott testified that it had been appropriate for Dr. Nucklos to have ordered a urine drug screen for Patient 2 as he had done on March 21, 2002. He did not address that no results were documented in the medical record. (St. Ex. 2 at 33; Tr. at 667)
69. Dr. Knott testified that hospital records of past medical treatment are helpful if they can be obtained. Dr. Knott further testified, however, that there is usually a significant delay between the request and actually receiving them, on the order of six months. (Tr. at 879-881)
70. Dr. Knott testified that medical records should be written for the treating physician himself or herself. Dr. Knott acknowledged that it can be helpful to have thorough medical records from prior treatment physicians, however, when he receives copious notes from another physician, he does not appreciate having “to look at all those stupid notes and * * * ferret through them. All I need is just a very few words of telling me what’s going on with the patient that helps me, because most notes don’t help me.” (Tr. at 884-885)
71. Dr. Knott was questioned concerning Dr. Nucklos’ December 13, 2001, unembellished diagnosis of “insomnia.” Dr. Knott testified:

Well, a lot of times, you know, we have conversations with patients and we don’t write a book about it. You know, it’s—this is the most important thing, insomnia, okay. Whether or not he talked about it was anxiety, whether it was thinking about work, whether he—doesn’t matter. The guy can’t sleep. He needs to get some sleep. So [Dr. Nucklos] gave him sleeping medication for that purpose.

(Tr. at 883-884)

Dr. Knott acknowledged that insomnia can be a symptom of other conditions such as depression, and stated that he has treated patients for depression himself. Dr. Knott added that, if a patient does not respond to Dr. Knott’s treatment for depression, he refers the patient to a psychiatrist. Dr. Knott further testified that the use of Ambien to treat insomnia is appropriate even if the underlying cause is depression or anxiety; “at least they’re getting sleep.” Dr. Knott acknowledged that patients can develop a dependency on Ambien; however, when asked if it would therefore be a better idea to explore something else, Dr. Knott replied: “Not necessarily. Not putting them on an SSRI and taking the chance of liver damage and all of the other attendant factors that go along with that, I’d much rather use Ambien or Lunesta or something of that nature.” (Tr. at 885-887)

72. Dr. Knott acknowledged that he would probably have started Patient 2 on a lower dose of OxyContin or some alternative treatment, inasmuch as Patient 2 had not been using medication at the time of the initial visit. (Tr. at 881-882)
73. With regard to a gap in Dr. Nucklos’ treatment of Patient 2 between December 13, 2001, and February 21, 2002, Dr. Knott acknowledged that there were no notes in the medical

record about what Patient 2 had done while off OxyContin. Dr. Knott testified that that would concern him. Dr. Knott further testified that he would have had a conversation with the patient about the gap in treatment and whether that meant that an alternative treatment modality might be effective. Moreover, Dr. Knott testified that he would have documented that conversation in the patient's medical record. (St. Ex. 2 at 29-31; Tr. at 887-888)

Criminal Trial Testimony of Dr. Nucklos

74. Dr. Nucklos testified at the criminal trial that he and Patient 2 had attempted to obtain Patient 2's old medical records, without success. Dr. Nucklos testified that Patient 2 had been advised that the records had been lost.³ (St. Ex. 32A at 1655)

On cross-examination, Dr. Nucklos testified that he did not personally attempt to obtain Patient 2's medical records, and that that had been a staff function. Dr. Nucklos further testified that he had noted in the chart to obtain Patient 2's medical records, and that Ms. Woodruff "typically read what I had signed for a treatment plan for a patient." (St. Ex. 32A at 1681-1682)

75. Dr. Nucklos testified that, among other things, at Patient 2's initial visit, he had obtained her past medical history, social history, and information concerning her use of tobacco and alcohol. He also performed a physical examination. Dr. Nucklos further testified that he had prescribed OxyContin every 12 hours, Soma one to three times per day as needed, and Lortab 10 mg twice per day as needed. When asked why he had prescribed OxyContin to Patient 2, Dr. Nucklos replied:

Well, given the—the nature and extent of her injuries as noted per her history and my physical and neurological examination, I came up with that determination because in dealing with these patients, No. 1, you try to be—all things considered, you try to be as cost effective as possible. That is why I give patients samples if I have them; and a lot of medicines that you think are safe, you find out they're not safe as relates—as come about with Bextra and Vioxx.

These are non steroidal. They seem like innocent medicines. We know they've been taken off the market. People have suffered a lot of problems as a result of these medications.

(St. Ex. 32A at 1658-1659)

³ Note that information that the prior medical records had been lost is not documented in Patient 2's medical record. Note also that Patient 2's medical record indicates that Patient 2 could not remember the name of her previous treating physician. (St. Ex. 2)

76. At the trial, Dr. Nucklos was questioned concerning the period of time during which Patient 2 was absent from his practice. The following exchange took place:

Q. [By Ms. O'Brien, Prosecuting Attorney] [Patient 2 was] absent from your practice for over a month. Where was she?

A. [By Dr. Nucklos] I'm not sure where she was, but we had gotten a report or Trish or someone had read in the paper where [Patient 2] had got into some problems and—

Q. Meaning she'd been arrested in a drug ring?

A. Right, yes.

Q. Right.

A. I didn't know what the specifics were but—and so [Patient 2] wasn't able to come back to the practice until she cleared that up.

Q. Did you check into it?

A. As I recall, she came back to the office after she had cleared that up.

Q. Is that in the file?

A. No, it's not in the file.

* * *

Q. * * * Just because they have charges dismissed against them, does that mean they don't need assistance; or you don't have a red flag that means you don't need to refer them?

A. Well, I didn't have a red flag at that time.

Q. Did you check out the charges?

A. Not me specifically, but we indicated at that time that anybody with charges would have to have them either dropped or what have you. I believe she had indicated they were not founded.

Q. So they were dismissed. No big deal.

A. Well, it's not a matter [of] it's not a big deal. I think we had gone to the crux of the problem as to whether or not those charges were true. They were, obviously, dismissed for some reason.

Q. Is that in the file?

A. No.

Q. What were the charges, Doctor?

A. I'm not aware of what the charges were.

Q. Is that in the chart?

A. No. I'm not aware of what the chart is.

Q. Did you bother to find out? You personally because you're the one responsible for the treatment.

A. No, I didn't personally—I didn't personally pursue that.

Q. And—and you heard that they were drug related. You heard that in court the other day; correct?

A. I heard her say that, yes.

Q. Yeah. And did you believe her?

A. Well, she was under oath.

Q. Okay. So you didn't bother to find out what the charges are. As long as the case is dismissed, it's not your concern.

A. It's not a matter it's not my concern, but what else was I to do with it once they were dismissed if they weren't true?

Q. Did you refer her to an addiction specialist in either substance abuse or alcohol or—

A. Nothing.

Q. Nothing. You did nothing?

A. No. My opinion, there was no clear evidence of drug abuse.

Q. Did you have a reason to believe there might be drug abuse or diversion going on? It doesn't have to be abuse, Doctor.

- A. No, because we were the ones who had opted not to see her until she got those charges cleared up so that wasn't at issue.
- Q. I guess what I'm hearing you say, Doctor, you don't know what the charges are, you don't really know what happened to them except they were dismissed. You're not quite sure what the resolution was other than they were dismissed. You don't care.
- A. No, I—
- Q. Because it doesn't matter to you in terms of your—your treating her as long as she doesn't have criminal charges pending.
- A. In other word, in terms of specific charges, I'm not even aware of what they were.
- Q. Important to find out, especially if they're drug related?

* * *

- A. Of course, if they're—if they're dropped.

(St. Ex. 32A at 1723-1727)

Patient 3

77. Patient 3, a male born in 1965, first visited Dr. Nucklos on August 16, 2001. His chief complaint was pain in his left hand, left knee, and left calf secondary to three gunshot wounds in 1994. Dr. Nucklos' notes concerning the initial visit indicate that a "Dr. Perry" had performed reconstruction surgery on his hand, and that Dr. Jenkins had been his previous treating physician. Dr. Nucklos further noted that Patient 3 reported that he had been taking OxyContin and Percocet at that time. On examination, Dr. Nucklos found decreased left grip strength and "left wrist| Flexor/extensors." Dr. Nucklos' impression included chronic pain syndrome. He prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, and OxyIR 5 mg #30 with instructions to take one tablet twice per day as needed. (St. Ex. 3 at 17)

Testimony of Dr. Parran

78. Dr. Parran testified that, in the case of Patient 3, there is no evidence that Dr. Nucklos had either obtained prior medical records or obtained new studies. Dr. Parran further testified that there is no consult from a physician specializing in the area the patient's pain. Moreover, there is a January 3, 2002, note documenting a call from a pharmacy "indicating that the patient was continuing to see other doctors" and was receiving controlled substances from the other physicians. (Tr. at 117)

The medical record documents no further visits following the January 3, 2002, call from the pharmacist. (St. Ex. 3 at 13)

79. Dr. Parran testified that, at Patient 3's first visit, Dr. Nucklos prescribed a daily dose of:

90 milligrams of oxycodone, the equivalent of 18 Percocet in one day, in a patient where there's no verification whatsoever from an outside source that he was on any preexisting opiates. This—If this patient had been not telling the truth about taking the oxycodone and then took this as prescribed, it would kill him if this patient had no tolerance for opiates. And there's no evidence of verification of tolerance to opiates. This would be expected to result in a fatal overdose if taken as directed.

(Tr. at 119)

Dr. Parran further testified: “[I]t literally takes two minutes for an office staff member, not the physician, just a staff member to say, ‘Tell me the name of your pharmacy,’ and to just call the pharmacy to verify the fact that this person has been actually on this medicine. That’s a basic safety precaution.” (Tr. at 120) Dr. Parran added that simply relying on the patient’s word in a situation where a misrepresentation could result in the patient’s death, “without getting some verification, is inconsistent with reasonable care and concern for the life and safety of a patient.” (Tr. at 120-121)

Testimony of Dr. Knott

80. Dr. Knott testified concerning Dr. Nucklos’ physical examination of Patient 3: “The deep tendon reflexes were tested; they were found to be normal in the upper extremities. Manual muscle testing revealed decreased grip strength on the left, and there was decreased strength of the left wrist flexor and extensors. Two-point discrimination was performed, which was fine.” (Tr. at 669)

Dr. Knott further testified concerning Dr. Nucklos’ diagnosis: “Chronic pain syndrome, status post gunshot wound to the left hand and left medial gastroc.” (Tr. at 669)

81. Dr. Knott testified that Dr. Nucklos’ prescriptions at the initial visit had been appropriate “on the basis that [Patient 3] had been receiving this prior to that time[.]” (Tr. at 669-670)

When asked if the standard of care requires that the physician verify with the previous physician or another source that the patient has been on the dosage claimed, Dr. Knott replied: “That would be helpful, but, you know, I tend to believe my patients more often than not. If I suspect some ill-conceived plan to get drugs, yes, I think it would be wise to—to maybe talk to the physician.” Dr. Knott further testified that, if Patient 3 had not actually been taking such medications, “[t]hat dosage could have probably caused some problems.” Finally, Dr. Knott testified that he would have started Patient 3 on a lower dose. (Tr. at 671-672)

82. Dr. Knott testified that Dr. Nucklos discharged Patient 3 from his practice after receiving a report from a pharmacy that Patient 3 had been obtaining medication from more than one physician. Dr. Knott testified that, in accordance with the treatment contract that Dr. Nucklos had all his patients sign, that had been an appropriate response. Dr. Knott added, however, that he would have consulted with the patient to obtain more information. (St. Ex. 3 at 13; Tr. at 670)
83. Dr. Knott acknowledged that Dr. Nucklos did not document a physical examination of the patient's left knee. Left knee pain had been included in the patient's complaints. (St. Ex. 3 at 17; Tr. at 888-889)

Criminal Trial Testimony of Dr. Nucklos

84. Dr. Nucklos testified at the criminal trial that Patient 3 had presented with a complaint of left hand and left knee pain. Dr. Nucklos further testified that he had performed a neurological examination that showed that Patient 3's deep tendon reflexes were normal. Dr. Nucklos further testified that the physical examination further revealed that Patient 3's left hand was severely deformed and had severe loss of muscle, his grip strength was significantly decreased, and he had pain inhibition weakness. He further testified that he performed a sensory examination, checked Patient 3's wrist flexion and extension, and checked the medial gastrocnemius muscle. Dr. Nucklos testified that he diagnosed status post gunshot wound to the left hand and left medial gastrocnemius that resulted in chronic pain syndrome. (St. Ex. 32A at 1643-1648)

Dr. Nucklos testified that he had issued prescriptions to Patient 3 at the initial visit. At Patient 3's second visit, he had complained of breakthrough pain. Dr. Nucklos testified that studies have confirmed that OxyContin does not actually provide relief for 12 hours, and "that it may last a little more than six hours, half of what it was purported to last in terms of pain control. (St. Ex. 32A at 1649-1650)

85. With regard to his receiving information from a pharmacy that Patient 3 was seeing another physician, Dr. Nucklos testified: "Well, I actually received it secondhand as to what he was doing; and we had made it clear really that if there was ever any doctor shopping identified, that that patient would be discharged; and he was discharged." (St. Ex. 32A at 1668)
86. Noting that he had treated Patient 3 for five months, Dr. Nucklos was asked whether he had obtained any records of prior medical treatment. Dr. Nucklos replied: "By that time I was very aware of him myself and what his condition was and what I was treating. So at that point the records wouldn't have been as much value as they would have been at the initial onset." When asked how he could know that without having seen the records, Dr. Nucklos replied: "Well, that's what—in other words, I was treating him appropriately so after examining him and taking a history and seeing him for five months, the records wouldn't have been of much value." (St. Ex. 32A at 1684-1685)

Dr. Nucklos further testified that Patient 3's local physician had been Dr. Jenkins, and Dr. Jenkins was deceased. Dr. Nucklos acknowledged that he had been able to obtain other records of Dr. Jenkins' patients, but that he had not obtained Dr. Jenkins' records for Patient 3. However, Dr. Nucklos asserted that it had been Ms. Woodruff's responsibility to obtain Patient 3's prior medical records. (St. Ex. 32A at 1685-1686)

87. Dr. Nucklos testified that he would not have treated Patient 3 if he had been aware that Patient 3 had been seeing other physicians. Whereupon the following exchange took place:

Q. [By Ms. O'Brien, Prosecuting Attorney] So maybe if you had [Patient 3's] previous records, that may have helped you determine whether or not he was still seeing someone.

A. [By Dr. Nucklos] If I had been able to get the records from Dr. Jenkins, that would have been helpful.

Q. Doctor, show me where you tried. Dr. Jenkins, you took over his practice.

A. That is incorrect. That is totally incorrect.

Q. What about his other treating physician? Did you even try? Show me anywhere in that record where you tried to get the medical records more than—and actually I don't even know if it's in his initial health and physical exam report that you did. Show me where it is, doctor.

A. I can't.

Q. Thank you. Patient 28, same thing. Anywhere in [her] record that you even tried to get her records?

A. That was supposed to be a normal function of the staff.

Q. Doctor, if you don't have the records in two months, are you going to ask for them again? "Tricia, where are they?"

A. Perhaps. Let me say this. In medicine, after you've seen a patient for two months, the records are most critical before you've seen—initially. After you've seen a patient for two months, the records aren't as important because at that point, you already have a working diagnosis; and you're treating the patient.

(St. Ex. 32A at 1686-1687)

88. Dr. Nucklos further testified that, as a specialist in physical medicine and rehabilitation, it had been unnecessary to refer Patient 3 to a specialist. (St. Ex. 32A at 1692-1694)

Patient 4

Testimony of Dr. Parran

89. Dr. Parran testified that Patient 4 first visited Dr. Nucklos on August 23, 2001. Dr. Nucklos continued to treat Patient 4 through May 15, 2002. The name of Patient 4's family doctor was noted at the initial visit. (St. Ex. 4 at 25; Tr. at 125-127)

Dr. Parran criticized Dr. Nucklos for failing to obtain prior medical records, and noted that no release for prior medical records had been included in the chart for Patient 4. Dr. Parran further criticized Dr. Nucklos for failing to document a diagnosis at the initial visit: "There really is not a substantial diagnosis made. Basically, symptoms are listed." (Tr. at 127-128, 131-132)

90. Dr. Parran noted that Patient 4 reported at the initial visit that he had been taking OxyContin 40 mg and Percocet; however, no verification of that information was included in medical record. Nevertheless, at the first visit, Dr. Nucklos prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, and Percocet 7.5 mg #42 with instructions to take one tablet three times per day as needed. (St. Ex. 4 at 25; Tr. at 128)

Dr. Parran testified that Dr. Nucklos had prescribed a dose of 95 mg of oxycodone per day to Patient 4 without verifying that the patient had been taking such a dose at that time. Dr. Parran noted that, if the patient had had no tolerance to opiate medication, "that clearly could and should be fatal[.]" (Tr. at 128)

91. Dr. Parran testified that, over time, Patient 4's dose of OxyContin 40 mg increased from twice per day to three times per day. Lortab 10 mg was added at four times per day instead of the Percocet 7.5 mg three times per day. Moreover, Xanax 0.5 mg at four times per day was added, although that was later decreased to three times per day. Dr. Parran testified that there is no indication in the medical record as to why the OxyContin dosage was increased, nor was there any indication given for the addition of Xanax. (St. Ex. 4 at 3; Tr. at 129-130)

92. Dr. Nucklos' February 6, 2002, progress note indicates that Patient 4's mother had been present, and that Patient 4 had agreed to allow discussions with her at any time concerning Patient 4's medical condition. (St. Ex. 4 at 20)

Dr. Parran testified that a thirty-something construction worker being accompanied by his mother to a medical appointment is unusual but not unheard of. Dr. Parran further testified, however, that it had added another reason to obtain records of prior medical treatment. (Tr. at 134)

93. Dr. Nucklos' April 3, 2002, note states that Patient 4 had reported having had his medications stolen on March 24, 2002. (St. Ex. 4 at 19)

Dr. Parran testified that Patient 4 had “received early prescriptions when he reported his medications had been stolen.” (Tr. at 130)

94. The medical record indicates that, on January 10, 2002, Patient 4 had reported having been treated for depression at Greenhill. (St. Ex. 4 at 21)

Dr. Parran testified that the medical record does not reflect any request to obtain records from Greenhill concerning Patient 4’s depression. Dr. Parran noted that it is not uncommon for patients with intractable pain to have depression. However, obtaining the records of Patient 4’s treatment for depression would be “a routine part of patient care.” (Tr. at 133)

Testimony of Dr. Knott

95. Dr. Knott described the physical examination performed by Dr. Nucklos on Patient 4:

Well, the general assessment being as normal, well-nourished, well-developed male, and in moderate distress.

Range of motion of the cervical spine showed a restriction in side bending to about 20 to 25 percent of the expected normal. Range of motion of the lumbosacral spine showed a restriction in extension of approximately 35 to 40 percent of expected normal. McMurray’s test, Apley’s test, drawer signs, all of that was negative in the knee, in the left knee.

He auscultated the patient and there was—and listened to the heart, the lungs. Normal sinus rhythm. No wheeze, rhonchi or rubs noted.

Then the remainder of the examination, there was no torticollis or list. Negative Spurling’s maneuver. Cervical spine compression of nerve root foramina was negative. Straight-leg raise test, in the sitting position most likely, was negative. I don’t know if you—he had done it prone or sitting. Braggard’s reinforcement test also was negative. Deep tendon reflexes were normal in the upper and lower extremities.

Did show two-point and position sense sensation to be normal. There was tenderness in the cervical paraspinals and the trapezii or trapezius on the right side, and tenderness in the lumbosacral paraspinal muscles. Tenderness was noted in the right second metacarpal and the third, fourth, fifth metacarpals on the left.

There was tenderness adjacent to the left knee joint along the course of the medial and lateral collateral ligaments. And that was it.

(Tr. at 676-677)

96. Dr. Knott acknowledged that, in Dr. Nucklos' documentation at the initial visit for deep tendon reflexes [DTR], Dr. Nucklos had not documented that he performed them on both the upper and lower extremities, but had simply noted "WNL" next to DTR. Dr. Knott further acknowledged that he had made an educated guess that Dr. Nucklos had covered both upper and lower extremities based on Dr. Knott's experience and the injuries reported by the patient. (St. Ex. 4 at 25; Tr. at 891-892)
97. Dr. Knott acknowledged that, although the patient had complained of having the most intense pain in the lower back and feet, Dr. Nucklos did not document a physical examination of the feet. (St. Ex. 4 at 9, 25; Tr. at 896-897)
98. Dr. Knott testified that the medication and dosage that Dr. Nucklos prescribed at Patient 4's first visit was appropriate based on the patient's condition. Dr. Knott further testified that the patient had reported being on the same dosage as prescribed. Dr. Knott acknowledged that no verification had been documented. (Tr. at 677-678)
99. Dr. Knott testified that the visit when Patient 4's mother was present did not strike him as unusual or raise a red flag. (Tr. at 678-679)
100. When asked what specialist would have been appropriate to perform an assessment of Patient 4's condition, as required by the Board's rule, Dr. Knott replied that that physical medicine and rehabilitation physicians such as he and Dr. Nucklos assess such conditions. Dr. Knott further testified that physical medicine and rehabilitation is a "cross-section practice in the assessment of neurological and musculoskeletal problems, and that's what this patient had. So this comes under the purview of what we do and what we're trained to do." When asked if Dr. Nucklos had violated the standard of care by not sending Patient 4 to another physician for an evaluation, Dr. Knott replied:

No, it's not a—it's not a violation. The standard of care was written for—my interpretation, at least—the guidelines are a little ambiguous, quite honestly.

Requesting a consultation with someone who is familiar with this body part, I think it was written for general practitioners, internists, people like that who don't know a lot about the musculoskeletal and neurological systems. That's what [PM&R physicians are] trained in.

When it comes time for me to send a patient out to make a diagnosis with one of my colleagues, then I'm going to retire, because that's what I do. People send people to me, other doctors send people to me to make these diagnoses. There's no reason to be redundant and send this patient to someone else.

(Tr. at 680-681)

Dr. Knott added that there are situations where he would send his patient to a specialist; for example, if the patient had a tumor or had a fractured bone. (Tr. at 681-682)

Patient 5

Testimony of Dr. Parran

101. Patient 5, a female born in 1966, first visited Dr. Nucklos on July 26, 2001. Patient 5 complained of right shoulder pain, sacral and coccyx pain, and left knee pain. The name of her previous treating physician was noted. The medical record indicates that Patient 5 reported having taken OxyContin 20 mg three times per day and Soma, but that she had taken no medications for one month. (St. Ex. 579; Tr. at 136-137)

Dr. Parran testified,

Again, here is a patient with two years' worth of longitudinal pain * * * who reports being on a high dose of a potent Schedule II opiate on a daily basis; and who clearly has old medical records available, clearly would have, you know, pharmacy profiles and those sorts of things available. And so certainly that kind of information would be important to obtain.

(Tr. at 138)

At her initial visit, Patient 5 was prescribed OxyContin 20 mg #30 with instructions to take one tablet twice per day, Maxidone #30 with instructions to take one tablet twice per day as needed,⁴ and Soma 350 mg with instructions to take one tablet twice per day as needed.⁵ (St. Ex. 5 at 79) Dr. Parran testified that, at her second visit, Patient 5's dose of OxyContin increased from twice per day to three times per day. (Tr. at 139-140)

Following her second appointment on August 9, 2001, Patient 5 did not see Dr. Nucklos again until November 29, 2001. The November 29, 2001, progress note states that Patient 5 had not visited for the previous three months because she had been in jail. It further states, "Just released and wants pain meds." (St. Ex. 5 at 77) Dr. Parran testified that the medical record did not include any mention of why Patient 5 had been in jail, and that that had been "inconsistent with basic caring for the patient." Dr. Parran testified that people do not go to jail for three months for no reason, and that there is a correlation between incarceration and "out-of-control chemically-dependent behavior[.]" (Tr. at 141-142)

Furthermore, Dr. Parran testified:

[K]nowing that she hadn't received any opiates for three months, starting her right back on OxyContin 20 milligrams three times a day; adding in quick-release oxycodone, which is the OxyIR; reestablishing the Soma; and adding

⁴ Maxidone was prescribed only once. OxyIR was prescribed on one additional occasion and Percocet 10/650 was prescribed twice, in addition to OxyContin and Xanax. (St. Ex. 5 at 73-79)

⁵ Soma was discontinued after the third visit. (St. Ex. 5 at 73-79)

in the Xanax, is just, again, that—that—clinically, that’s reckless. It’s—That demonstrates a disregard for the health and safety and maybe life of the patient.

(Tr. at 141-142)

In addition, the medical records indicate that, following her visit on November 29, 2001, Patient 5 did not see Dr. Nucklos again until February 28, 2002. (St. Ex. 5 at 129-131)

102. Dr. Parran testified that restarting Patient 5 on high doses of controlled substances following gaps in treatment had endangered Patient 5. Dr. Parran further testified that the medical records never reflected discussions with the patient concerning withdrawal symptoms or treatment for detoxification during the periods of time when she should have run out of medication. (Tr. at 141-151)
103. Dr. Parran testified that an undated note states that the patient had reported that “all of her prescriptions flew out the window of a car on her way home from Columbus.” Dr. Parran testified that that is a “fairly transparent sort of scamming-type behavior in order to try to get early prescription refills.” (St. Ex. 5 at 5; Tr. at 149)
104. The prescription log for Patient 5 indicates that on March 14, 2002, Patient 5’s dose of OxyContin was increased to 40 mg with instructions to take one every 12 hours. Subsequently, on July 9, 2002, her OxyContin was increased to 40 mg three times per day. (St. Ex. 5 at 59)

Dr. Parran testified that there were no reasons noted in the medical records for the increasing doses of OxyContin. (Tr. at 145-146)

105. A progress note dated February 28, 2002, indicates that patient had complained of increased left knee pain over the previous three months. Among other things, Dr. Nucklos ordered, “Obtain surg records [left] knee & refer to Ortho.” (St. Ex. 5 at 61) However, Dr. Parran testified that there is no evidence that the records were obtained, and no records of an orthopedic consultation having been performed. Furthermore, Dr. Parran testified that there had been an order for x-rays but there is no evidence in the medical records that the x-rays were ever performed. (St. Ex. 5 at 5, 61; Tr. at 153-154)

Testimony of Dr. Knott

106. Dr. Knott testified concerning the findings from Dr. Nucklos’ physical examination of Patient 5:

[T]here was no list or torticollis. Cervical spine range of motion was normal with the exception of forward flexion, which was limited by about 30 percent. Upper—Upper and lower extremity deep tendon reflexes were normal.

Manual muscle testing and sensation was normal in all extremities, with the exception of decreased sensation in the—to light touch and pinprick in the left lower extremity below the knee in the L5-S1 distribution.

Spurling's maneuver, distraction, compression and Valsalva were all negative. Apley's, and McMurray's, drawer signs were all negative in the knee. Upper extremity range of motion was normal. Let's see here. Abduction, external rotation were limited to 50 percent in the upper extremity.

(Tr. at 685) Dr. Knott added that he believes that Dr. Nucklos had performed an appropriate physical examination based on Patient 5's presenting complaint. (Tr. at 686)

Dr. Knott described Dr. Nucklos' diagnosis thusly: "Status post multiple fractures. Lumbosacral sprain and left knee sprain, chronic." (Tr. at 686)

107. Dr. Knott testified that Dr. Nucklos had prescribed appropriate medications and dosages based on the patient's medical complaints. (Tr. at 686)

Dr. Knott testified that a typical reason for prescribing a short-acting analgesic along with OxyContin is to control breakthrough pain. Dr. Knott further testified, "Even though this sustained-release OxyContin is supposed to last 12 hours, it very rarely does. So medication is given for that period of time during which they need pain relief that is not covered by OxyContin." (Tr. at 688)

108. Dr. Knott testified that if a patient misses an appointment and is gone from his practice for a period of time, then returns, he would inquire as to the reason for the absence. Dr. Knott further testified that, depending on the patient's response, he may continue treating the patient. Dr. Knott added that, depending on the dosage of medication the patient had been taking, he may continue the patient at the same dose or reduce it. (Tr. at 687)

109. Dr. Knott testified that, in his practice, if he needs records of prior medical treatment, he asks the patient to bring any records they have. If any more records are needed, he has the patient sign a release and faxes a request for medical records to the previous physician. (Tr. at 689-690)

Patient 6

110. Patient 6, a female born in 1978, first visited Dr. Nucklos on September 13, 2001. Dr. Nucklos' notes concerning Patient 6's initial visit indicate that she had slipped and fallen two or three years previously and landed on her lower back. Her chief complaint was low back pain. A CT scan and MRI were noted to have shown "Disk Herniations x4." The names of previous treating physicians were noted as were visits to the emergency room, the last having occurred about four months prior to the patient's initial visit. Patient 6 reported taking Vicodin and Tylox. Dr. Nucklos prescribed OxyContin 20 mg

#42 with instructions to take one tablet three times per day, and Percocet 5 mg #30 with instructions to take one tablet three times per day as needed. (St. Ex. 6 at 27)

At Patient 6's next visit on September 27, 2001, Dr. Nucklos increased the dose of OxyContin to 40 mg twice per day. (St. Ex. 6 at 26) On October 25, 2001, Dr. Nucklos added Soma 350 mg #30, with instructions take one tablet twice per day as needed. (St. Ex. 6 at 25)

111. A progress note dated December 6, 2001, indicates that Patient 6 reported good pain control. It also indicated that, the previous night, she had slipped and fallen and landed on her back, resulting in a trip to the ER. Dr. Nucklos' assessment stated, "Inadequate pain control." At that visit, Percocet was discontinued, the dose of OxyContin was increased to 40 mg three times per day, and the dose of Soma was increased to three times per day. (St. Ex. 6 at 24)

Testimony of Dr. Parran

112. Dr. Parran criticized Dr. Nucklos for prescribing at Patient 6's initial visit 70 milligrams of oxycodone per day to a patient who reported being on an unknown dose of Vicodin and Tylox four months earlier. Dr. Parran testified that that could have been a fatal dose, and evidenced a disregard for the patient's safety. (Tr. at 160-161)
113. Dr. Parran testified that there had been no reports in the medical record of the results of the CT scan and MRI, and that the results that were noted had been "per patient history." (Tr. at 158)

Dr. Parran noted that in March 2002 it was noted that Patient 6 reported that the medications allowed her to function and perform her activities of daily living; however, oxycodone screening ordered at that visit had evidently resulted in the patient being discharged from the practice. No explanation was given for the discharge, however. (St. Ex. 6 at 21; Tr. at 159)

114. Dr. Parran testified that the medical record for Patient 6 included "no old records, no studies, no consults, no workup, minimal history and physical, [and] no labs." (Tr. at 159)

Testimony of Dr. Knott

115. Dr. Knott testified that Patient 6 first presented to Dr. Nucklos with a complaint of low back pain. He described the physical examination performed by Dr. Nucklos thusly:

The general assessment of a patient in moderate distress. She was oriented times three. No list. Straight leg raising maneuver was negative. Braggard's reinforcement test was negative. Two-plus and equal reflexes throughout the lower extremities. Manual muscle testing was normal. She had normal

pinprick and two-point discrimination in the lower extremities. Normal to light touch, as well.

Tenderness was noted in the lumbosacral spine and the midline and over the bilateral sacroiliac joints. That's it.

He did a—an assessment of the—of the heart, as well, and the lungs. Auscultation with normal sinus rhythm, no wheeze, rhonchi, rubs.

And range of motion of the lumbosacral spine was normal, but there was a break in rhythm upon a return to—to the erect position.

(Tr. at 696-697)

Dr. Knott testified that Dr. Nucklos diagnosed Patient 6 with chronic lumbosacral sprain and strain. (Tr. at 698)

116. Dr. Knott testified that the medication and dosage prescribed to Patient 6 at her initial visit had been appropriate for her condition. (Tr. at 698)
117. Dr. Knott acknowledged that, although Patient 6 had complained of migraine headaches, Dr. Nucklos' documentation of the initial visit did not include a history, examination, or workup for migraine headaches. (St. Ex. 6 at 17, 27; Tr. at 898-899)
118. Dr. Knott testified that Dr. Nucklos had not documented why he had prescribed Percocet at Patient 6's initial visit in addition to the OxyContin. Dr. Knott noted that Percocet normally would have been prescribed for breakthrough pain, and acknowledged that Dr. Nucklos would have had no way of knowing at the initial visit that Patient 6 would experience breakthrough pain. Dr. Knott testified that, in his practice, he does not typically prescribe medication for breakthrough pain at a patient's initial visit. (St. Ex. 6 at 27; Tr. at 900-901)

Patient 7

119. Patient 7, a female born in 1958, first visited Dr. Nucklos' office on August 16, 2001. On her Pain Assessment Questionnaire, she indicated that she had been taking OxyContin 20 mg and Soma. No indication of her current medication was noted on Dr. Nucklos' initial evaluation note, however. At that visit, Dr. Nucklos prescribed Lidoderm patches to be applied to Patient 7's lower back, OxyContin 20 mg #42 with instructions to take one tablet three times per day, Soma 350 mg #30 with instructions to take one tablet twice per day, and Maxidone 10 mg #30 with instructions to take one tablet twice per day. (St. Ex. 7 at 41)
120. Testimony concerning a page in the record that states simply "Deceased" is not deemed relevant because there is no substantial evidence that that page had been included in Dr. Nucklos' medical records for Patient 7. (St. Ex. 7 at 43)

Ms. Woodruff testified that Patient 7 had died in a house fire. (Tr. at 469-470)

Dr. Parran's Written Report

121. In his written report, Dr. Parran criticizes Dr. Nucklos' treatment of Patient 7 for, among other things, for failing to obtain records of prior medical treatment and for having performed an "awful H&P" at Patient 7's initial visit. (St. Ex. 31)

Testimony of Dr. Parran

122. Dr. Parran testified that Patient 7, a 42-year-old female, had reported back pain from a previous injury. At her initial visit, she reported having been on no medication. Nevertheless, Dr. Nucklos prescribed 60 mg of oxycodone per day. Dr. Parran further testified that the history and physical examination were inconsistent with an initial evaluation of a chronic pain patient. Dr. Parran further testified, "No old records, no studies, no workup ordered." (St. Ex. 7 at 85; Tr. at 162-163)

Dr. Parran further testified that, at Patient 7's second visit on August 30, 2001, Dr. Nucklos found "Pain adequately controlled." Dr. Parran further testified that, nevertheless, Dr. Nucklos added OxyIR 5 mg with instructions to take one tablet twice per day as needed. (St. Ex. 7 at 83; Tr. at 163)

Moreover, Dr. Parran testified that Dr. Nucklos prescribed additional controlled medications to Patient 7's regimen during the course of her treatment without documenting any legitimate purpose. For example, at Patient 7's visit on October 11, 2001, Patient 7 reported occasional breakthrough pain, and Dr. Nucklos found that pain control was adequate. Nevertheless, Dr. Nucklos added Percocet and Xanax to her regimen. (St. Ex. 7 at 81; Tr. at 162-164)

Testimony of Dr. Knott

123. Dr. Knott testified concerning Dr. Nucklos' physical examination of Patient 7:

Range of motion of the neck and lower back. She did have a list in her posture to the right side. The deep tendon reflexes were normal in the—in the extremities. Manual muscle testing was—it doesn't say; that simply means it was normal.

* * *

Sensation to light touch and pinprick, two-point, and position sense were all normal; however, with the exception of hypersensitivity to light touch in the right fourth and fifth digits.

Palpation was—showed tenderness in the cervical and lumbosacral paraspinal muscles and facet joints, the C2-3 and C3-4, and the—there was an evaluation and observation of status post laceration of right lower extremity gastroc area, and it was tender to palpation, as well.

(Tr. at 704-705)

Dr. Knott testified concerning Dr. Nucklos' diagnosis: "Well, it's a chronic cervical and lumbosacral strain and sprain with chronic pain syndrome, and a facet syndrome at C2-3 and C3-4, and status post laceration of the right lower extremity primarily over the gastroc, and it's tender to palpation, as well, and the Achilles' area." (Tr. at 705)

124. Dr. Knott testified that the medications and dosages that Dr. Nucklos prescribed to Patient 7 at her initial visit had been appropriate. (Tr. at 706)

Patient 8

125. Note that this exhibit contains medical records from individuals other than Patient 8. (St. Ex. 8)

126. Patient 8, a female born in 1968, first visited Dr. Nucklos' office on August 16, 2001. She reported suffering from low back pain and migraine headaches following being raped in 2000. She reported having been taking OxyContin 40 mg and Vicodin at that time. Dr. Nucklos prescribed Lidoderm patches, OxyContin 40 mg #30 with instructions to take one tablet twice per day, OxyIR 5 mg #30 with instructions to take one capsule twice per day as needed, and exercise. (St. Ex. 8 at 49)

Testimony of Dr. Parran

127. Dr. Parran testified that the medical record for Patient 8 contained no old records or requests for old records, no studies, and "[c]learly insufficient initial history and physical." Patient 8 reported taking OxyContin 40 mg and Vicodin. (St. Ex. 8 at 49; Tr. at 165)

Dr. Parran testified that Patient 8 had been "prescribed the equivalent of 90 milligrams of oxycodone per day from the first visit with no verification that she actually was on that medication." Dr. Parran testified that that could have been a lethal dose if Patient 8 had not actually been taking that medication. (Tr. at 165-166)

128. Dr. Parran testified that, at her second visit, Patient 8 received a prescription for Ambien, which Dr. Parran characterized as a "benzodiazepine-type drug," based on Patient 8's complaint that she had had difficulty sleeping. (St. Ex. 8 at 48; Tr. at 166) Moreover, Dr. Parran testified that, during the course of Dr. Nucklos' treatment of Patient 8, other medications were added, such as Xanax and Soma, with no documentation concerning a reason. (St. Ex. 8 at 46-47; Tr. at 166-167)

129. Dr. Parran testified that, during her course of treatment with Dr. Nucklos, Patient 8 had reported that her medications were stolen and received early refills. A progress note dated May 9, 2002, indicates that Dr. Nucklos had prescribed OxyContin 40 mg #30 to be taken twice per day, Percocet 5 mg #60 to be taken every six hours, Soma 350 mg #30 to be taken twice per day, and Xanax 0.5 mg #42 to be taken three times per day. The progress note for the following visit, dated May 16, 2002, states, in part, “[Patient] reports meds being stolen 5/10/2002 while in jail for bad check.” At that visit, Dr. Nucklos issued prescriptions for OxyContin 40 mg #30 to be taken twice per day, Percocet 5 mg #60 to be taken once every six hours, Soma 350 mg #30 to be taken twice per day, and Xanax 0.5 mg #42 to be taken three times per day. In addition, Dr. Nucklos ordered a med check at 9:00 a.m. on May 23, 2002. (St. Ex. 8 at 40-41; Tr. at 166-167)

Dr. Parran testified concerning issues with Patient 8:

In February of 2002, the Xanax dose was doubled and there was no explanation for why. She missed a medication check and a urine drug screen in March of 2002 and the prescribing continued. She reported in May of 2002 that her medicines were stolen while she was in jail, supposedly in jail for a bad check, but this was never verified. And an early prescription was provided.

She was gone from the practice for a little while in the summer of ‘02. And then she says that she had increased pain and stiffness while incarcerated. And the prescribing continued through 10-14 of ‘02, and, again, for the same reasons as—as the others.

But with this even additional reasons with the incarcerations, the stolen medicines, the—the missing med checks, the not getting the urine drug screens, the going back and forth to jail it appears, are all not * * * evaluated, not worked up, not elucidated; just the prescribing continued.

(Tr. at 167-168)

Testimony of Dr. Knott

130. Dr. Knott testified concerning the physical examination performed by Dr. Nucklos at Patient 8’s initial visit:

She appeared in moderate distress. She was oriented times three. Her range of motion was limited in the forward flexion of the lumbosacral spine to 40 degrees. There was a break in rhythm when arising to the erect position. Side bending and rotation were—were limited by 40 to 50 percent. * * *

* * *

Normal sinus rhythm noted with auscultation. * * * No wheezes, rhonchi or rales noted.

No list with the posture. There is a negative straight-leg raise test and—and there was a negative Braggard's reinforcement test. The deep tendon reflexes were physiologic and symmetrical. Manual muscle testing was normal. Sensation was noted—light touch, pinprick two-point discrimination, and position sense to be normal; proprioception, that is. And that's the extent of the physical exam.

(Tr. at 709-710)

Dr. Knott testified that Dr. Nucklos diagnosed chronic low back pain secondary to lumbosacral sprain and strain, and migraine headaches. (Tr. at 710-711)

131. Dr. Knott testified that the Dr. Nucklos' treatment plan for Patient 8 had been appropriate. (Tr. at 711)
132. Dr. Knott testified that Dr. Nucklos' August 30, 2001, prescription for Ambien had been appropriate based upon the patient's complaint of difficulty sleeping. Dr. Knott disagreed that it had been necessary for Dr. Nucklos to obtain diagnostic testing or evaluations prior to prescribing Ambien. Dr. Knott further testified: "You base it upon the patient's complaints. The patient says they can't sleep, I believe them, give them Ambien, and they come back and I assess them at that time." (Tr. at 712-713)

Patient 9

133. Patient 9 is a male born in 1967. He presented with identification indicating that he is a non-driver. On the Pain Assessment Questionnaire, Patient 9 indicated that he had pain in his "[b]ack and legs and sometimes head," and noted that his most intense pain was in his back. At his initial visit on December 13, 2001, he claimed to have been taking OxyContin 80 mg three times per day, Soma eight times per day, and Percocet eight times per day. Dr. Nucklos prescribed OxyContin 20 mg [quantity illegible] with instructions to take one tablet three times per day, Ambien 10 mg with instructions to take one tablet at bedtime as needed, Soma 350 mg with instructions to take one tablet three times per day. Dr. Nucklos noted that he had discussed the benefits versus the side effects with Patient 9, and further noted, "Obtain old medical records." (St. Ex. 9 at 9, 20, 41-43)

Testimony of Dr. Parran

134. Dr. Parran noted that Patient 9 was another adult non-driver. He presented with low back pain secondary to a herniated disk from 1996. Dr. Parran testified that Dr. Nucklos had indicated in his plan to obtain previous medical records, however no release form was signed to get the old records, and there is no evidence of any attempt to obtain them.

Dr. Parran further testified that Dr. Nucklos had not performed or ordered any studies, work up, or consults. (Tr. at 169-170)

Further, Dr. Parran indicated that the patient had claimed to have been taking “huge doses of meds.” Dr. Parran noted that the dosing claimed by Patient 9 for Soma and Percocet is “inconsistent with prescribing.” (Tr. at 170)

In addition, Dr. Parran noted that a urine drug screen for oxycodone had been ordered in April 2002, but there were no results in the chart. (Tr. at 170)

Moreover, Dr. Parran testified that, in August 2002, Patient 9’s dose of OxyContin was increased and Percocet was added. Dr. Parran further testified that there appears to have been no reason to increase Patient 9’s medication because he had reported at that visit that his pain control was sufficient and he presented with no new complaints. (Tr. at 170-171)

Finally, Dr. Parran testified that the prescribing initiated by Dr. Nucklos at Patient 9’s first visit was done without first verifying that the patient had actually been taking that level of medication. Dr. Parran stated that the dosage as prescribed would have been at the very least harmful to the patient’s health, and potentially fatal. He characterized such prescribing as “not consistent with doctoring” and “unsafe.” (Tr. at 171)

Testimony of Dr. Knott

135. Dr. Knott testified that he does not regard a non-driver State identification card as a red flag. (Tr. at 714)

136. Dr. Knott described Dr. Nucklos’ physical examination of Patient 9 thusly:

Forward flexion of the lumbosacral spine was limited to 35 to 40 degrees, which is quite limited. He had no extension of his lumbosacral spine. There was no list with his posture. No report of a gait abnormality. Straight-leg raise test and Braggard’s reinforcement test were both negative. The deep tendon reflexes, manual muscle testing, and sensation testing, to proprioception, two-point discrimination, light touch, and pinprick were all normal in the lower extremities.

Auscultation and percussion of the chest revealed normal sinus rhythm; no wheezes—wheezes, rales, or rhonchi. And that’s the extent of that.

(Tr. at 7126-717)

137. When asked whether the initial dose of medication prescribed by Dr. Nucklos had been too high, Dr. Knott replied:

No, the dosage here is not high at all. The man had already been on 80s, it looks like here. And it looks like he was prescribed 20 milligrams three times a day. I would be worried it didn't provide pain relief if he'd already been on 80s.

But 20 milligrams of OxyContin is not a high dose at all. That's not—That's not correct.

(Tr. at 718)

138. Dr. Knott acknowledged that Dr. Nucklos had not documented a workup for Patient 9's complaint of head pain, nor did he document any impressions or diagnoses. Dr. Knott further acknowledged that Dr. Nucklos did not document any workup concerning the drug and alcohol use history of Patient 9. (Tr. at 914-915)

Patient 10

139. Patient 10, a female born in 1960, first visited Dr. Nucklos office on August 2, 2001. She presented with non-driver State identification. Patient 10 complained of neck and back pain following a January 2001 industrial injury. The record also indicates that she had complained of migraines and nerve problems. She claimed to been taking OxyContin 40 mg and Vicodin. Dr. Nucklos noted concerning Patient 10's then-current medications, "none at present, last meds were June." Dr. Nucklos prescribed exercises, OxyContin 40 mg #30 with instructions to take one tablet twice per day, and Ambien 10 mg #10 with instructions to take one tablet at bedtime as needed. (St. Ex. 10 at 23, 37)

Dr. Parran's Written Report

140. In his written report, Dr. Parran criticized Dr. Nucklos for, among other things, continuing to treat Patient 10 with controlled substances despite Patient 10 having "[s]kipped two UDS [urine drug screen] orders." (St. Ex. 31)

Testimony of Dr. Parran

141. Dr. Parran testified that, in Patient 10's case, Dr. Nucklos failed to obtain previous medical records, perform or order any work up, or order a consult. Dr. Parran further criticized Dr. Nucklos for prescribing OxyContin 40 mg at her first visit without verifying her claim that she had been taking that level of medication. (Tr. at 171-172)

A report in the medical record indicates that on October 4, 2002, Patient 10 had been an inmate in the Clark County Jail. However, at her next visit to Dr. Nucklos office on

October 16, 2002, there is no reference to that event. (St. Ex. 10 at 9, 25) Dr. Parran criticized Dr. Nucklos for failing to inquire why Patient 10 had been jailed. (Tr. at 172-173)

Testimony of Dr. Knott

142. Dr. Knott testified that Dr. Nucklos' impression at Patient 10's initial visit had been "that she had a cervical spine/lumbosacral spine strain and sprain with facet joint capsular injury bilaterally C2-3 and C3-4 from which she had developed chronic pain syndrome." Dr. Knott further testified that Dr. Nucklos had prescribed exercises, application of heat and cold, and medication. Dr. Knott testified that the exercises and use of heat and cold were treatments taught in PM&R residency. (Tr. at 720-722)
143. Dr. Knott testified that Dr. Nucklos' prescribing of medications to Patient 10 had been appropriate. (Tr. at 722)
144. Dr. Knott testified that he would not be concerned about prescribing OxyContin 40 mg twice per day to Patient 10. Dr. Knott noted that she could have experienced side effects: "Lethargy. Just out of it. Goofy." However, Dr. Knott testified that she does not believe that she would have experienced respiratory problems or risk of death. Dr. Knott noted that a patient can have an idiosyncratic reaction to any medication; however, "the chances of her dying from 40 milligrams of OxyContin twice a day is very, very minimal. Almost so rare that it would never happen." (Tr. at 921)

Patient 11

145. Dr. Nucklos' medical record for Patient 11 states that Patient 11 was a male born in 1970. Patient 11 complained of headache and severe left knee pain secondary to an automobile accident. Dates of injuries reported were 1997 and 1999. On his Pain Assessment Questionnaire, however, Patient 11 stated that he had first experienced pain in summer 1996. The Pain Assessment Questionnaire further indicates that Patient 11 had been taking OxyContin 40 mg and oxycodone 5 mg. A note on Dr. Nucklos' initial visit record appears to state "No meds in 3 wks."⁶ Dr. Nucklos' note also states that Patient 11's meniscus had been removed. Dr. Nucklos prescribed medication to Patient 11 at the initial visit that included OxyContin 40 mg [no quantity noted] with instructions to take one tablet twice per day, and OxyIR [quantity not noted] with instructions to take one capsule twice per day. (St. Ex. 11 at 23-25; 77)

Testimony of Dr. Parran

146. Dr. Parran criticized Dr. Nucklos for failing to inquire why Patient 11, a male born in 1970, was a non-driver. Dr. Parran further criticized Dr. Nucklos for failing to obtain previous medical records, or perform or order studies. Dr. Parran further testified that the history and physical examination recorded was very scant. (Tr. at 175-176)

⁶ The note was partially cut off on the copy. (St. Ex. 11 at 77)

Moreover, Dr. Parran criticized Dr. Nucklos for prescribing at the initial visit 90 mg of oxycodone per day with no evidence that Patient 11 had been taking such medications. Dr. Parran testified that if a patient who has not been previously exposed to opiates were to take that level of medication, even a patient who weighs 215 pounds as did Patient 11, it “easily could have killed the patient if taken as directed in the first 48 hours of prescribing.” (Tr. at 176-177)

Moreover, OxyContin was eventually increased to three times per day, and Percocet was added in October 2001. Finally, Dr. Parran testified that, on July 11, 2002, Patient 11 had been referred to consult another physician; however, there is no evidence in the medical record that the patient kept that referral. (St. Ex. 11 at 7; Tr. at 177)

Testimony of Dr. Knott

147. Dr. Knott described the physical examination performed by Dr. Nucklos on Patient 11 at Patient 11’s initial visit:

[R]ange of motion was assessed, extension and flexion of the knee, that was normal. Apley’s compression and distraction test was noted to be normal. McMurray’s sign and—was normal. That’s crepitation, movement with external and internal rotation. The drawer sign posteriorly and anteriorly were both negative. And there was a positive distraction test, meaning that there’s some apprehension when—with distraction.

(Tr. at 725) Dr. Knott further testified that the physical examination performed by Dr. Nucklos had been appropriate for the patient’s complaint. Moreover, Dr. Knott testified:

[I]f a patient comes in with an injury to their right finger, I’m not going to do another exam on them for just the sake of making someone else happy. The—The physical examination should be limited to the area of the body involved. That’s what the complaint is about. And that’s what the examination here involved.

(Tr. at 725)

In addition, Dr. Knott testified that Dr. Nucklos had placed Patient 11 on the same medication that Patient 11 had said he was taking. Finally, Dr. Knott testified that the medication prescribed by Dr. Nucklos had been appropriate based on Patient 11’s presenting complaint. (Tr. at 726-727)

Patient 12

148. Patient 12, male born in 1960, first visited Dr. Nucklos office on December 27, 2001. Despite having been 41 years of age, Patient 12 presented with a temporary Ohio driver's license. Patient 12 reported having fallen 10 feet from a porch roof six to seven years previous to the appointment. He claimed he had been taking OxyContin 40 mg, Percocet, and Soma. At his first visit, Dr. Nucklos prescribed OxyContin 20 mg #30 with instructions to take one tablet every 12 hours, Percocet 5 mg #30 with instructions take one tablet twice a day, and Soma 350 mg #30 with instructions to take one tablet twice per day. (St. Ex. 12 at 23, 49)

Testimony of Dr. Parran

149. Dr. Parran testified that Dr. Nucklos had failed to obtain records of previous medical treatment. Dr. Parran further testified that medications had been increased on multiple occasions. Two progress notes, dated March 21 and April 4, 2002, indicate that urine drug screens had been ordered or completed; however, there were no results documented in the medical record. (Tr. at 178-179)

Dr. Parran further testified that a 41 year old man with a temporary driver's license "is totally aberrant." (Tr. at 179)

Moreover, Dr. Parran testified that there had been no studies, no workup, and no verification that Patient 12 had been taking medications as he had claimed. Dr. Parran further testified that, if Patient 12 had not been taking the medications as he had claimed, then Dr. Nucklos' prescribing 70 milligrams of oxycodone per day at the initial visit could have resulted in an accidental overdose. (Tr. at 179)

Testimony of Dr. Knott

150. Dr. Knott described the physical examination performed by Dr. Nucklos at Patient 12's initial visit:

Well-nourished, well-developed gentleman in severe distress. No torticollis or list. There is a negative straight-leg raise maneuver, negative Braggard's reinforcement test. The deep tendon reflexes in his lower extremities were normal. Two-point discrimination, and light touch, pinprick, and proprioception all normal. Tenderness over the lumbosacral paraspinals and right sacroiliac joint area. Diagnosed with a lumbosacral sprain and strain.

(Tr. at 728-729)

151. Dr. Knott testified that, in his opinion, Patient 12's temporary driver's license does not raise a red flag. (Tr. at 732)

Patient 13

Testimony of Dr. Parran

152. Dr. Parran testified that Patient 13 was obese and was prescribed controlled substance diet medication by Dr. Nucklos. Dr. Parran testified that Dr. Nucklos had failed to follow Ohio law with regard to both the diet medication and the opiate medication that was later prescribed for her. Dr. Parran further testified that Dr. Nucklos had prescribed controlled substance anorectics for a period longer than the three-month maximum imposed by Board rules. Moreover, Dr. Parran testified that Patient 13 had gained weight during this time and continued to receive controlled substance anorectics. Finally, Dr. Parran noted that, later in her treatment, Patient 13 complained of pain and Dr. Nucklos placed her on Lortab. (Tr. at 180-182)

Testimony of Dr. Knott

153. Dr. Knott noted that Patient 13 had first seen Dr. Nucklos for weight management. Dr. Knott further testified that on April 5, 2001, Dr. Nucklos had prescribed Darvocet-N 100 to Patient 13 for left knee pain. Dr. Knott testified that it is not unusual for a physician to treat a patient for both obesity and pain. (Tr. at 732-735)

Patient 14

154. Patient 14, a female born in 1964, first visited Dr. Nucklos' office on August 9, 2001. Dr. Nucklos' note for that visit indicates that Patient 14 had reported taking OxyContin 20 mg and Soma; however, in a different location in the same note, it states "Injection & Oxy 40 & SOMA." Nothing is noted concerning that conflict in information. Dr. Nucklos' impression was "Chronic LB." He prescribed OxyContin 40 mg #30 with instructions to take one tablet every 12 hours, and Soma 350 mg #30 with instructions to take one tablet twice per day. Dr. Nucklos also prescribed abdominal exercises. (St. Ex. 14 at 87) (Emphasis added)

Testimony of Dr. Parran

155. Dr. Parran criticized Dr. Nucklos' treatment of Patient 14 as follows:

- Dr. Parran testified that Dr. Nucklos' initial history and physical examination was inadequate.
- Dr. Parran stated that Patient 14 had already been treated for pain for three years, which means that previous medical records would have existed, but there is no evidence of any attempt to obtain records of prior treatment.
- Dr. Parran testified that there is no documentation of a workup or consults.

- Patient 14 claimed that she had been taking OxyContin 40 mg and Soma. Dr. Parran criticized Dr. Nucklos for prescribing 80 mg of oxycodone per day at the initial visit without first verifying that Patient 14 had actually been taking that level of medication.
- Dr. Parran noted that Dr. Nucklos added Fioricet and Ambien during the course of treatment Patient 14. Dr. Parran testified that that meant that Patient 14 had been prescribed, in addition to OxyContin, a benzodiazepine (Ambien) and 2 barbiturates (Soma and Fioricet). In addition, Dr. Parran testified that Patient 14 later complained of unresponsive headache pain, and Dr. Nucklos stopped the Fioricet and began prescribing Percocet. When asked if that was appropriate, Dr. Parran responded, “No, not in a person who’s on OxyContin 40 milligrams twice a day already. And without an evaluation, it just doesn’t make any clinical sense.”

(Tr. at 182-185)

156. Dr. Nucklos medical records for Patient 14 include an authorization to release and request information from McKinley Hall in Springfield, Ohio. The request is dated July 17, 2002. It was signed by Patient 14 and Vanessa Porter, CCDC II. However, fax information at the top of the page indicates that it had not been faxed to Dr. Nucklos until July 26, 2002. Dr. Parran testified that no further prescriptions for controlled substances appear to have been issued by Dr. Nucklos after July 26, 2002. (St. Ex. 14 at 5, 37; Tr. at 317-321)

Testimony of Dr. Knott

157. Dr. Knott described the physical examination documented by Dr. Nucklos at Patient 14’s initial visit:

Well-nourished, well-developed female in mild distress with increased pain in her lower back after the examination. Range of motion of the lumbosacral spine was normal in all planes, but she did show a break in rhythm when arising to the standing position. Straight-leg raise maneuver and Braggard’s reinforcement test, both negative, bilaterally, deep tendon reflexes three-plus and equal. Sensation testing, pinprick, light touch, position and two-point all normal. Manual muscle testing normal.

(Tr. at 736-737)

Dr. Knott further testified that Dr. Nucklos documented an impression of chronic lower back pain. Moreover, Dr. Knott testified that Dr. Nucklos prescribed medication and Williams flexion exercises. Finally, Dr. Knott opined that Dr. Nucklos’ treatment plan was consistent with his evaluation and diagnosis of Patient 14. (Tr. at 737)

158. Dr. Knott acknowledged that Dr. Nucklos had failed to document in his initial visit notes any information concerning Patient 14's complaint of headache, which she had identified on her Pain Assessment Questionnaire. (St. Ex. 14 at 19, 57; Tr. at 927-928)

Dr. Knott further acknowledged that, in his notes from the initial visit, Dr. Nucklos documented in one location that Patient 14 had been taking OxyContin 20 mg and Soma, and on another location on the same page that she had been taking OxyContin 40 mg and Soma. Dr. Knott testified that he would have ascertained which amount had been correct, and acknowledged that Dr. Nucklos had failed to do so. (St. Ex. 19; Tr. at 929-930)

Patient 15

Testimony of Dr. Parran

159. Dr. Parran testified that Patient 15 was a 35 year-old woman, and was a non-driver. There is no documentation of any inquiry concerning the reason why she did not drive. (Tr. at 187)

Dr. Parran further testified that Patient 15 had had a previous treating physician whom she last saw six to seven months earlier, and she reported that she had been taking hydrocodone 7.5 mg and Valium. Dr. Parran testified that, although she stated that she had not seen her physician for six months, Dr. Nucklos started her on OxyContin 20 mg with instructions to take one tablet every 12 hours, and Lortab 10 mg with instructions to take one tablet three times per day as needed. Furthermore, Dr. Parran testified that Dr. Nucklos had prescribed 70 mg of opiate per day to Patient 15 even though she had reported that she had not seen a doctor in six to seven months. Dr. Parran testified that this could have resulted in over-sedation. Dr. Parran testified that she should have been placed on a lower dose of medication, or started on a non-opiate medication. (Tr. at 187-189)

Moreover, Dr. Parran testified that, six weeks later, OxyContin was increased to 20 mg three times per day and, based upon a note that says that she had complained of nervousness, Dr. Nucklos added Xanax to her regimen. Further, Dr. Parran testified that, on January 3, 2002, Dr. Nucklos gave Patient 15 an early refill of Xanax based upon her statement that she had "lost script." Finally, Dr. Parran testified that, in his opinion, the prescribing of opiates and benzodiazepines to Patient 15 "was just inconsistent with the usual course of medical practice and with the State statutes regarding the management of chronic intractable pain." (Tr. at 189-190)

Testimony of Dr. Knott

160. Dr. Knott described the history taken by Dr. Nucklos at Patient 15's initial visit:

Patient was involved in a motor vehicle accident in 1987. Sustained an injury to her lower back which gradually got worse over the ensuing time. Five-foot-ten, 140. Had seen Dr. Bryson in the past in Texas.

Was diagnosed as having an L4-5 slipped disk by MRI. Had been taking hydrocodone and Valium. Her present complaints were lower back pain with bilateral lower extremity numbness. Noncontributory past medical history. No allergies to medications. Single with two children, ages 17 and 12. High school graduate with two years of college. Patient was not employed.

(Tr. at 742-743) Dr. Knott noted that it further states that Patient 15 had been in three car accidents. (Tr. at 743)

Dr. Knott further described the physical examination documented by Dr. Nucklos:

Well-nourished, well-developed lady in moderate distress. Oriented times three. No torticollis or list. Spurling's maneuver, straight leg raising maneuver, Braggard's reinforcement test all negative. Normal reflexes, deep tendon reflexes.

Pain inhibition weakness in knee, lower extremities, bilaterally. Two-point discrimination, light touch, proprioception, and pinprick all normal. Range of motion of the lumbosacral spine revealed a restriction in forward flexion to 50 degrees, extension was limited to 15 degrees. Side bending was approximately 40 to 60 percent of the expected normal.

And her diagnosis, after palpation and consideration of the neurological, was severe lumbosacral sprain and strain.

(Tr. at 743-744)

161. Dr. Knott testified that the medication prescribed at the initial visit had been appropriate. Dr. Knott noted that Patient 15 had already been on medication; however, even if she had not, the dosage would not be too high. (Tr. at 745)

Dr. Knott further testified that the initial visit report states that Patient 15 had last seen her previous physician six or seven months before her initial visit with Dr. Nucklos. Dr. Knott noted that there is no information indicating whether Patient 15 was on any medication immediately preceding her visit with Dr. Nucklos. Dr. Knott reiterated that he would not be concerned that the initial dosage prescribed by Dr. Nucklos could have caused the patient to overdose. (Tr. at 745-746)

162. Dr. Knott testified that Dr. Nucklos' diagnosis of anxiety on December 6, 2001, had been sufficient to warrant prescribing Xanax to Patient 15. (St. Ex. 15 at 18; Tr. at 746-747)

Patient 16

163. Patient 16 is a female born in 1962. She first visited Dr. Nucklos on September 27, 2001. At that time, Patient 16 filled out a Pain Assessment Questionnaire. With regard to the location and intensity of pain, Patient 16 responded: “pancreas but mostly from back to front. Right hip/but straight down back of leg to ankle.” In answer to a question concerning the location of the most intense pain, Patient 16 wrote, “pancreas.” (St. Ex. 16 at 19)

However, in his note concerning Patient 16’s initial visit, Dr. Nucklos did not mention any problem with Patient 16’s pancreas, but instead recorded only “Back pain” with regard to her complaint, and his impression of right sciatica and myofascial pain. Dr. Nucklos’ note concerning Patient 16’s current medications states that Patient 16 had reported taking OxyContin 40 mg; and elsewhere on the same note states “no meds at this time.” Dr. Nucklos prescribed OxyContin 20 mg #30 with instructions to take one every 12 hours, and Lortab 10 mg #30 with instructions take one tablet twice per day as needed. (St. Ex. 16 at 39)

Testimony of Dr. Parran

164. Dr. Parran testified that Patient 16 “was a patient who was 38 years old and had chronic pancreatitis secondary to chronic alcoholism.”⁷ Dr. Parran further testified that “a tiny fraction of people with alcoholism develop pancreatitis, usually ones with very severe alcoholism. And the fact this patient had a chronic pancreatitis secondary to the alcoholism indicates more severe alcoholism than—than even the average alcoholic. So it’s a bad sign.” Dr. Parran further testified that there appears to be an inconsistency with regard to Patient 16’s statements she was taking OxyContin 40 mg and another statement on the same note that said that she was taking no medication at that time. (Tr. at 190-191)

Dr. Parran further testified that no records of prior medical treatment were obtained; there was “no workup, no consultations, [and] no chemical dependency evaluation.” Dr. Parran also noted that, although she had evidently not been taking any medication, she was started on the equivalent of 60 milligrams of high potency opiates per day. Dr. Parran testified that that was “inconsistent with the usual course of medical practice[.]” Dr. Parran further noted that Soma was added on February 14, 2002. (St. Ex. 16 at 31; Tr. at 191-194)

Moreover, Dr. Parran testified that, on January 31, 2002, Patient 16 had a flare-up of her pancreatitis pain. Dr. Parran further testified, “It’s possible for a person to have spontaneous flares of chronic pancreatitis pain once they have developed it, but it’s much more typical that people get flares from their chronic pancreatitis because they’re still drinking.” However, Dr. Parran testified that Dr. Nucklos had not evaluated Patient 16 to determine whether she had still been drinking. (St. Ex. 16 at 31; Tr. at 192-193)

⁷ An undated note from another physician in Patient 16’s chart states that Patient 16 “has had severe pancreatitis (ETOH) in past [with] surgical resection. Now [with] chronic pancreatitis & chronic pain.” (St. Ex. 16 at 23)

Furthermore, Dr. Parran testified that a history of alcoholism is a contraindication to the scheduled drugs that Dr. Nucklos had prescribed to Patient 16. In addition, Dr. Parran testified that Patient 16 had missed a medication check on March 7, 2002, but was still prescribed her regimen of medications on March 14, 2000. Finally, on March 21, 2002, after Patient 16 had missed another medication check, and because Patient 16 was seeing multiple doctors, she was dismissed from the practice. (St. Ex. 16 at 29-31; Tr. at 193-194)

Testimony of Dr. Knott

165. Dr. Knott testified that Dr. Nucklos documented the following history for Patient 16's initial visit:

[S]he had had back pain for an extended period of time. That she had been on OxyContin 40s for the pain control. She was still complaining of back pain. She had a past medical history of a splenectomy in 1987. She was single with two children, a high school graduate, unemployed.

She's been smoking a pack a day for 20 years, so 20 pack year history of smoking. She was allergic to ampicillin, penicillin, Rocephin. She stood five-foot-one-inches tall, weighed 107 pounds. Blood pressure 112 over 74, pulse was 80. Had seen Dr. Watson in the past.

(Tr. at 749)

Dr. Knott further testified concerning the physical examination performed by Dr. Nucklos:

General assessment of the—of this 38-year-old lady in moderate-severe distress. DTRs in her lower extremities were physiologic and symmetrical two- to three-plus. Manual muscle testing, normal. Light touch, pinprick, two-point, and proprioceptive sensory was all normal.

Tenderness was noted in the thoracic spine on the left and bilateral sacroiliac joints, greater on the right than the left. Diagnosed with myofascial pain and sciatica.

(Tr. at 749-750)

166. Dr. Knott testified that the medication prescribed to Patient 16 by Dr. Nucklos had been appropriate and that the dosage was not too high. Dr. Knott testified: "I'm not sure why we keep going over this. OxyContin 20 is not a high dose narcotic. That's actually a very low dose." Dr. Knott noted, however, that for most people it may seem like a lot of medication. (Tr. at 751-752)

Dr. Knott further testified that it had been appropriate for Dr. Nucklos to evaluate and treat Patient 16 himself rather than send her to another physician for an evaluation. Dr. Knott testified that PM&R physicians are the physicians who treat such problems, and that there is no reason to send a patient out to another physician “to do the same thing.” (Tr. at 752)

Note Concerning Patients 17 through 22

Testimony of Dr. Parran

167. Dr. Parran testified that Patients 17 through 22 all shared the same surname. Dr. Parran further testified that all of them are in their late 30s to early 40s, three out of the five are non-drivers, and appear “to be related to each other; although, again, given the medical records available, it’s very difficult to tell.” Dr. Parran further testified that that “is absolutely inconsistent with the usual standard of care to be taking care of multiple people from the same family, and trying to decide whether they’re from the same family, and not being able to determine whether there was any relationship between them from the medical records.” (Tr. at 196-197)
168. Dr. Parran testified that chronic intractable pain “does not cluster in families.” However, he testified that addiction clusters in families “more than any other disease set that we know of[.]” (Tr. at 198)
169. On cross-examination, Dr. Parran testified that, other than Patient 17 and Patient 21, who appear to have been married to each other, he had been unable to determine whether the other patients with the same surname had been related. Further, Dr. Parran acknowledged that, other than Patient 17 and Patient 21, he is unable to conclude that Patients 17 through 22 are related to each other. (Tr. at 322-324)

Testimony of Dr. Knott

170. Dr. Knott testified that he had not seen anything in the medical records for Patients 17 through 22 that indicated that they were related to each other, although it appeared that Patients 17 and 21 were married. (Tr. at 753-754, 779)

Patient 17

Testimony of Dr. Parran

171. Dr. Parran testified that the medical records for Patient 17 indicate that he was a non-driver, and that he had been discharged from another physician’s practice “due to stolen meds and a failed medication check.” Nevertheless, Dr. Parran testified that, at Patient 17’s initial visit, Dr. Nucklos prescribed OxyContin 40 mg twice per day and Tylox. (Tr. at 203) [The Hearing Examiner was unable to find a prescription for Tylox at Patient 17’s first visit; however, two weeks later at Patient 17’s second visit, Tylox capsules were added. (St. Ex. 17 at 13-15)]

Dr. Parran further testified that Dr. Nucklos' medical records for Patient 17 contained no medical records of prior treatment, no workup, no consultations, inadequate histories and physical examinations, and "the prescribing was inconsistent with the standard of care and it was inconsistent with the statutes regarding prescribing of chronic opiates for chronic pain." (Tr. at 203)

Testimony of Dr. Knott

172. Dr. Knott noted that, one month prior to his initial visit with Dr. Nucklos, Patient 17 had been discharged from his previous physician's practice for failing medication checks. Dr. Knott testified that, when presented with such a patient, a physician can either choose not to treat the patient or to "be cognizant of it and be very, very watchful if you choose to undertake their care." (Tr. at 755) Dr. Knott testified that, if he had been presented with such a patient, he would ensure that they were med checked and subjected to drug screens, and he would "watch them like a hawk." (Tr. at 755)

173. Dr. Knott described the physical examination performed by Dr. Nucklos at Patient 17's initial visit:

It included the general assessment. It included an assessment of his gait pattern. It did show antalgia on the left side, which is a short stance phase on the left side, indicating pain in the left lower extremity.

His auscultation of the heart and lungs was normal. Deep tendon reflexes in the lower extremities were normal with the exception of an absent left ankle reflex tendo-Achille's. Muscle testing was normal. All sensory parameters were normal.

And there was tenderness to palpation in the left anterior tibular area and the distal fibula, with a diagnosis of status post compound fracture of the left tibia and fibula with chronic pain syndrome.

(Tr. at 756-757)

174. Dr. Knott acknowledged that no alcohol or drug history was documented at Patient 17's initial visit. Dr. Knott further acknowledged that he would consider that to be important information with this patient. (Tr. at 937)

Patient 18

175. Patient 18, a male born in 1959, first visited Dr. Nucklos on July 26, 2001. He complained of pain in his lower back, legs, and stomach. He stated on the Pain Assessment Questionnaire that he had previously been prescribed OxyContin 40 mg, Lortab 10 mg, and Valium 10 mg; however, Dr. Nucklos' initial visit report states that Patient 18 had received

Xanax and “Oxy \bar{n} BID” from a Dr. Cole. Dr. Nucklos’ initial visit note also states that Patient 18 had been taking no medication for 1½ months. Moreover, Dr. Nucklos’ office staff noted: “Seen Dr. Cole had surgery Feb 2000. Was diagnosed with colon cancer. In April had colostomy. Not currently seeing any physicians for anything. Has no insurance to do anything with his health.” Dr. Nucklos performed a physical examination and diagnosed chronic low back pain. Dr. Nucklos prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, Lortab 10 mg #30 with instructions to take one tablet twice per day, and Ambien 10 mg #10 with instructions to take one tablet at bedtime as needed. He also discussed with Patient 18 meditation, diet, and supplements. (St. Ex. 18 at 13-14, 53)

Testimony of Dr. Parran

176. Dr. Parran noted that, on August 23, 2001, Patient 18 had reported having no problems and that his medications were working well; however, Dr. Nucklos “added Valium 10 milligrams three times a day to the prescribing for no apparent medical purpose.” Dr. Parran further testified that Patient 18 had an abnormal medication check on January 31, 2002, and, in March and April 2002, “failed to get urine drug screens that were ordered.” Moreover, Dr. Parran testified that, in May 2002, Patient 18 missed a medication check and was dismissed from the practice. However, within days, claiming that he had missed the medication check because he had been in the hospital, he was reinstated to the practice. Dr. Parran noted that there were no hospital records, discharge summary, or other evidence in the medical record that supported Patient 18’s claim. In addition, Dr. Parran testified that Patient 18 missed another medication check in June 2002 and, “as a consequence, his medicines were decreased from OxyContin to only Percocet and Xanax. But by the next month, in July of 2002, he was back up to OxyContin, Percocet and Xanax.” Finally, Dr. Parran noted that, despite Patient 18 “demonstrating wildly out-of-control behavior * * * over a several month period of time,” Dr. Nucklos continued prescribing controlled substances “despite this evidence of deterioration on the part of the patient.” (Tr. at 201-203)

Testimony of Dr. Knott

177. Dr. Knott described the physical examination performed by Dr. Nucklos at Patient 18’s initial visit:

[A]n assessment of his posture. He stood erect with a right list. Heel and toe walking and squatting were asymmetrical. They amounted to about 50 percent of what was expected as normal. Lumbosacral range of motion forward flexion was 35 to 40 percent of the expected normal with a break in rhythm upon rising to the erect position.

The deep tendon reflexes, manual muscle testing, and sensation testing to pinprick, light touch, proprioception, and two-point discrimination is normal.

* * *

There was abdominal pain with no rebound adjacent to the colostomy.
There's lumbosacral tenderness with spasm.

(Tr. at 759-760)

178. Dr. Knott noted that Patient 18 was discharged from Dr. Nucklos' practice on May 9, 2002, for missing a med check, pending explanation. When Patient 18 returned on May 16, 2002, Dr. Nucklos documented that Patient 18 had reported having problems with his brother's death and funeral, and continued prescribing. (St. Ex. 18 at 35; Tr. at 761-762)

Dr. Knott testified that another med check was scheduled for May 23, 2002, which Patient 18 also missed. He was discharged from Dr. Nucklos' practice again. Dr. Knott noted that that response had been appropriate. (St. Ex. 18 at 35; Tr. at 762)

[Note that Dr. Nucklos continued seeing Patient 18 and prescribing controlled substances on seven subsequent visits through August 26, 2002, after which Patient 18 missed another med check and was discharged. No further visits are documented in the chart. (St. Ex. 18 at 27-33)]

Patient 19

179. Patient 19, a male born in 1960, first saw Dr. Nucklos on August 30, 2001. He presented with non-driver State identification. Patient 19 complained of pain in his neck, lower back, arms, and legs secondary "to being struck by office chairs" in 1996 and a motor vehicle accident in 1997. However, on his Pain Assessment Questionnaire, Patient 19 reported pain only in his low back and right leg. He left blank the space for listing current medications. Dr. Nucklos' notes for the initial visit state, among other things, that Patient 19 had been taking OxyContin; on the other side of the same page it states, "Currently on Fioricet [two tablets] for migraine [and] Valium 10 mg, one tablet three times per day." No further comment concerning Patient 19's different pain reports or medications was documented. Dr. Nucklos diagnosed cervical sprain/strain, facet joint injury, and lumbosacral sprain/strain "[with] neuro deficit." He prescribed OxyContin 40 mg #30 with instructions to take one tablet every 12 hours, OxyIR 5 mg [no quantity documented] with instructions to take one capsule twice per day as needed, and Zonegram 100 mg #28 with instructions to take one capsule at bedtime. (St. Ex. 19 at 11-15, 65)

Testimony of Dr. Parran

180. Dr. Parran testified that Patient 19 was a non-driver, and he "had increasing medications. * * * On February 28th of 2002, went to jail for six weeks, and the prescribing continued, and there was no assessment of why he'd gone to jail." (Tr. at 201-202) At that time, Dr. Nucklos provided Patient 19's public defender with prescriptions for OxyContin 40 mg

#30 with instructions to take one tablet three times per day, and Ambien 10 mg #10 with instructions to take one tablet at bedtime as needed. (St. Ex. 19 at 57)

The next progress note following February 28, 2002, is dated April 11, 2002. At that visit, Dr. Nucklos prescribed the same medication and dosages he had prescribed on February 28, 2002. (St. Ex. 19 at 57)

Testimony of Dr. Knott

181. Dr. Knott described the physical examination that Dr. Nucklos performed at Patient 19's initial visit:

Well-nourished, well-developed, thin male in moderate distress. No torticollis or list. Spurling's was negative, but painful. Straight-leg raise test was negative bilaterally, and Braggard's reinforcement test was negative. Phelan's test was positive bilaterally, as was Tinel's sign of the wrist. His upper and lower extremity deep tendon reflexes were normal.

He exhibited normal report of sensation to pinprick, light touch. Proprioception and two-point discrimination and manual muscle testing was normal. He—However, he did complain of decreased light touch and pinprick in both hands, and he had decreased sensation below the knee in his right lower extremity.

(Tr. at 764-765)

Dr. Knott further testified that Dr. Nucklos diagnosed Patient 19 with "[f]acet joint injury, cervical spine; cervical sprain/strain; and lumbosacral sprain and strain with neurological deficit." (Tr. at 765)

Patient 20

182. Patient 20 first visited Dr. Nucklos office with on July 19, 2001. With regard to his complaint, the note for that visit states "[Patient] here for Pain Management evaluation. Not seeing any physicians at this time. Just released from jail July 14th. [Patient] states he drinks no alcohol, no rec. drugs." (St. Ex. 20 at 75) In his notes from the initial visit, Dr. Nucklos indicated, in part, as subjective information, "Meds – OxyContin 20 – Soma - Valium." Dr. Nucklos prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, and Zanaflex 4 mg [no quantity noted] with instructions to take one tablet twice per day as needed. (St. Ex. 20 at 75)

A note dated November 15, 2001, states that Nationwide Insurance had called wanting a copy of Patient 20's medical records along with the medical records of another individual. The note further states: "They are both turning in bills for treatment here for an automobile accident. Nationwide thinks they are trying to 'pull something with the bills.['] I see no

notes of us treating them for the car accident 10/12/01. I will send the records on 11/30/01. Tricia.” (St. Ex. 20 at 39)

Testimony of Dr. Parran

183. Dr. Parran testified that Patient 20 was “[a]nother non-driver who presented to the office having been just released from jail on no medicine, no prior medical records were obtained, no workup was done, [and] no consultations were obtained.” (Tr. at 204)

Dr. Parran noted that, following the visit on January 3, 2002 (at which time Patient 20 was prescribed OxyContin 40 mg #42 with instructions to take one tablet three times per day, and Soma 350 mg #30 with instructions to take one tablet twice per day), Dr. Nucklos did not see Patient 20 again until September 11, 2002. No reason for the extended absence was noted. Nevertheless, Dr. Parran noted that Dr. Nucklos restarted Patient 21 on OxyContin 20 mg twice per day. Dr. Parran noted that that was probably not such a high dose that it would result in a fatal overdose, but was still an unsafe amount. (Tr. at 204-205)

Testimony of Dr. Knott

184. Dr. Knott testified that if a patient came to him and had just gotten out of jail he would watch the patient a little closer, because people usually “go to jail for some reason[.]” (Tr. at 766-767)
185. Dr. Knott testified concerning the physical examination performed by Dr. Nucklos at Patient 20’s initial visit:

It included the auscultation of the chest and heart; no wheezes, rubs or rhonchi, normal sinus rhythm, S1 and 2 sounds were normal.

His range of motion of the cervical spine was restricted by 70 to 80 percent. Range of motion of the upper extremities was normal. The upper extremity deep tendon reflexes were three-plus and equal and also present in the lower extremities to the same degree.

Manual muscle testing in the upper extremities was normal with the exception of a decreased grip strength on the right. Upper extremity sensation was noted to be diminished in the right C5-6 and 7 dermatomes. Tinel’s and Phelan’s sign were negative.

(Tr. at 767-768)

Patient 21

186. Patient 21, a female born in 1960, first visited Dr. Nucklos’ office on August 9, 2001. At that time Patient 21 weighed 85 pounds. She reported that in 1997 she had slid out of a

machine and cracked four ribs. She reported taking several non-controlled substance medications and OxyContin 20 mg three times per day. Dr. Nucklos diagnosed chronic low back pain, and prescribed OxyContin 20 mg with instructions to take one tablet twice per day, and Ambien 10 mg with instructions to take one tablet at bedtime as needed. No quantities were documented for either prescription. (St. Ex. 21 at 55)

187. Dr. Nucklos' progress notes for Patient 21 document, among other things, the following:

- On September 5, 2001, Patient 21 fell and fractured a forearm and hand in four places. (St. Ex. 21 at 54)
- Patient 21 reported on November 29, 2001, that she had fallen out of bed. (St. Ex. 21 at 53)
- On June 13, 2002, Patient 21 reported having injured her knee when she tripped over a mat and fell. (St. Ex. 21 at 48)
- On August 7, 2002, Patient 21 reported increased low back pain and stiffness after falling down a flight of stairs. (St. Ex. 21 at 46)
- On August 21, 2002, Patient 21 reported having fallen while picking tomatoes and felt something pop in her lower back. (St. Ex. 21 at 46)

Testimony of Dr. Parran

188. Dr. Parran testified that Patient 21 was an 85-pound woman who had had her dose of OxyContin doubled and Valium added at her second visit. However, the medical record indicates that Patient 21 had continued to receive the same OxyContin prescription that she had received at her initial visit—OxyContin 20 mg twice per day—through the last visit recorded, October 15, 2002. (Tr. at 199-200)

Testimony of Dr. Knott

189. Dr. Knott testified concerning Dr. Nucklos' physical examination:

That the lady had no list in her posture, gait was essentially normal, straight-leg raise test negative, Braggard's reinforcement test negative. The deep tendon reflexes in the lower extremities were three-plus and equal. Her sensory parameters were all normal. Manual muscle testing was normal. There was tenderness in the thoracic and lumbosacral spines.

Auscultation revealed normal sinus rhythm; no—no wheezes, or rales, or rhonchi. Diagnosis was chronic lower back pain.

(Tr. at 769-770)

190. Noting that, at 85 pounds, Patient 21 had been an exceptionally small woman, Dr. Knott testified that he does not believe that Dr. Nucklos had prescribed excessive dosages of medication to Patient 21 at her initial visit. Dr. Knott further testified that Dr. Nucklos' records for Patient 21 indicate that she had been on medications prior to seeing Dr. Nucklos. (Tr. at 770-771)
191. With regard to Patient 21's reports of having fallen, Dr. Knott testified that he does not believe that the medications that Dr. Nucklos had prescribed to Patient 21 could have contributed to her falling because "[i]t's just not a high enough dose * * * [e]ven for a woman her size[.]" although he acknowledged that medication can make a person groggy. Dr. Knott testified that it could have been "knee buckling and pain inhibition weakness" that caused her fall. Dr. Knott further testified:

[I]t's easy to point fingers at medications when people fall, but that's usually not the reason why they fall. They typically fall because of pain inhibition weakness with knee buckling.

What happens is the sensory input is so—is so much that it inhibits the outflow of the axon—axons, and their—their weakness overcomes them, and they—they lose control of the stabilizers of the knee and their knees buckle. We—We used to see it all the time in the—in the training program, and we were warned that people get knee buckling; when they get knee buckling, they get pain inhibition weakness. And, in fact, that's true, that's what happens.

(Tr. at 772-774)

When asked if he would have treated Patient 21 differently from Dr. Nucklos, Dr. Knott testified that he probably would have tried "injection procedures adjacent to the ligaments involved * * * and maybe tried to get her some more pain relief that way." (St. Ex. 21 at 774)

192. Dr. Knott testified that the treatment of this patient was within the abilities of Dr. Nucklos, as a PM&R physician, to treat. (Tr. at 775-776)

Patient 22

193. Patient 22, a male born in 1962, first visited Dr. Nucklos on July 19, 2001 (although the copy in the medical records makes it appear to say "1/19/01"). He complained of being injured in 1988 when he slipped and fractured 3 vertebrae, and having spinal fusion surgery 1992. He reported that he did not drink alcohol or abuse drugs. He further reported that he was not seeing a doctor at that time. Dr. Nucklos diagnosed chronic L4-L5 radiculopathy with chronic pain syndrome. He prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, Maxidone #60 with instructions to take one tablet every six hours (this prescription was filled with Lortab 10 mg because the pharmacy was out of

Maxidone), and Zanaflex 2 mg #42 with instructions to take one tablet three times per day. (St. Ex. 22 at 27)

Testimony of Dr. Parran

194. Dr. Parran testified that Patient 22 had denied alcohol or drug use, but was also a non-driver. (Tr. at 201)

Testimony of Dr. Knott

195. Dr. Knott testified concerning Dr. Nucklos' physical examination of Patient 22:

It showed no list and it showed a slow antalgic gait. He was able to heel and toe walk and squat to about 35 to 40 percent. The deep tendon reflexes were three-plus and equal. Manual muscle testing showed slight weakness in the left L4-5 musculature. And sensation was diminished on the left side in the L-L4 dermatome. Lumbosacral range of motion was diminished by up to 50 percent. And his side bending and rotation were limited—or, he achieved 60 to 70 percent of normal.

The diagnosis was chronic L4-5 radiculopathy with chronic pain syndrome.

(Tr. at 777-778)

Patient 23

196. Patient 23, initials J.D.R., is a male born in 1959. He first visited Dr. Nucklos' office on July 26, 2001. He presented with non-driver State identification. Patient 3 complained of low back pain referred to his legs that resulted from a motor vehicle accident seven months earlier, headaches, and insomnia. He named two prior physicians, and indicated that he had been prescribed OxyContin 40 mg to be taken every six hours; however, under Current Medications, it was noted that Patient 23 was not taking any medications at that time. Dr. Nucklos prescribed OxyContin 40 mg #30 with instructions to take one tablet twice per day, Maxidone tablets #30 with instructions to take one tablet twice per day as needed, and Ambien 10 mg with instructions to take one tablet at bedtime as needed. (St. Ex. 23 at 21, 29)

The next note is dated September 27, 2001 (although the copy in the medical records makes it appear to say "1/27/01") and appears to have been written by office staff. The note indicates that Patient 23 had called to make an appointment. The note further states: "Spoke with Chris at Dr. Andorfer's office [Patient 23] was just seen on 9/4 & 9/20. Asked [Patient 23] when he was last at Dr. Andorfer's he stated over a year ago and I said they had you down as 9/4/01 & 9/20/01. When I told him this he didn't deny it he stated that well, can my brother make an appt? I told him his brother would have to call us." (St. Ex. 23 at 44)

The following note, dated October 3, 2001, states: “Spoke [with] Chris and Dr. Andorfer. [Patient 23] is stating that his brother is using his name to come into our office and get meds. Faxed over the [patient’s] signature to Dr. Andorfer’s office it matched [Patient 23’s]. We will no longer see or treat the patient per Dr. Nucklos.” (St. Ex. 23 at 44)

Another initial visit form in State’s Exhibit 23 is dated November 8, 2001. This concerns the visit of a patient with the initials D.R., but with the same last name, date of birth, and Social Security number as Patient 23. The note indicates that D.R. had been injured in a motorcycle accident, and complained of low back pain referred to his right leg. The note indicates that D.R. was being prescribed OxyContin 80 mg, Dilaudid 4 mg, Soma 350 mg, and Xanax 1 mg. On a Pain Assessment Questionnaire dated November 8, 2001, D.R. indicated that he suffered from “severe/unbearable” back pain that was a 9 on a scale of 1 to 10, that he takes OxyContin 80 mg for his pain, but that “nothing eases pain.” Dr. Nucklos prescribed OxyContin 40 mg #30 with instructions to take one tablet every 12 hours, Soma 350 mg with instructions to take one tablet three times per day as needed, OxyIR 5 mg with instructions to take one tablet twice per day as needed, and Xanax 0.5 mg #30 with instructions take one tablet twice per day. (St. Ex. 23 at 17-19, 31; Tr. at 206)

A November 15, 2001, note states that Patient 23 had visited Dr. Nucklos on November 8, 2001, posing as another individual, that Dr. Nucklos had discharged Patient 23 from his practice, and that Patient 23 had been notified. The date of notification is difficult to read, but it states either “11/15” or “11/18.” (St. Ex. 23 at 27)

The next note, chronologically, is dated December 20, 2001. In the subjective portion of the note, it states that “[Patient 23] reports severe LBP & pleaded to be seen & will abide by all rules including med checks. Denies seeing any other docs.” At that visit, Dr. Nucklos prescribed OxyContin 40 mg #30 with instructions take one tablet every 12 hours, Lortab 10 mg #30 with instructions to take one tablet twice per day, and Xanax 1.0 mg #42 with instructions to take one tablet three times per day. (St. Ex. 23 at 44)

Patient 23 continued to see Dr. Nucklos on a regular basis after that and was prescribed controlled substances at each visit. (St. Ex. 23 at 33-44)

Testimony of Dr. Parran

197. Dr. Parran noted that Patient 23 had presented with a non-driver State identification card. Dr. Parran testified that, at the first visit, without obtaining medical records of prior treatment, no workups, and no consultations, Dr. Nucklos started Patient 23 on OxyContin 80 mg⁸ twice per day, Maxidone, and Ambien. (Tr. at 205-206)

⁸ The medical records indicate that Dr. Nucklos prescribed OxyContin 40 mg, not OxyContin 80 mg, throughout his treatment of Patient 23. (St. Ex. 23 at 29-44)

In addition, Dr. Parran testified that notes in the medical record indicate that Patient 23 had been “multisourcing” and was seeing different physicians’ offices to obtain controlled substances. Following that disclosure, on November 8, 2001, Patient 23 returned to Dr. Nucklos office posing as another person. That ruse was discovered, according to a note dated November 15, 2001. Nevertheless, Dr. Nucklos reinstated Patient 23 on December 20, 2001, and prescribed OxyContin 40 mg, Lortab, and Xanax. Dr. Parran noted that there was no diagnosis recorded for the Xanax prescription. At another visit, on February 7, 2002, Patient 23 told Dr. Nucklos office that his mother had spilled his medication in the toilet. The medical records indicate that Dr. Nucklos continued seeing Patient 23 on a regular basis through October 9, 2002, and prescribed controlled substances at each visit. (St. Ex. 23 at 33-44, 99; Tr. at 207-209)

Dr. Parran testified: “[H]ere is a person who was a non-driver with clear-cut out-of-control chemical dependency behavior throughout his time, and continued to receive controlled substances in a manner which is inconceivable and inconsistent with the usual course of medical practice and for other than a medical purpose.” (Tr. at 209)

Testimony of Dr. Knott

198. Dr. Knott described the physical examination performed by Dr. Nucklos at Patient 23’s initial visit:

Range of motion testing was done of the lower back. It was normal with a break in rhythm returning to the upright position. The extension, however, was limited by 50 percent. Manual muscle testing, deep tendon reflexes, and sensory testing in the lower extremities was all noted to be normal. Palpation revealed tenderness in the lumbosacral area and midline. The diagnosis was lumbosacral strain and sprain chronic.

(Tr. at 780)

199. Dr. Knott testified that Dr. Nucklos’ monitoring of Patient 23 had increased after Patient 23 had been discharged and reinstated to Dr. Nucklos’ practice and that Dr. Nucklos had been “very strict.” (Tr. at 785-786)

Dr. Knott testified on cross-examination that Patient 23 had exhibited drug-seeking behaviors and that he would have obtained more information concerning this patient. (Tr. at 961-964)

Patient 24

Testimony of Dr. Parran

200. Dr. Parran testified that Patient 24 first presented to Dr. Nucklos office on January 17, 2002. He presented with a non-driver State identification card. The note indicates that

Patient 24 was not on any medications at a time. He further indicated that he had seen his last treating physician two years previously. Dr. Parran testified that there were no workups and no consultations. Nevertheless, Dr. Nucklos prescribed OxyContin 20 mg #30 with instructions to take one tablet every 12 hours, and Soma 350 mg #30 with instructions to take one tablet twice per day. (St. Ex. 24 at 23; Tr. at 215)

Dr. Nucklos' progress note for Patient 24's second visit on January 31, 2002, indicates that Dr. Nucklos had ordered x-rays and an MRI. However, Dr. Parran testified that there are no reports of x-rays or MRIs in the medical records. (St. Ex. 24 at 22; Tr. at 215)

The progress notes indicate that, on May 30, 2002, Patient 24 was in jail. Dr. Parran testified that there is no mention why Patient 24 had been in jail, or why he was a non-driver. Moreover, Dr. Parran testified that the prescribing continued through October 2002. During that time, Patient 24 received OxyContin 20 mg three times per day and Percocet at each visit. (St. Ex. 24 at 19; Tr. at 215-216)

Dr. Parran also noted that, on numerous occasions throughout the medical record, Patient 24 reported blackouts. Dr. Parran testified that these notes continued "without any further information in the medical record about what is meant by 'blackouts.'" Dr. Parran further testified that is inconsistent "with the usual and minimal standard of care to just write that in the chart and not document more about what might be going on." (St. Ex. 24 at 17-23; Tr. at 216-217)

201. Dr. Parran testified on cross-examination that the medical records indicate that Dr. Nucklos' office had sent Patient 24's medication to the Jail on May 30, 2002. Dr. Parran acknowledged that Patient 24 may not have been off his medication during the time he was in jail. However, Dr. Parran testified that he would have been appropriate for Dr. Nucklos to document in the medical record why the patient was in jail, what the charges were about, and why the patient was a non-driver. (Tr. at 328-330)

Testimony of Dr. Knott

202. Dr. Knott described the physical examination performed by Dr. Nucklos on Patient 24 at Patient 24's initial visit:

Well-nourished, well-developed adult male in moderate distress. No torticollis or list. Spurling's negative. Straight-leg raise test negative. Braggard's reinforcement test negative. Deep tendon reflexes and his strength testing normal. Two-point and position sense, light touch, pinprick sensation normal in the lower extremities.

Tenderness noted in the right posterior neck region. Tenderness also noted in the lumbosacral spine and bilaterally over the sacroiliac joints.

Impression was a three-by-three-centimeter lipoma, left post—right posterior neck and a lumbosacral sprain and strain. Range of motion was also checked in the lower back of this—it was 60 to 65 percent of normal.

(Tr. at 789-790)

203. Dr. Knott testified concerning the progress notes that state that Patient 24 had been experiencing blackouts. Dr. Knott testified that, a note dated March 28, 2002, states that the patient reported having scheduled tests for his blackouts; however, the note for the next visit does not say whether Patient 24 had been tested. (St. Ex. 24 at 21; Tr. at 790-791)

When asked what should have been done with Patient 24 with regard to his blackouts, Dr. Knott testified: “Well, I think a CAT scan would be indicated, an MRI or a neurological consult, just to—just to see if there’s some sort of lesion causing this, or if he’s having TIAs, mini strokes.” (Tr. at 792-793)

204. Dr. Knott does not believe that that medication prescribed by Dr. Nucklos had caused the blackouts. Dr. Knott further testified: “I’ve been doing this 30 years. I’ve never had anybody black out from pain medication, especially this low a dose.” (Tr. at 793)

When asked if it had been appropriate for Dr. Nucklos to continue treating Patient 24 despite the fact Patient 24 did not submit to a CT scan until August 2002,⁹ Dr. Knott testified: “Yes. I mean, you can’t make people do things. It’s still a free country. You can tell them they need a CAT scan or an MRI, and if they don’t get it, there’s not much you can do about it, especially if they can’t afford it.” (Tr. at 793)

When asked if Dr. Nucklos’ office should have assisted Patient 24 in making the arrangements for a CT scan, Dr. Knott replied:

No. The patient has to accept some responsibility for [himself]. You know, you can’t—you can’t mother hen patients to death. Number one, you don’t have time. You can give suggestions. They’re paying for your advice and your guidance, and you’re not in there to determine the fate of their life. You know, you tell them, “This could be dangerous. You need to have this looked at. Please go get this done. Here is the prescription. If you need some help, let us know.” You know, that sort of talk will do.

(Tr. at 795-796)

⁹ The progress note dated August 8, 2002, states that Patient 24 “has gone for CT scan due to fact he has gotten his health card to date.” (St. Ex. 24 at 35)

Patient 25

Testimony of Dr. Parran

205. Dr. Parran testified that Patient 25 had had two initial office visits. The first occurred on October 25, 2001, for weight management.¹⁰ The other occurred on December 20, 2001, for pain management. Dr. Parran testified that Patient 25's pain complaint related to a fall, low back pain, and a diagnosis of lumbosacral strain, sprain, and contusion. On his Pain Assessment Questionnaire dated December 20, 2001, Patient 25 indicated that his pain had begun following a motor vehicle accident two years previously. He further indicated that he was taking no medication at that time.¹¹ At the initial visit, Dr. Nucklos prescribed, among other things, OxyContin 20 mg #30 with instructions to take one tablet every 12 hours, Vicodin HP 10 mg #30 with instructions to take one tablet twice per day, and Soma 350 mg #30 with instructions take one tablet twice per day. Dr. Parran further testified that, based on the diagnosis of lumbosacral strain, sprain, and contusion, Dr. Nucklos had continued to prescribe OxyContin and Vicodin to Patient 25 for 10 months without further diagnostic workup or evaluation. (St. Ex. 25 at 3, 13-17, 26-35; Tr. at 218- 219)

In addition, Dr. Parran testified that prescribing 60 mg of high potency opiate daily at the first visit had put Patient 25's health, and potentially his life, at risk. Furthermore, Dr. Parran noted that, at the initial visit for weight management on October 25, 2001, there was no mention of any pain complaint or opiate medication. Dr. Parran further testified: "[W]hen December 20th of 2001 rolls around, the patient suddenly reports that he's on OxyContin and Vicodin and Soma. There was no report of that when the patient showed up two months earlier for a chief complaint of obesity and weight management." (Tr. at 220)

Finally, Dr. Parran testified that "inconsistencies within the patient's story at two subsequent visits from each other and not evaluating that is, again, unsafe. And that's why it's inconsistent with the usual course of medical practice." (Tr. at 220-221)

Testimony of Dr. Knott

206. Dr. Knott testified concerning the physical examination performed by Dr. Nucklos at Patient 25 at the initial visit:

Well-nourished, well-developed, obese male in moderate distress. No list.
His range of motion of the lumbosacral spine was normal with a break in rhythm.

¹⁰ Dr. Parran testified that lab studies were performed at Patient 25's first visit for weight management. Dr. Parran noted that Dr. Nucklos' office clearly was capable of getting lab results and putting them in the chart; however, that never occurred in relation to pain management patients. (St. Ex. 221)

¹¹ Dr. Nucklos notes from the initial pain management visit indicate that Patient 25 had been taking OxyContin 20 mg twice per day, Vicodin 10 mg, and Soma 350 mg. (St. Ex. at 25 at 29)

* * *

The straight-leg raise test was negative. Braggard's reinforcement test was negative. There was facilitation used with the deep tendon reflexes, but they were found to be normal. Manual muscle testing was normal. And sensation testing in all four parameters that I've been describing was normal, as well.

There was tenderness in the midline and the lumbosacral area and over the sacroiliac joints bilaterally. The impression was status post lumbosacral strain and sprain with contusion.

(Tr. at 798)

207. A progress note dated March 27, 2002, states that Patient 25 was ready to return to work thanks to the medication. (St. Ex. 25 at 17) When asked if it would then be appropriate to continue Patient 25 on his medication, Dr. Knott testified:

Well, you know, you're between a rock and a hard place there because the pain medications [are] what's resulted in his pain amelioration. You stop the pain meds, and then his pain's coming back and then he's going to stop working again.

The problem is the drowsiness associated with the medication. You have to warn the patient, you know, very strictly about that.

(Tr. at 799-800) Dr. Knott further testified: "These patients will develop a tolerance to this and these side effects tend to go away and they function quite well. So I would give him meds, yes." (Tr. at 800)

Patient 26

Testimony of Dr. Parran

208. Dr. Parran testified that Patient 26, a 34 year-old woman, had first visited Dr. Nucklos on August 16, 2001. She complained of a five-year history of migraine headaches and low back pain. She reported that her low back pain related to scoliosis, which Dr. Parran characterized as a lifelong condition. She reported having had a previous treating physician. She further reported her current medications as OxyContin 40 mg and Soma. (St. Ex. 26; Tr. at 222-223)

Dr. Parran testified that there was no indication in the medical record concerning when the patient last saw her previous treating physician; there were no old records from the previous physician, no request for prior medical records, and no documentation of a workup or consultation. Nevertheless, Dr. Nucklos prescribed OxyContin 40 mg twice per

day and Soma at the first visit without any verification of her current level of medication. Dr. Parran testified, "That's dangerous." Further, Dr. Parran testified that the medications were increased over time with the addition of OxyIR and Xanax. Patient 26 failed a medication check on January 31, 2002, yet the prescribing continued. In addition, Dr. Parran testified that, on March 7, 2002, Patient 26 had reported good pain control and difficulty sleeping. Dr. Parran noted that, at that time, her OxyContin was increased from 40 mg twice per day to 40 mg three times per day despite good pain control. (St. Ex. 26 at 40, 77, 85-89; Tr. at 222-224)

Dr. Parran testified that, "based upon all of this data, it's my opinion that the prescribing was inconsistent with the usual course of medical practice and inconsistent with State Medical Board rules regarding chronic opiates for chronic pain." (Tr. at 224)

209. Dr. Parran testified that a patient who fails a med check is not taking the medication as prescribed. Dr. Parran further testified that that is a violation of the treatment contract. Moreover, Dr. Parran testified: "You need to change the treatment plan at that point. You have evidence that the patient is unable or unwilling to follow the simple parameters of the controlled substances agreement. * * * [Continued prescribing] is potentially dangerous. And you just can't continue to do potentially dangerous things to patients in an effort to try to provide comfort. You have to protect them, their safety first, and then provide comfort." (Tr. at 225-227)

Testimony of Dr. Knott

210. Dr. Knott described the physical examination performed by Dr. Nucklos at Patient 26's initial visit:

[G]eneral assessment, well-nourished well-developed lady in moderate distress, oriented timed three. No torticollis or list. Negative distraction compression, Valsalva maneuver, negative straight-leg raise. Deep tendon reflexes, manual muscle testing all normal. Sensation and pinprick, light touch, two-point, and position sense all normal.

Chest clear to auscultation and percussion. Normal sinus rhythm.

And impression was migraine secondary to hypoglycemia.

(Tr. at 803)

211. Dr. Knott indicated that a progress note dated September 27, 2001, states to hold off on Patient 26's Xanax prescription that visit because she still had one refill remaining. Dr. Knott testified that that indicates that Dr. Nucklos had been monitoring Patient 26's medications very closely. (St. Ex. 26 at 43; Tr. at 805)

Patient 27

Testimony of Dr. Parran

212. Patient 27, a female born in 1963, first visited Dr. Nucklos on September 27, 2001. She reported low back pain and right knee pain. She identified her previous treating physician, Dr. Jenkins, and stated that her prior medications had been OxyContin 40 mg and Soma. Dr. Parran testified that “no old records were obtained, no old records apparently were requested, no workup was done, no studies were done, [and] no consult was done.” Despite that, Dr. Nucklos prescribed OxyContin 40 mg #30 with instructions to take one tablet every 12 hours, Lortab 10 mg #30 with instructions to take one tablet twice per day as needed, and Soma 350 mg #30 with instructions to take one tablet twice per day as needed. (St. Ex. 27 at 29; Tr. at 227-228)

Dr. Parran criticized Dr. Nucklos for having prescribed the equivalent of 100 mg per day of high potency opiate without verifying that Patient 27 had actually been taking those medications. Dr. Parran further testified that that had been dangerous and threatened the life of Patient 27. (Tr. at 228-229)

213. Dr. Parran testified that, on November 18, 2001, Xanax 0.5 mg three times per day had been added to Patient 27’s regimen based upon a statement in the assessment that “anxiety persists.” Dr. Parran testified that was not appropriate because there had been no evaluation of an anxiety disorder, nor was there a diagnosis of anxiety. Dr. Parran testified that the minimal standards of care require “an assessment of an anxiety disorder and a reason to start Xanax on top of Percocet and OxyContin.” Furthermore, on December 20, 2001, Patient 27 had reported good pain control with decreased anxiety, and Dr. Nucklos’ assessment indicated adequate pain and anxiety control. Nevertheless, Dr. Nucklos doubled his prescribing of Xanax to Patient 27, and prescribed Xanax 1.0 mg three times per day. Dr. Parran testified, “There’s just no evidence of a legitimate medical purpose for that change. There’s inadequate evidence for a legitimate medical purpose to start the Xanax on 11-8-01, and no evidence for the doubling of the Xanax in December.” (St. Ex. 27 at 26-27; Tr. at 228-230)

214. Dr. Parran testified that Dr. Nucklos’ treatment of Patient 27 had been inconsistent with the Board rules concerning long-term prescribing of opiates for chronic intractable pain. (Tr. at 229)

Testimony of Dr. Knott

215. Dr. Knott described the physical examination performed by Dr. Nucklos at Patient 27’s initial visit:

It consisted of the -- the generalized assessment, 39-year-old obese, white female in moderate distress. No list. Straight-leg raise was negative in the sitting and supine positions. Braggard’s reinforcement test was negative.

Two-plus and equal deep tendon reflexes in the lower extremities. Manual muscle testing was normal. Sensation testing to all parameters was normal.

Tenderness was noted over the left SI joint and the right medial and lateral KJ line, knee joint. And the impression was a right knee strain/sprain and a lumbosacral strain/sprain chronic pain syndrome under both.

(Tr. at 807-808)

216. Dr. Knott testified that the medications prescribed to Patient 27 at her initial visit were appropriate based on her medical condition. Dr. Knott characterized as “absurd” testimony that the dosages given Patient 27 had been “downright dangerous.” (Tr. at 809)

Patient 28

217. Note that State’s Exhibit 28 includes medical records for patients other than Patient 28. (St. Ex. 28)

Testimony of Dr. Parran

218. Dr. Parran testified that Patient 28 first visited Dr. Nucklos on July 19, 2001. Patient 28 complained of pain secondary to having been shot with a deer rifle in 1991 by an intruder. She reported having been using OxyContin and Tylox. Dr. Parran testified that there were no workup, no consultation, and no records of prior medical treatment in the chart. Nevertheless, Dr. Nucklos prescribed OxyContin 80 mg #30 with instructions to take one tablet twice per day, and Lortab 10 mg #30 with instructions to take as needed. Dr. Parran testified that the medication that Dr. Nucklos prescribed to Patient 28 would kill her if she had not already been taking that level of medication. Nevertheless, there is no evidence that Dr. Nucklos had attempted to verify her current medications. (St. Ex. 28 at 7; Tr. at 232-233)

Dr. Parran testified that Patient 28 was seen again by Dr. Nucklos on August 2 and August 16, 2001, and received the same prescription for OxyContin. Dr. Parran noted that, on August 16, Dr. Nucklos switched her from Lortab to Maxidone. Ambien 10 mg #5 with instructions to take one tablet at bedtime as needed was also added. (St. Ex. 28 at 9; Tr. at 233)

219. A note following the August 16, 2001, progress note states as follows:

Pharmacist @ Whit-Lagonda Ave – called stated that [Patient 28] just had OxyContin 20 mg #60 filled 8-15-01 per Dr. Shah’s office. Pharmacy filled her script today then noticed it. Seeing Dr. Shah at Northpark medicine. Told Dr. Nucklos stated we’d speak to her on next visit re: above.

(St. Ex. 28 at 9)

The next progress note, apparently written by office staff and dated August 30, 2001, states: “[Patient 28] here for Pain Management. Spoke to [Patient 28] about [the previous note]. Stated that Dr. Shah discharged her as a pt and pt stated she discarded remaining amt of OxyContin’s that were given by Dr. Shah.” (St. Ex. 28 at 9)

A second progress note dated the same day, August 30, 2001, indicates that Patient 28 reported having had breakthrough pain periodically. Dr. Nucklos prescribed OxyContin 80 mg #30 with instructions to take one tablet every 12 hours, and OxyIR 5 mg [no quantity noted] with instructions to take one tablet per day as needed for breakthrough pain. (St. Ex. 28 at 10)

Dr. Parran testified that Patient 28’s explanation had been accepted by Dr. Nucklos and the prescribing continued. Dr. Parran further testified: “Dr. Shah’s office wasn’t contacted, faxes to Dr. Shah’s offices weren’t obtained. Again, this is simply unbelievable * * *.” (Tr. at 233-234)

220. Dr. Parran further testified that Dr. Nucklos started prescribing Xanax to Patient 28 on September 13, 2001, for anxiety with no further documentation. (St. Ex. 28 at 10; Tr. at 234)
221. Moreover, Dr. Parran testified that a progress note dated September 20, 2001, indicates that Patient 28 had talked to “Det. Bowen” regarding medications having been stolen on September 18, 2001. Dr. Nucklos prescribed a lower dosage of OxyContin—OxyContin 40 mg #28 with instructions to take two tablets every two hours. Dr. Parran testified that that early prescription was given even though Patient 28 had violated the pain management agreement. (St. Ex. 28 at 11; Tr. at 234)

At Patient 28’s next visit on September 27, 2001, the dosage of OxyContin went back up to 80 milligrams twice per day. Patient 28 continued seeing Dr. Nucklos on a regular basis through September 3, 2002, and received controlled substances at each visit. (St. Ex. 28 at 11-22)

222. On July 18, 2002, the Ohio Department of Job and Family Services sent a letter to Dr. Nucklos advising that Patient 28 had been receiving controlled substances inappropriately. The agency asked Dr. Nucklos to review an attached medication history and discuss it with Patient 28. The agency further asked Dr. Nucklos to respond to a Drug Utilization Review Physician Response form. Dr. Nucklos completed the form and a copy of the undated, completed form is included in the chart. (St. Ex. 28 at 23-37)

Dr. Parran testified that the drug utilization report sent to Dr. Nucklos indicated that Patient 28 had continued to see multiple physicians, just as the pharmacist had reported a year earlier. Dr. Parran further testified:

Again, no workup, no documentation of the legitimate medical purpose, no documentation of the previous prescribing, and a response to clearly aberrant behavior on the part of the patient, which primarily included continued prescribing of controlled meds, in contrast to the controlled substance

agreement that was actually in the chart is what makes this inconsistent with the standard of care in the community and inconsistent with the State Medical Board rules regarding the chronic prescribing of opiates for intractable pain syndromes.

(Tr. at 235)

Dr. Parran noted that the drug utilization review report *would* have been available to Dr. Nucklos and was included in his medical records. (Tr. at 247)

Testimony of Dr. Knott

223. Dr. Knott testified that, for a first-time patient, the dosages prescribed to Patient 28 at Patient 28's initial visit "might be * * * a little excessive. But this isn't a first-time patient for taking the medications * * *." Dr. Knott further testified that, on her Pain Assessment Questionnaire, Patient 28 stated that she had been taking OxyContin 80 mg and oxycodone 5 mg. When asked if he would have believed a patient who gave that information at her first visit, Dr. Knott testified, "I believe all my patients. That's why I am a doctor. * * * If I had the records [of previous prescribing], I would have been more comfortable, but I wouldn't have to absolutely identify exactly what she had been taking. I would believe the patient." (Tr. at 811-813)
224. Regarding the note that a pharmacist had called stating that Patient 28 was receiving medication from another physician, and Dr. Nucklos' continuing her treatment, Dr. Knott testified that that is "a judgment call" but that he "would just be very leery of this patient." Nevertheless, Dr. Knott testified that it can be appropriate to continue treating such a patient. (Tr. at 815)
225. Dr. Knott testified that there is no way for a physician to know that a patient is seeing multiple physicians until they get that information from a third party. (Tr. at 816-817)

Criminal Trial Testimony of Dr. Nucklos

226. Dr. Nucklos testified at the criminal trial that, based upon Patient 28's history of severe injury secondary to being shot with a deer rifle, his concern had been, "does this lady have what we call RSD, reflex sympathetic dystrophy?" Dr. Nucklos testified that patients with RSD no longer respond to the usual doses of medication.¹² Dr. Nucklos also testified that Patient 28 had reported her usual pain level to be 10 on a scale of 1 to 10, her worst pain to be 10, and her pain at that time to be 10. Patient 28 reported that she had been taking "OxyContin 80 milligrams and 5 milligrams." Dr. Nucklos described the information he

¹² Neither "RSD" nor "reflex sympathetic dystrophy" is recorded in Dr. Nucklos' initial visit notes. (St. Ex. 28 at 7) Dr. Nucklos acknowledged that he had not documented anything about RSD in his chart for Patient 28, and stated, "I was concerned about it in my thinking." (St. Ex. 32A at 1671)

gleaned from the history and physical examination, and testified that he diagnosed Patient 28 as suffering from chronic pain syndrome. (St. Ex. 32A at 1660-1665)

Dr. Nucklos testified that his treatment plan for Patient 28 had included exercise, including active assistive range-of-motion exercises. (St. Ex. 32A at 1665-1666)

227. Dr. Nucklos acknowledged that he had prescribed OxyContin 80 mg to Patient 28. When asked why, Dr. Nucklos replied:

Well, Patient 28 was very unusual. She had tremendous restricted range of motion throughout her whole left shoulder girdle. She had significant weakness and tenderness throughout the whole complex from the middle of her back on the scapula which we call your shoulder blade.

And she indicated by history and based on the severe nature of her injuries and the resultant disability related to those injuries, it's obvious to me that she had developed what we call adhesions, which when you can't move a part, it's actually a contracture in this case, actually a contracture, when you don't move a part, even if it's normal, if you don't work on the range of motion, you will lose range of motion of that part.

(St. Ex. 32A at 1667)

228. Dr. Nucklos acknowledged that there was nothing in the medical record for Patient 28 concerning the medication she had been taking prior to her initial visit other than Patient 28's self report. Dr. Nucklos could not recall asking Patient 28 who had been prescribing that medication for her. Dr. Nucklos further testified that Patient 28 had told him she was out of her medication, but he acknowledged that that was not documented in the chart. When asked if Patient 28 had been in withdrawal, Dr. Nucklos testified that it was possible "but there was nothing to indicate on her vital signs that she was going through that so I don't believe she was going through withdrawals * * *." (St. Ex. 32A at 1674-1677)

Dr. Nucklos acknowledged that he did not ask Patient 28 about her alcohol or substance abuse history. (St. Ex. 32A at 1677)

229. Dr. Nucklos testified that, at the time he treated Patients 2, 3, and 28, he had not been aware of the Board's rules concerning treatment of intractable pain. Dr. Nucklos further testified that he had since familiarized himself with those rules and applied them in his practice. (St. Ex. 32A at 1678)
230. Dr. Nucklos testified that, as a specialist in PM&R, it had been unnecessary to refer Patient 28 to a specialist. (St. Ex. 32A at 1689-1692)
231. With regard to the note in Patient 28's chart concerning the call from a pharmacist, Dr. Nucklos testified that he cannot recall if he had seen the note prior to treating Patient 28

on August 30, 2001. When pressed on whether he reads prior notes in his medical records, or if Ms. Woodruff enters information that he doesn't read, Dr. Nucklos testified, "I don't recall reading that; or I would have responded to that, as I did with Patient 3." (St. Ex. 32A at 1703-1704)

232. On November 8, 2001, Dr. Nucklos saw Patient 28 for a regular visit and prescribed OxyContin 80 mg #30 with instructions to take one tablet every 12 hours, Tylox #30 with instructions to take one capsule twice per day as needed, and Xanax 1.0 mg #90 with instructions to take one tablet three times per day. (St. Ex. 28 at 12)

One week later, on November 15, 2001, Patient 28 returned to Dr. Nucklos' office, stating that she would be going out of town the following week. Dr. Nucklos prescribed OxyContin 80 mg #30 with instructions to take one tablet every 12 hours, Tylox #30 with instructions to take on capsule twice per day as needed, and "Cont Xanax." (St. Ex. 28 at 13)

Dr. Nucklos did not believe the early refill to be inappropriate because Patient 28 had told him that she was going out of town. (St. Ex. 32A at 1704-1705)

233. Dr. Nucklos testified that he does not recall seeing the July 2002 Drug Utilization Review. Dr. Nucklos further testified that he does not believe that that had been put into the chart at the time it was received. Dr. Nucklos blamed his staff for not filing that document. (St. Ex. 32A at 1706-1707)
234. Dr. Nucklos testified that Patient 28 had told him that her medication had been stolen and that she had reported it to the police. Dr. Nucklos acknowledged that neither he nor Ms. Woodruff had contacted the police to verify that Patient 28 had filed a report. (Tr. at 1721)
235. Dr. Nucklos acknowledged that he had continued to see and treat Patient 28, without referring her to an addiction specialist, despite clear indications of drug-seeking behavior. (St. Ex. 32A at 1722-1723)

Dr. Parran's Conclusion

236. In his written report, Dr. Parran made the following statement with regard to each patient in this case:

It is my opinion to a reasonable degree of medical certainty that in the care of this patient, Dr. Nucklos did not maintain minimal standards applicable to the selection or administration of drugs, and failed to employ acceptable scientific methods in the selection of drugs or other modalities for treatment. In addition Dr. Nucklos' care of this patient did constitute prescribing controlled drugs for other than legal and legitimate therapeutic purposes. Therefore, it appears that to within a reasonable degree of medical certainty, Dr. Nucklos

violated Section 4731.22(B)(2), Section 4731.22(B)(3), and Section 4731.22(B)(6) of the Ohio Revised Code.

(St. Ex. 31)

Dr. Parran reiterated these opinions in his testimony at hearing. (Tr. at 235-237)

Dr. Knott's Conclusion

237. Dr. Knott testified that, in his treatment of Patients of Patients 1 through 28, Dr. Nucklos:

- Documented an initial evaluation;
- Documented an adequate patient history;
- Performed an adequate physical examination;
- Document a diagnosis;
- Documented a treatment plan that addressed the specific needs of the individual patient;
- Followed the SOAP format of note taking;
- Consulted with patients when appropriate when a red flag appeared;
- In applicable situations, requested that prior medical records be obtained, although the records were not always obtained;
- Ordered diagnostic tests when applicable;
- Discharged patients if they violated the terms of their treatment contract; and
- Prescribed appropriate medications and dosages.

(Tr. at 817-822)

238. In his written report and in his testimony, Dr. Knott stated that Dr. Nucklos' treatment of Patients 1 through 28 had not constituted a failure to employ scientific methods in the selection of drugs or other modalities for the treatment of disease. Dr. Knott further testified that it did not constitute prescription drugs for other than legal or legitimate therapeutic purposes. Moreover, Dr. Knott testified that Dr. Nucklos' treatment of Patients 1 through 28 did not fall below the minimal standard of care. Finally, Dr. Nucklos testified that Dr. Nucklos' treatment of Patients 1 through 28 had complied with the Board's rules concerning the treatment of intractable pain. (Resp. Ex. B; Tr. at 658-659, 665-666, 672-694, 818-820)

Dr. Nucklos' Criminal Trial and Subsequent Board Action

239. Dr. Parran testified that he had been contacted by the Springfield Police Department in late 2004 concerning Dr. Nucklos and was asked to review some material. Dr. Parran further testified that, for his review concerning the criminal case, he had been provided with transcripts of tapes obtained by two undercover visits to Dr. Nucklos' office, and was further provided with medical records. Dr. Parran noted that each of those records had contained a Pharmacy Board controlled substance profile of all the prescriptions that they

had been able to find during an approximately 2-year time period. Dr. Parran noted that the 28 patient records included in the Board's case had been included in the original medical records that he had reviewed for the criminal case. Dr. Parran noted that the trial took place in 2006. (Tr. at 239-241)

240. Documents maintained by the Board indicate that Dr. Nucklos' medical license had been immediately suspended by the Board on March 9, 2006, based upon Dr. Nucklos' criminal conviction. (Resp. Ex. DD)
241. Dr. Parran testified that, in late August 2007, he had been contacted by the Board to evaluate Dr. Nucklos' records. Dr. Parran noted that he completed his review and submitted his written report around October 7, 2007. (Tr. at 250-251)
242. Rebecca J. Marshall testified that she is the Board's Chief Enforcement Attorney. In that capacity, she supervises the Board's Enforcement Section in investigating and developing cases for formal action by the Board. (Tr. at 397)

Ms. Marshall testified that the criminal conviction upon which Dr. Nucklos' license had been immediately suspended was subsequently overturned on appeal. Ms. Marshall further testified that the Board had lifted the immediate suspension at its October 2007 meeting. (Tr. at 406-408)

243. Ms. Marshall testified that, around October 2007, she had become involved in the summary suspension of Dr. Nucklos' medical license. In October 2007, she and a Board Enforcement Attorney had presented information concerning Dr. Nucklos to the Secretary and Supervising Member of the Board. She testified that the information consisted of transcripts of the criminal trial testimony of Dr. Nucklos, Dr. Knott, and Dr. Parran, as well as Dr. Parran's October 7, 2007, report. Ms. Marshall stated that the Secretary and Supervising Member reviewed the material and made a determination that Dr. Nucklos' continued practice presented a danger of immediate and serious harm to the public. They directed Ms. Marshall to prepare and present to the full Board an order summarily suspending Dr. Nucklos' medical license. Ms. Marshall testified that the Board voted to approve the order at its October 2007 meeting. (St. Ex. 34A; Tr. at 398-401)
244. Ms. Marshall testified that the issue of immediacy was created because the Board had had to reactivate Dr. Nucklos' license, which had previously been inactive. (Tr. at 402-403)

Additional Information

245. Dr. Nucklos presented a number of character reference letters from friends, patients, other professionals, and colleagues. They characterize Dr. Nucklos as a generous and compassionate person and a caring, dedicated physician. (Resp. Exs. C-E, G-J, L-P, R-BB) (The State did not have an opportunity to cross-examine the authors of these letters.)

FINDINGS OF FACT

In or about March 2001 through in or about October 2002, in the course of his medical practice, William W. Nucklos, M.D., undertook the care of Patients 1 through 28 as identified on a confidential patient key.

The State presented evidence that overwhelmingly supports a finding that Dr. Nucklos inappropriately prescribed controlled substances and/or dangerous drugs to Patients 1 through 28 in a manner that was below the minimal standards of care and/or without a legitimate medical purpose. Examples of such conduct include prescribing controlled substances and other dangerous drugs despite his failure to order and/or document ordering appropriate consultations, his failure to perform and/or document performing appropriate physical examinations, and his failure to order and/or document ordering appropriate diagnostic tests.

CONCLUSIONS OF LAW

1. The conduct of William W. Nucklos, M.D., as set forth in the Findings of Fact, constitutes: “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.
2. Dr. Nucklos’ conduct, as set forth in the Findings of Fact, constitutes: “[s]elling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes * * *,” as those clauses are used in Section 4731.22(B)(3), Ohio Revised Code.
4. Dr. Nucklos’ conduct, as set forth in the Findings of Fact, constitutes: “[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established,” as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.
5. Dr. Nucklos’ conduct, as set forth in the Findings of Fact, 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 4731-21-02, Ohio Administrative Code, Utilizing Prescription Drugs for the Treatment of Intractable Pain.

* * * * *

The evidence shows that Dr. Nucklos’ treatment of Patients 1 through 28 violated the Board’s rules concerning the treatment of patients with intractable pain. Further, the evidence indicates that he had either ignored, or failed to further investigate or to document any concern regarding, patients who exhibited obvious signs of abuse or diversion of medication. Even when he learned

that the cause of a patient's absence from his practice was a result of her arrest for suspected involvement in a "drug ring," Dr. Nucklos failed to document anything about that in the medical record. Lastly, in some cases, Dr. Nucklos prescribed very large dosages of OxyContin at patients' initial visits—in one case 80 milligrams to be taken twice per day—without first verifying that the patients had actually been taking such levels of medication and had the tolerance necessary to safely take that dose of medication. Dr. Nucklos' prescribing placed those patients' lives in potential jeopardy. Such conduct merits the permanent revocation of his certificate to practice medicine and surgery in Ohio.

PROPOSED ORDER

It is hereby ORDERED that:

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

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



R. Gregory Porter
Hearing Examiner

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127



Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

EXCERPT FROM THE DRAFT MINUTES OF AUGUST 13, 2008

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Varyani announced that the Board would now consider the Proposed Findings and Proposed Orders appearing on its agenda. He asked whether each member of the Board had received, read and considered the hearing record; the findings of fact, conclusions and proposed orders; and any objections filed in the matters of: Shelly Bade, M.D.; Eugene Allan Brewer, M.D.; William David Leak, M.D.; Brian Frederic Griffin, M.D.; Kyle Elliott Hoogendoorn, D.P.M.; Parisa Khatibi, M.D.; and William W. Nucklos, M.D.; and the Proposed Findings and Proposed Orders in the matters of John A. Halpin, M.D., and Frank Murray Strasek, D.P.M. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Varyani	- aye

Dr. Varyani 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. Suppan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Mr. Hairston	- aye

Dr. Stephens	- aye
Dr. Mahajan	- aye
Dr. Steinbergh	- aye
Dr. Varyani	- aye

Dr. Varyani 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. They may, however, participate in the matter of Dr. Khatibi, as that case is not disciplinary in nature and concerns only the doctors' qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

The original Proposed Findings and Proposed Orders shall be maintained in the exhibits section of this Journal.

.....

Prior to the vote being taken, Dr. Madia advised that he has an acquaintance with Dr. Leak and would, therefore, abstain from voting on this case.

.....

WILLIAM W. NUCKLOS, M.D.

.....

Mr. Albert left the meeting during the previous discussion.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF WILLIAM W. NUCKLOS, M.D. DR. MADIA SECONDED THE MOTION.

.....

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

ROLL CALL:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Suppan	- aye

EXCERPT FROM THE DRAFT MINUTES OF AUGUST 13, 2008
IN THE MATTER OF WILLIAM W. NUCKLOS, M.D.

Dr. Madia	- abstain
Mr. Browning	- aye
Mr. Hairston	- aye
Dr. Amato	- aye
Dr. Stephens	- aye
Dr. Mahajan	- aye
Dr. Steinbergh	- aye
Dr. Varyani	- aye

The motion carried.

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

William W. Nucklos, M.D.,

Appellant,

v.

The State Medical Board of Ohio,

Appellee.

:
:
: Case No. 07 CVF-10-14544
:
: Judge John A. Connor
:

:
: **Appeal from the Decision and**
: **Entry Rendered May 13, 2008**
: **and Filed May 16, 2008**
:

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FRANKLIN CO. OHIO
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CLERK OF COURTS

NOTICE OF APPEAL

Notice is hereby given that William W. Nucklos, M.D. hereby appeals to the Court of Appeals of Franklin County, Ohio, Tenth Appellate District, the May 16, 2008 Decision and Entry sustaining Motion to Dismiss. A copy of the Decision and Entry is attached as Exhibit A and incorporated herein by reference.

Respectfully submitted,

BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP

Janice Casanova

Eric J. Plinke (0059463)
Janice E. Casanova (0075565)
191 West Nationwide Blvd., Suite 300
Columbus, OH 43215-8120
(614) 221-8448
Fax: (614) 221-8590
E-mail: EPlinke@bdblaw.com
JCasanova@bdblaw.com
Attorneys for William W. Nucklos, M.D.

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HEALTH & HUMAN

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SERVICES SECTION

CERTIFICATE OF SERVICE

I certify that on this 16th day of June 2008 the foregoing Notice of Appeal was filed via hand delivery with the Court of Common Pleas of Franklin County, Court of Appeals of Franklin County, Tenth Appellate District, and that a copy was served via regular mail upon:

Barbara J. Pfeiffer
Assistant Attorneys General
Health & Human Services Section
30 East Broad Street, 26th Floor
Columbus, Ohio 43215-3428



Eric J. Plinke

«CO2:414622_v1»

COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

FINAL APPEALABLE ORDER

William W. Nucklos, M.D.,

:

Appellant,

:

CASE NO. 07CVF10-14544

-vs-

:

JUDGE JOHN A. CONNOR

State Medical Board of Ohio,

:

Appellee.

:

TERMINATION NO. <u>18</u>
BY <u>[Signature]</u> <u>5-15-08</u>

**DECISION AND ENTRY SUSTAINING
MOTION TO DISMISS**

Rendered this 13th day of May, 2008.

CONNOR, JUDGE

I. INTRODUCTION

This action was initiated on October 25, 2007. Appellant, William W. Nucklos, M.D. (hereinafter "Appellant"), is licensed to practice medicine in Ohio. The State Medical Board of Ohio (hereinafter "Board") issued a Notice of Summary Suspension of Appellant's license and Opportunity for Hearing on the suspension on October 10, 2008. Appellant filed this action which asserts that said Order issued by the Board is not supported by substantial, probative and reliable evidence, and is not in accordance with law.

II. PROCEDURAL HISTORY & FACTUAL BACKGROUND

The Board determined that there is clear and convincing evidence of violation of R.C. 4731.22(B)(26) and that continued practice by Appellant presents a danger of immediate and serious harm to the public. Appellant requested a hearing before the Board on the suspension. The hearing was initially set for November 16, 2007 and was subsequently continued to January 28, 2008. That hearing presently has been held in

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 FRANKLIN COUNTY, OHIO
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 CLERK OF COURT

abeyance pursuant to Order of this Court upon the request by Appellant for a Temporary Restraining Order. Appellant filed the instant action seeking a determination on the merits and reversal of the summary suspension under authority of R.C. 119.12.

III. ANALYSIS AND FINDINGS OF THE COURT

The language of the statute cited by the Board as to violation is contained in R.C. 4731.22, which states the following in relevant part:

“Grounds for discipline; investigations; reinstatement; withdrawal of application; quality intervention program.

[***]

(B) The board, by an affirmative vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend an individual's certificate to practice, refuse to register an individual, refuse to reinstate a certificate, or reprimand or place on probation the holder of a certificate for one or more of the following reasons:

[***]

(2) Failure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease;

(3) Selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug.

The statutory provisions for summary suspension under which the Board has acted are contained in 4731.22 (G), which provides as follows

“If the secretary and supervising member determine that there is clear and convincing evidence that an individual has violated division (B) of this section and that the individual's continued practice presents a danger of

immediate and serious harm to the public, they may recommend that the board suspend the individual's certificate to practice without a prior hearing. Written allegations shall be prepared for consideration by the board. The board, upon review of those allegations and by an affirmative vote of not fewer than six of its members, excluding the secretary and supervising member, may suspend a certificate without a prior hearing. A telephone conference call may be utilized for reviewing the allegations and taking the vote on the summary suspension. The board shall issue a written order of suspension by certified mail or in person in accordance with section 119.07 of the Revised Code. The order shall not be subject to suspension by the court during pendency of any appeal filed under section 119.12 of the Revised Code. If the individual subject to the summary suspension requests an adjudicatory hearing by the board, the date set for the hearing shall be within fifteen days, but not earlier than seven days, after the individual requests the hearing, unless otherwise agreed to by both the board and the individual. Any summary suspension imposed under this division shall remain in effect, unless reversed on appeal, until a final adjudicative order issued by the board pursuant to this section and Chapter 119. of the Revised Code becomes effective. The board shall issue its final adjudicative order within sixty days after completion of its hearing. A failure to issue the order within sixty days shall result in dissolution of the summary suspension order but shall not invalidate any subsequent, final adjudicative order

The board shall notify the individual subject to the suspension by certified mail or in person in accordance with section 119.07 of the Revised Code. If an individual whose certificate is suspended under this division fails to make a timely request for an adjudication under Chapter 119. of the Revised Code, the board shall enter a final order permanently revoking the individual's certificate to practice

The aforementioned statute expressly prohibits the Court from entering a stay of a summary suspension, but does not address the issue of a right of appeal. Appellant offers that this Court nevertheless can make a merit determination of the Board's action.

Since Appellant is relying upon the provisions of Chapter 119 for authority for his appeal, the relevant portions of will be set forth below.

"R.C. 119.12 Appeal by party adversely affected.

Any party adversely affected by any order of an agency issued pursuant to an adjudication denying an applicant admission to an examination, or denying the issuance or renewal of a license or registration of a licensee, or revoking or suspending a license, or allowing the payment of a forfeiture under section 4301.252 [4301.25.2] of the Revised Code, may appeal from the order of the agency to the court of common pleas of the county in which the place of business of the licensee is located or the county in which the licensee is a resident, except that appeals from decisions of the liquor control commission, the state medical board, state chiropractic board, and board of nursing shall be to the court of common pleas of Franklin county [*]**

In the case of an appeal from the state medical board or state chiropractic 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. [*]**

Within thirty days after receipt of a notice of appeal from an order in any case in which a hearing is required by sections 119.01 to 119.13 of the Revised Code, the agency shall prepare and certify to the court a complete record of the proceedings in the case. [*]**

Unless otherwise provided by law, in the hearing of the appeal, the court is confined to the record as certified to it by the agency Unless otherwise provided by law, the court may grant a request for the admission of additional evidence when satisfied that such additional evidence is newly discovered and could not with reasonable diligence have been ascertained prior to the hearing before the agency [*]**

The court shall conduct a hearing on such appeal and shall give preference to all proceedings under sections 119.01 to 119.13 of the Revised Code, over all other civil cases, irrespective of the position of the proceedings on the calendar of the court. An appeal from an order of the state

medical board issued pursuant to division (G) of either section 4730.25 or 4731.22 of the Revised Code, the state chiropractic board issued pursuant to section 4734.37 of the Revised Code, or the liquor control commission issued pursuant to Chapter 4301. or 4303. of the Revised Code shall be set down for hearing at the earliest possible time and takes precedence over all other actions. The hearing in the court of common pleas shall proceed as in the trial of a civil action, and the court shall determine the rights of the parties in accordance with the laws applicable to such action. [***]

The court may affirm the order of the agency complained of in the appeal if it finds, upon consideration of the entire record and such additional evidence as the court has admitted, that the order is supported by reliable, probative, and substantial evidence and is in accordance with law. In the absence of such a finding, it may reverse, vacate, or modify the order or make such other ruling as is supported by reliable, probative, and substantial evidence and is in accordance with law [***]"

R C. 119.01(D) further defines *adjudication* as "the determination by the highest or ultimate authority of an agency of the rights, duties, privileges, benefits, or legal relationships of a specified person. [***]."

The precise issue raised in this action has not been addressed by an appellate decision. In *Angerman v State Medical Bd.* (February 27, 1990), Franklin App No. 89AP-896, No. 89AP-897 (Dismissed by: *Angerman v Ohio State Medical Bd.* (1990), 52 Ohio St. 3d 706) the Tenth District Court of Appeals noted the following in dictum:

"In passing, however, it should be noted that, assuming arguendo, a common please court does have equitable jurisdiction over R.C. 4731.22(D), summary suspension orders, that jurisdiction should be exercised with care and caution and only in extreme cases. Further, we recognize the dilemma encountered by the appellants in this case, as in *Westerheide*, and would only suggest that the problem may be avoided if appellants were to conduct a brief, pre-summary suspension evidentiary hearing similar to that prescribed in Civ. R. 65 relative to the issuance of temporary restraining orders. Appellants also have the

option of testing the issues they have presented to this court in an independent action for declaratory judgment which subsequently could be reviewed on direct appeal

Id. at 6.

The doctor in that case was ultimately stripped of his license after the summary suspension hearing and review by the trial court. *Angerman v. State Medical Bd* (1990), 70 Ohio App. 3d 346. The stay of license suspension issued in *Angerman* was from a request for injunctive relief. There were two separately filed actions, an R.C. 119 appeal and one for injunctive relief, which had been consolidated. The appellate court declined to review whether the injunction was proper, finding it was moot due to the Board's subsequent action. That court similarly did not find that there was or was not a right to seek an injunction, but did recommend implementation of a pre-suspension hearing, citing the need for a type of *Loudermill* due process. *Cleveland Board of Education v Loudermill* (1985), 470 U.S. 532, 546, 105 S.Ct. 1487, 1495, 84 L. Ed. 2d 494.

A review of the holding and the dictum of the above-cited case does not resolve the issues raised in this matter. While the Board sought to have the Court of Appeals consider the merits issues, the Court chose not to do so. The trial court is thus left to navigate the course of this apparently recurring issue without guidance from the higher courts. This Court is equally cognizant of the brutal effect that may be visited upon a doctor under a summary suspension. However, the sagacity of the procedure, if due process is met, is to be judged not by the Court, but by the General Assembly.

The statutory provisions provide a licensee the right to have a hearing conducted within fifteen days by the Board to examine the Board's evidence and offer mitigating evidence. As a practical matter, these hearings may be unable to proceed within fifteen

days. In the instant matter, the suspension went into effect on October 10, 2007, and the hearing had yet to take place as of January 28, 2008. The Court must note that it was continued at Appellant's request. While Appellant was granted a Temporary Restraining Order on January 25, 2008, that Order has expired. Accordingly, the Motion to Dissolve, filed by the Board on January 30, 2008 and Appellant's Motion to Strike are rendered moot, due to the expiration of the Temporary Restraining Order.

The issue left for this Court's consideration is whether Appellant has a right to bring an appeal prior to the summary suspension hearing. A fair reading of R.C. 119.12 provides a circumstance in which the Court reviews a record of the administrative action. It will normally include an evidentiary presentation from both sides. An appeal prior to a suspension hearing provides no such record and very minimal basis for review. Additionally, the language of R.C. 4731.22 specifically prohibits the Court from entertaining a stay of the summary license suspension upon the filing of an appeal. Ostensibly, this was placed into the statute by the legislature to protect the public in those instances where the Board has an immediate and genuine concern for public welfare. It set the guideline for a timely hearing and requires the Board to act on only clear and convincing evidence before imposing a suspension.

The Court must also consider whether there is a final order or whether this is an attempt at appeal of an interlocutory order. The rationale for allowing appeals only from final orders is to avoid piecemeal appeals. This has been reiterated in various cases. See *In re Dixon Health Care Ctr., Inc.* (July 11, 1985) Franklin App.No. 85AP-244, *Ashtabula v Pub Utilities Comm.* (1942), 139 Ohio St. 213. Since, at least to the Court's knowledge, there has been no evidentiary hearing conducted with participation by

Appellant, this attempt to appeal is premature. The Court may not interpose as a fact finder, nor decider of issues of law without having the legislatively delegated tribunal consider the issues first.

The Board has also asked the Court to dismiss the action for failure to properly notice the appeal. Although the Board has offered a number of decisions considering the sufficiency of grounds of appeal, required in pleading a Chapter 119 appeal, the case of *Derakhshan, M.D. v State Medical Board of Ohio* (2007), Franklin App. No 07AP-261, 2007 Ohio 5802, counters the Board's position. That Court cited a number of cases and found them inapplicable. The grounds for appeal in *Derakhshan* are not that dissimilar from those recited in the case *sub judice*. The Court therefore finds the notice of appeal sufficient, but conversely, that there is not right of appeal.

It is concluded that the Appellant has no legal right to seek redress of the summary suspension under the provisions of R.C. 119.12 where the appeal is filed prior to the summary suspension hearing. While Appellant may have other redress, it is not under the auspices of Chapter 119.

Based on the foregoing, this Court finds that the Board's Motion to Dismiss is well-founded and meritorious. Accordingly, the Court hereby **SUSTAINS** the Board's Motion to Dismiss.

Rule 58(B) of the Ohio Rules of Civil Procedure provides the following:

(B) Notice of filing. When the court signs a judgment, the court shall endorse thereon a direction to the clerk to serve upon all parties not in default for failure to appear notice of the judgment and its date of entry upon the journal. Within three days of entering the judgment on the journal, the clerk shall serve the parties in a manner prescribed by Civ. R. 5(B) and note the service in the appearance docket. Upon serving the notice and

notation of the service in the appearance docket, the service is complete. The failure of the clerk to serve notice does not affect the validity of the judgment or the running of the time for appeal except as provided in App. R. 4(A).

The Court finds that there is no just reason for delay. This is a final appealable order The Clerk is instructed to serve the parties in accordance with Civ. R. 58(B) as set forth above.



JOHN A. CONNOR, JUDGE

COPIES TO:
Eric J. Plinke
191 S. Nationwide Blvd
Suite 300
Columbus, OH 43215-8120
Attorney for Appellant

Barbara J. Pfeiffer
Assistant Attorney General
30 East Broad Street, 26th Floor
Columbus, OH 43215-3400
Attorney for Appellee

STATE MEDICAL BOARD
IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO

2008 JAN 25 P 4: 58

WILLIAM W. NUCKLOS, M.D., :
 :
 Plaintiff-Appellant, :
 :
 vs. :
 :
 STATE MEDICAL BOARD OF OHIO, :
 :
 Defendant-Appellee. :

Case No. 07CVF-10-14544

JUDGE CONNOR

FILED
COMMON PLEAS COURT
FRANKLIN COUNTY, OHIO
2008 JAN 25 PM 4: 22
CLERK OF COURTS

ORDER

This matter came before this Court on motion of William W. Nucklos, M.D. [Dr. Nucklos] seeking an Order compelling a continuance of a hearing before the State Medical Board of Ohio [Board] hearing officer, which is now set for Monday, January 28, 2008 at 9:00 a.m. A motion seeking the continuance was duly filed with the State Medical Board and was denied by the hearing officer based upon his understanding that he had no discretion in considering the request, because the Board itself was withholding its consent.

It is **ORDERED** that the hearing scheduled for January 28, 2008 is stayed until such time that this Court can consider proper briefs and evidence as to whether the hearing examiner should have discretion to consider the request, even if the Board does not acquiesce and if not, whether the Board has sufficient factual and legal reasoning for denying the request. The parties shall confer on a briefing schedule and submit it to the court by January 30, 2008.

In the interim, Dr. Nucklos consents and it is so Ordered by this court that he will not practice medicine and surgery in the State of Ohio in any form or manner until the allegations contained in the October 10, 2007, Notice of Opportunity for Hearing [October 2007 Notice] issued by the State Medical Board of Ohio [Board] have been considered by the Board and the

Board has issued a Final Order or approved a Consent Agreement. Dr. Nucklos further agrees that any violation of the above-referenced limitation shall subject him to further disciplinary action pursuant to Section 4731.22, Ohio Revised Code.

Nothing in this Order shall be construed as an admission by Dr. Nucklos to the allegations contained in the October 2007 Notice. Nothing in this Order shall be construed to limit Dr. Nucklos's right to a full hearing on the allegations contained in the Board's October 2007 Notice to the extent he is entitled by law.



JUDGE CONNOR

Submitted by:

BUCKINGHAM, DOOLITTLE & BURROUGHS, LLP

By:


Eric J. Plinke (0059463)
Michael F. Copley (0033796)
Nicole M. Loucks (0076912)
191 West Nationwide Blvd., Suite 300
Columbus, Ohio 43215
Telephone: (614) 221-8448/Facsimile: (614) 221-8590
Attorneys for Plaintiff-Appellant

..CO2-102888_v1*

STATE MEDICAL BOARD
OF OHIO
2008 JAN 25 P 4: 58

BEFORE THE STATE MEDICAL BOARD OF OHIO

WILLIAM W. NUCKLOS, M.D.
1671 Heatherwae Loop
Powell, Ohio 43065,

Appellant,

vs.

STATE MEDICAL BOARD OF OHIO
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215

07CVF10-14544

Case No. _____

Judge _____

APPEAL FROM THE ENTRY
OF ORDER OF OCTOBER 10, 2007
MAILED OCTOBER 11, 2007

APPELLANT'S NOTICE OF APPEAL

Now comes Appellant, William W. Nucklos, M.D., by and through counsel, and pursuant to Ohio Revised Code Section 119.12, hereby gives notice of his appeal of the Entry of Order of the Appellee, State Medical Board of Ohio ("Board"), which pursuant to Ohio Revised Code Section 4731.22(G) issued a Summary Suspension of Appellant's medical license. The Board's Entry of Order was dated October 10, 2007, and mailed on October 11, 2007. The basis of the Appellant's Appeal is that the Board's Entry of Order is not supported by substantial, probative, and reliable evidence nor is it in accordance with law. A copy of the Board's Entry of Order is attached hereto as Exhibit A.

Respectfully submitted,

BUCKINGHAM DOOLITTLE & BURROUGHS, LLP



Eric J. Plinke (0059463)
191 W. Nationwide Boulevard, Suite 300
Columbus, Ohio 43215- 8120
Phone: (614) 221-8448
Facsimile: (614) 277-7334

FILED COURT
COMMUNICATIONS
FRANKLIN COUNTY
2007 OCT 25 PM 3:49
CLERK OF COURTS-CV

STATE MEDICAL BOARD
OF OHIO
2007 OCT 25 P 3:23

E-Mail: eplinke@bdblaw.com
Attorneys for Appellant, William W. Nucklos, M.D.

CERTIFICATE OF SERVICE

I hereby certify that on this 25th day of October, 2007, the foregoing Notice of Appeal was filed via hand delivery with the State Medical Board of Ohio, was filed via hand delivery with the Court of Common Pleas of Franklin County, Ohio, and that a copy was served via ordinary U.S. mail, postage prepaid, upon the following:

Barbara Pfeiffer
Assistant Attorney General
Ohio Attorney General's Office
Health and Human Services
30 East Broad Street
26th Floor
Columbus, Ohio 43215


Eric J. Plinke

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor Columbus, OH 43215-6127



Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

October 10, 2007

William W. Nucklos, M.D.
1671 Heatherwae Loop
Powell, OH 43065

Dear Doctor Nucklos:

Enclosed please find certified copies of the Entry of Order, the Notice of Summary Suspension and Opportunity for Hearing, and an excerpt of the Minutes of the State Medical Board, meeting in regular session on October 10, 2007, including a Motion adopting the Order of Summary Suspension and issuing the Notice of Summary Suspension and Opportunity for Hearing.

You are advised that continued practice after receipt of this Order shall be considered practicing without a certificate, in violation of Section 4731.41, Ohio Revised Code.

Pursuant to Chapter 119, Ohio Revised Code, you are hereby advised that you are entitled to a hearing on the matters set forth in the Notice of Summary Suspension and Opportunity for Hearing. If you wish to request such hearing, that request must be made in writing and be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice. Further information concerning such hearing is contained within the Notice of Summary Suspension and Opportunity for Hearing.

THE STATE MEDICAL BOARD OF OHIO

A handwritten signature in black ink, appearing to read "Lance A. Talmage", is written over a horizontal line.

Lance A. Talmage, M.D., Secretary

LAT/LAZ/flb
Enclosures

Mailed 10-11-07

CERTIFICATION

I hereby certify that the attached copies of the Entry of Order of the State Medical Board of Ohio and the Motion by the State Medical Board, meeting in regular session on October 10, 2007, to Adopt the Order of Summary Suspension and to Issue the Notice of Summary Suspension and Opportunity for Hearing, constitute true and complete copies of the Motion and Order in the Matter of William W. Nucklos, M.D., as they appear in the Journal of the State Medical Board of Ohio.

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



Lance A. Talmage, M.D., Secretary

(SEAL)

October 10, 2007

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF :
 :
 :
 WILLIAM W. NUCKLOS, M.D. :

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio the 10th of October, 2007.

Pursuant to Section 4731.22(G), Ohio Revised Code, and upon recommendation of Lance A. Talmage, M.D., Secretary, and Raymond J. Albert, Supervising Member; and

Pursuant to their determination, based upon their review of the information supporting the allegations as set forth in the Notice of Summary Suspension and Opportunity for Hearing, that there is clear and convincing evidence that William W. Nucklos, M.D., has violated Section 4731.22(B)(6), Ohio Revised Code, as alleged in the Notice of Summary Suspension and Opportunity for Hearing that is enclosed herewith and fully incorporated herein; and,

Pursuant to their further determination, based upon their review of the information supporting the allegations as set forth in the Notice of Summary Suspension and Opportunity for Hearing, that Dr. Nucklos's continued practice presents a danger of immediate and serious harm to the public;

The following Order is hereby entered on the Journal of the State Medical Board of Ohio for the 10th day of October, 2007:

It is hereby ORDERED that the certificate of William W. Nucklos, M.D., to practice medicine or surgery in the State of Ohio be summarily suspended.

It is hereby ORDERED that William W. Nucklos, M.D., shall immediately cease the practice of medicine and surgery in Ohio and immediately refer all active patients to other appropriate physicians.

This Order shall become effective immediately.

(SEAL)


Lance A. Talmage, M.D., Secretary

October 10, 2007
Date

State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127



Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

NOTICE OF SUMMARY SUSPENSION AND OPPORTUNITY FOR HEARING

October 10, 2007

William W. Nucklos, M.D.
1671 Heatherwae Loop
Powell, OH 43065

Dear Doctor Nucklos:

The Secretary and the Supervising Member of the State Medical Board of Ohio [Board] have determined that there is clear and convincing evidence that you have violated Section 4731.22(B)(6), Ohio Revised Code, and have further determined that your continued practice presents a danger of immediate and serious harm to the public, as set forth in paragraph (1) below.

Therefore, pursuant to Section 4731.22(G), Ohio Revised Code, and upon recommendation of Lance A. Talmage, M.D., Secretary, and Raymond J. Albert, Supervising Member, you are hereby notified that, as set forth in the attached Entry of Order, your certificate to practice medicine or surgery in the State of Ohio is summarily suspended. Accordingly, at this time, you are no longer authorized to practice medicine and surgery in Ohio.

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

- (1) In or about March 2001 through in or about October 2002, in the course of your medical practice, you undertook the care of Patients 1-28 as identified on the attached patient key. [The Patient Key is confidential and shall be withheld from public disclosure.] You inappropriately prescribed controlled substances and/or dangerous drugs to said patients in a manner inconsistent with minimal standards of care and/or without a legitimate medical purpose. Examples of such conduct, include, but are not limited to, prescribing despite your failure to order and/or document ordering appropriate consultations, your failure to perform and/or

document performing appropriate physical examinations, and/or your failure to order and/or document ordering appropriate diagnostic testing.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute “[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease,” as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute “[s]elling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for treatment in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug,” as those clauses are used in Section 4731.22(B)(3), Ohio Revised Code.

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

Further, your acts, conduct, and/or omissions as alleged in paragraph (1) 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 4731-21-02, Ohio Administrative Code, Utilizing Prescription Drugs for the Treatment of Intractable Pain.

Pursuant to Chapter 119., Ohio Revised Code, and Chapter 4731., Ohio Revised Code, you are hereby advised that you are entitled to a hearing concerning these matters. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

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

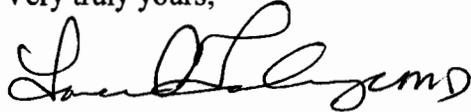
Notice of Summary Suspension
& Opportunity for Hearing
William W. Nucklos, M.D.
Page 3

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

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

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/LAZ/flb
Enclosures

CERTIFIED MAIL # 91 7108 2133 3933 4044 1262
RETURN RECEIPT REQUESTED

cc: Eric Plinke, Esq.
Buckingham Doolittle & Burroughs
191 West Nationwide Blvd.
P.O. Box 151120
Columbus, OH 43215-8120

CERTIFIED MAIL # 91 7108 2133 3933 4044 1279
RETURN RECEIPT REQUESTED

BEFORE THE STATE MEDICAL BOARD

IN THE MATTER OF :
:
WILLIAM W. NUCKLOS, M.D. :

ORDER AND ENTRY

By Board Order dated March 8, 2006, the State Medical Board of Ohio immediately suspended the medical license of William W. Nucklos, M.D., pursuant to Section 3719.121(C), Ohio Revised Code, and issued a Notice of Opportunity for Hearing [March 2006 Notice] based on his having been convicted in the Clark County Court of Common Pleas of ten felony counts of trafficking in drugs and ten felony counts of illegal processing of drug documents. Dr. Nucklos appealed the criminal convictions underlying the Ohio Medical Board's action to the Second District Court of Appeals. On March 9, 2007, that Court issued a decision reversing the convictions.

Subsequently, the State of Ohio appealed to the Supreme Court of Ohio, which accepted jurisdiction on August 29, 2007, of only one of two propositions of law. The State of Ohio has filed a Motion to Reconsider Jurisdiction of Proposition 2, which motion is still pending before the Supreme Court of Ohio.

On the basis of the foregoing, the State Medical Board's March 8, 2006, Order immediately suspending the license of William W. Nucklos, M.D., shall be and is hereby VACATED, and Dr. Nucklos' certificate to practice medicine and surgery in the State of Ohio is hereby REINSTATED.

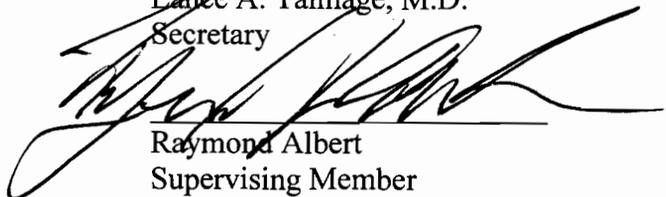
Further, on the basis of the foregoing, the March 2006 Notice shall be and is hereby DISMISSED without prejudice.

So Ordered this 10th day of October 2007.

(SEAL)



Lance A. Talmage, M.D.
Secretary



Raymond Albert
Supervising Member

CERTIFIED MAIL NO. 91 7108 2133 3933 4539 8073
RETURN RECEIPT REQUESTED

Eric J. Plinke, Esq.
191 W. Nationwide Blvd., Suite 300
Columbus, OH 43215-2568

CERTIFIED MAIL NO. 91 7108 2133 3933 4539 8080
RETURN RECEIPT REQUESTED

William W. Nucklos, M.D.
1671 Heatherwae Loop
Powell, OH 43065

BEFORE THE STATE MEDICAL BOARD

IN THE MATTER OF :
:
WILLIAM W. NUCKLOS, M.D. :

ORDER AND ENTRY

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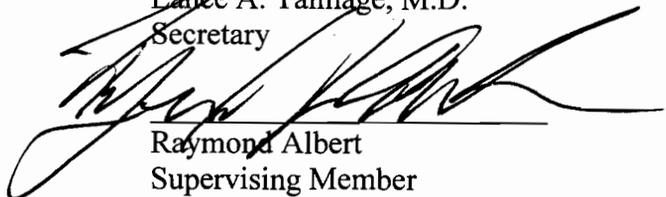
Further, on the basis of the foregoing, the March 2006 Notice shall be and is hereby DISMISSED without prejudice.

So Ordered this 10th day of October 2007.

(SEAL)



Lance A. Talmage, M.D.
Secretary



Raymond Albert
Supervising Member

CERTIFIED MAIL NO. 91 7108 2133 3933 4539 8073
RETURN RECEIPT REQUESTED

Eric J. Plinke, Esq.
191 W. Nationwide Blvd., Suite 300
Columbus, OH 43215-2568

CERTIFIED MAIL NO. 91 7108 2133 3933 4539 8080
RETURN RECEIPT REQUESTED

William W. Nucklos, M.D.
1671 Heatherwae Loop
Powell, OH 43065



State Medical Board of Ohio

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

NOTICE OF IMMEDIATE SUSPENSION AND OPPORTUNITY FOR HEARING

March 8, 2006

William W. Nucklos, M.D.
1671 Heatherwae Loop
Powell, OH 43065

Dear Doctor Nucklos:

In accordance with Sections 2929.42 and/or 3719.12, Ohio Revised Code, the Office of the Prosecuting Attorney of Clark County, Ohio, reported that, on or about February 16, 2006, in the Clark County Court of Common Pleas, you were found guilty of ten felony counts of Trafficking in Drugs, in violation of Section 2925.03, Ohio Revised Code, and ten felony counts of Illegal Processing of Drug Documents, in violation of Section 2925.23, Ohio Revised Code.

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

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

- (1) On or about October 19, 2004, you were indicted by the Clark County, Ohio, Grand Jury for ten felony counts of Trafficking in Drugs, in violation of Section 2925.03, Ohio Revised Code, and ten felony counts of Illegal Processing of Drug Documents, in violation of Section 2925.23, Ohio Revised Code. On or about February 16, 2006, in the Clark County Court of Common Pleas, after a trial by jury, you were found guilty of ten felony counts of Trafficking in Drugs, to wit: OxyContin, in violation of Section 2925.03, Ohio Revised Code, and ten felony counts of Illegal Processing of Drug Documents, in violation of Section 2925.23, Ohio Revised Code. The jury further found that all ten counts of Trafficking in Drugs involved an amount of OxyContin exceeding bulk amount,

Mailed 3-9-06

and that all ten counts of Illegal Processing of Drug Documents involved OxyContin. On or about February 22, 2006, in the Clark County Court of Common Pleas, you were sentenced to a term of twenty years in prison.

Your acts, conduct, and/or omissions as alleged in paragraph (1) above, individually and/or collectively, constitute “[s]elling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes or a plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for treatment in lieu of conviction of, a violation of any federal or state law regulating the possession, distribution, or use of any drug,” as those clauses are used in Section 4731.22(B)(3), Ohio Revised Code.

Your plea of guilty, the judicial finding of guilt, or the judicial finding of eligibility for intervention in lieu of conviction as alleged in paragraph (1) above, individually and/or collectively, constitute “[a] plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, a felony,” as that clause is used in Section 4731.22(B)(9), Ohio Revised Code.

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

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

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

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

Notice of Immediate Suspension and
Opportunity for Hearing
William W. Nucklos, M.D.
Page 3

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7003 0500 0002 4330 4072
RETURN RECEIPT REQUESTED

Duplicate mailing:

William W. Nucklos, M.D.
Inmate # A516814
Correctional Reception Center
11271 State Route 762
P.O. Box 300
Orient, OH 43146

CERTIFIED MAIL # 7003 0500 0002 4330 4065
RETURN RECEIPT REQUESTED

cc: James R. Willis, Esq.
310 W. Lakeshore Avenue, Suite 595
Cleveland, OH 44113

CERTIFIED MAIL # 7003 0500 0002 4330 3969
RETURN RECEIPT REQUESTED