

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

December 12, 2007

Willie Calvin Rabb, Jr., D.P.M.
3199 West 14th, #1
Cleveland, OH 44109

Dear Doctor Rabb:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Patricia A. Davidson, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 12, 2007, 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 that reads "Lance A. Talmage M.D." in a cursive style.

Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

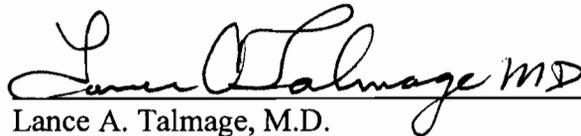
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RETURN RECEIPT REQUESTED

Mailed 12-14-07

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Patricia A. Davidson, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on December 12, 2007, 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 Willie Calvin Rabb, Jr., D.P.M., 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)

December 12, 2007

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

WILLIE CALVIN RABB, JR., D.P.M.

*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on December 12, 2007.

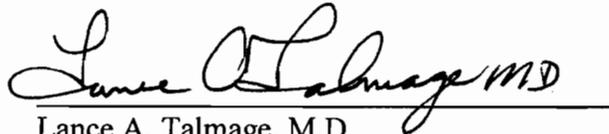
Upon the Report and Recommendation of Patricia A. Davidson, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the 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 Willie Calvin Rabb, Jr., D.P.M., 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

December 12, 2007

Date

2007 OCT 17 P 3: 33

**REPORT AND RECOMMENDATION
IN THE MATTER OF WILLIE CALVIN RABB, JR., D.P.M.**

The Matter of Willie Calvin Rabb, Jr., D.P.M., was heard by Patricia A. Davidson, Hearing Examiner for the State Medical Board of Ohio, on September 5, 2007.

INTRODUCTION

Basis for Hearing

By letter dated May 10, 2007, the State Medical Board of Ohio [Board] notified Willie Calvin Rabb, Jr., D.P.M., of proposed disciplinary action against his certificate to practice podiatric medicine and surgery in Ohio. The Board's proposed action was based on allegations that the Maryland State Board of Podiatric Medical Examiners [Maryland Board] had permanently revoked Dr. Rabb's license to practice podiatric medicine and surgery in Maryland, based on numerous findings, including that Dr. Rabb's patient care and record-keeping were below applicable standards and that he had falsified information on his Maryland application for license renewal.

The Board further alleged that the order of the Maryland Board constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of * * * podiatric medicine and surgery * * *, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as set forth in Ohio Revised Code Section 4731.22(B)(22).

The Board advised Dr. Rabb of his right to request a hearing, and received his written request for hearing on July 16, 2007. (State Exhibits 1A, 1C)

Appearances

Marc Dann, Attorney General, and Kyle C. Wilcox, Assistant Attorney General, for the State.

The Respondent filed his hearing request *pro se*. However, he did not attend the hearing in person or by representative.

EVIDENCE EXAMINED

Exhibits

State's Exhibits 1A through 1I: Procedural exhibits.

State's Exhibit 2: Documents maintained by the Maryland Board.

Witnesses

No witnesses testified at the hearing.

SUMMARY OF THE EVIDENCE

1. In an order issued by the Maryland Board pursuant to the Maryland Podiatry Act, Maryland Code Annotated, Health Occupations [H.O.] § 16-315(a), dated August 1, 2006 [the Maryland Order], the Maryland Board stated that it had received a complaint in 2000 regarding Willie Calvin Rabb, Jr., D.P.M., who had been practicing podiatric medicine in Maryland. (St. Ex. 2 at 1-2) The Maryland Board stated that it had conducted an investigation, which resulted in allegations against Dr. Rabb, including the following:

ALLEGATIONS REGARDING LICENSURE RENEWAL APPLICATION¹

On a license renewal form dated December 9, 1999, the Respondent answered “no” to Question Number 6 which asked “[h]ave you pled guilty, nolo contendere (sic), or been convicted of, or received probation before judgment of driving while intoxicated or of a controlled dangerous substance offense?”

However, the Respondent answered this question untruthfully, because on July 30, 1998, and on February 4, 1999, the Respondent was found guilty of driving while intoxicated (DWI) by the District Court of Maryland.

By answering “no” to the above questions, the Respondent violated the [Maryland Podiatry] Act.

ALLEGATIONS REGARDING PATIENT CARE

As part of its investigation, the Board subpoenaed 10 surgical charts from the Respondent. The charts revealed the following overall deficiencies: the Respondent’s handwritten progress and operation (op) reports are illegible. All op reports were handwritten on separate pages and not in sequence with the progress notes, leading to the appearance that the reports were written long after the operations took place, and in response to the Board’s subpoenas. No pathology reports were present with cases involving the removal of soft tissue masses. Consent forms were often not dated and/or witnessed; some did not describe the procedure to be performed. Some surgeries did not have operative reports. The Respondent failed to conduct an appropriate or adequate history of the patients and often failed to try a conservative approach or discuss alternatives to surgery. The Respondent often failed to obtain pre-op x-rays or post-op x-rays.

¹ Footnotes in the Maryland Order have been omitted except where necessary to understand the order.

When the Respondent obtained x-rays, there was no discussion in his records about his impressions or assessments. The Respondent failed to conduct a comprehensive pre-op work-up, and order specific tests, when indicated, such as blood work, urinalysis, and chest x-rays or EKGs, for surgical patients. [A footnote here states as follows: "Laboratory studies may be necessary for surgical candidates based on physical findings as established from the medical history. EKGs are standard for any surgical candidate over 40 years of age. Chest x-rays should be done at the discretion of the doctor, but are necessary for those surgical candidates who are heavy smokers."]

A. Patient A's * * * first visit to the Respondent occurred on October 9, 1998. Prior to that, Patient A had seen the previous owner of the clinic on October 16, 1995. Despite the lapse in treatment, the Respondent failed to take a detailed history from Patient A, who was seventy-five when she presented to the Respondent.

On August 17, 1999, the Respondent performed a hammertoe surgery on Patient A's left foot. The usual and customary period for removal of sutures is 10 to 14 days, post-op. The Respondent waited for 21 days before he removed Patient A's sutures. The Respondent failed to conduct a pre-op work-up on this elderly patient. The Respondent failed to take pre-op or post-op x-rays.

B. Patient B, who last saw the Respondent's predecessor in September 1997, presented to the Respondent on May 27, 1999. On July 22, 1999, Patient B signed a [c]onsent form for surgery, which was not witnessed. The Respondent failed to write a progress note for that appointment. On July 27, 1999, the Respondent performed a bunionectomy of the big toe, right foot, arthroplasty of the second toe, right foot, and a resection of a painful nerve, right foot. The Respondent failed to record a diagnosis or to discuss the need for surgery or its alternatives. Even though Patient B was to have anesthesia, the Respondent failed to take a history, failed to do a pre-op work-up, or do pre-op or post-op x-rays of Patient B. The Respondent also failed to submit the neuroma material to a pathology laboratory.

C. Patient C presented to the Respondent as a new patient on February 5, 2000. The Respondent failed to take an adequate history of the patient. The Respondent billed for an injection on that first visit, but because his notes are illegible, it is impossible to determine where or why the injection took place. The Respondent failed to date the [c]onsent form. The Respondent failed to discuss alternatives to surgery. Even though Patient C was undergoing anesthesia, the Respondent failed to do a pre-op work-up of Patient C. The Respondent took an x-ray on February 5, 2000, but failed to interpret or assess it. The Respondent failed to take a post-op x-ray.

D. Patient D had been seen by the Respondent's predecessor in August 1994. Patient D presented to the Respondent on June 16, 1999. Despite the gap in services, the Respondent failed to take an adequate history of Patient D. On July 23, 1999, the Respondent performed an osteotomy for a heel spur on Patient D. The Respondent's op report, written, as usual, on a sheet separate from the progress notes, is dated July 23, 2000. The Respondent's progress notes and op report are illegible.

Under the November 1, 1999 entry, another entry appears which is either undated or dated September 25th. On October 5, 1999, the Respondent sent Patient D for a nerve conduction study. The Respondent failed to include any interpretation or discussion about the results of that study into *[sic]* his progress notes. The Respondent took pre-op x-rays, but failed to interpret them. The Respondent failed to take post-op x-rays.

E. Patient E presented to Respondent as a new patient on August 23, 1999. The Respondent failed to take an appropriate history. The Respondent operated on a tumor on Patient E on October 18, 1999. The [c]onsent form is undated and un-witnessed. Although the Respondent removed soft tissue mass, he failed to obtain a pathology report. The Respondent took pre-op x-rays of Patient E, but failed to take post-op ones. The Respondent billed for hammertoe surgery and for a tenectomy, which is fragmentation.

F. Patient F was last seen by the Respondent's predecessor in March 1997. Patient F presented to the Respondent as a new patient on March 2, 2000. Despite the gap in care, the Respondent failed to take an appropriate history. Four days later, the Respondent performed hammertoe surgery on Patient F, without taking pre-op x-rays. The Respondent also failed to take post-op x-rays. The Respondent billed for two hammertoe surgeries, but the separate op report only noted surgery on the second toe.

G. Patient G's last visit with the Respondent's predecessor was in August 1997. Patient G presented to the Respondent on July 14, 1998. The Respondent failed to update Patient G's history. On December 1, 1998, the Respondent took an x-ray of Patient G, but did not assess same. On December 7, 1998, the Respondent performed bone surgery on Patient G, but failed to do a pre-op work-up. The Respondent failed to provide a note for the date of the surgery, and failed to do post-op x-rays. The [c]onsent for this surgery is un-witnessed.

H. On February 4, 2000, Patient H presented to the Respondent as a new patient. The Respondent took x-rays of Patient H, but failed to document an assessment of the x-rays. Without trying or discussing alternative/conservative treatments, the Respondent operated on Patient H on February 8, 2000. However, the Respondent failed to record a note regarding the surgery in his progress notes. The [c]onsent signed and dated by the patient as February 8,

2000, was un-witnessed. The [c]onsent states that the operation was for removal of a soft tissue mass on the right foot and removal of a bone spur on the big toe of the left foot. The Respondent wrote a separate op report, without placing the patient's name on the second page of the report. The report is dated February 8, 2000.

The Respondent billed for an ostectomy, which is a more expensive procedure involving the metatarsal, on February 8, 2000. The Respondent up coded. Even though the Respondent claims to have removed a soft tissue mass, he failed to send it to a pathology lab. The Respondent billed for a pre-op x-ray of one foot, but failed to obtain a post-op x-ray.

On February 9, 2000, the Respondent billed for the identical procedures billed on February 8, 2000. The Respondent failed to record any [c]onsent, office visit, notes, or op report for February 9, 2000. The Respondent double-billed.

I. Patient I was last seen by the Respondent's predecessor in January 1996. Patient I presented to the Respondent on August 27, 1999. Despite the gap in visits, the Respondent failed to update Patient's history. On August 30, 1999, the Respondent excised a mass on Patient I. The Respondent failed to send the excised matter to a pathology lab. The Respondent failed to obtain consent for this surgery. On November 5, 1999, the Respondent removed a soft tissue mass on Patient's right foot. The Respondent failed to obtain [c]onsent for this surgery, which required anesthesia. The Respondent failed to write an op report or to send the mass to a pathology lab. The Respondent also failed to do a pre-op work-up.

J. On March 7, 2000, Patient J presented as a new patient to the Respondent. Patient J had a painful deformity on the fifth toe of both feet. Patient J had filled out a questionnaire which indicated that she smoked 20-30 cigarettes a day. The Respondent failed to do a pre-op work-up with this heavy smoker, before performing surgery on her on March 12, 2000, under anesthesia. The anesthetist records that anesthesia was given on March 12, 2000, and Patient J signed [c]onsent to it on that date. The Respondent's nearly illegible handwritten op report indicates that surgery took place on March 12, 2000. However, Patient J's insurer okayed the surgery for March 13, 2000, and Patient J signed a [c]onsent form for the surgery, dated March 13, 2000. The [c]onsent form was un-witnessed. The Respondent billed for hammertoe surgery conducted on the 13th. The Respondent failed to write any progress notes at all for Patient J, from her first visit to her last.

The Respondent took pre-op x-rays of Patient J, but failed to provide an assessment of them. The Respondent failed to obtain post-op x-rays. The Respondent failed to send the specimen to the pathology lab.

* * *

ALLEGATIONS REGARDING ALCOHOL ABUSE AND IMPAIRMENT

* * * [I]n 1998 and 1999, the Respondent was convicted of driving while intoxicated. Furthermore, on April 15, 2001, the Respondent was again arrested for driving on a revoked license, exceeding the maximum speed limit, by going 100 in a 55 miles per hour zone, speed greater than reasonable, and DWI/DUI. As a result of the first DWI charge, the Respondent was placed on probation until October 13, 2001: a condition of probation is that he is not to drink any alcoholic beverages. The Respondent admitted to the Board's investigator that he had drunk a "few beers" on April 15, 2001, the date of his latest DWI arrest.

The Complainant informed the Board that she received a phone call from the Respondent, stating that he was in jail. The Respondent asked the Complainant to bail him out, which bond was \$7500. The Complainant further stated that the Respondent comes to work with the smell of alcohol on his breath and with his clothes smelling of "pot" (marijuana).

The Respondent is currently undergoing substance abuse treatment on an outpatient basis, as a part of his probation, but continues to drink alcohol.

* * *

ALLEGATIONS REGARDING FAILURE TO COOPERATE
WITH A LAWFUL BOARD INVESTIGATION

During the course of the Board's investigation, the Board subpoenaed an additional patient file. The Respondent * * * promised the Board on several occasions thereafter that he would forward the file to the Board. The Respondent has failed to forward said file. * * *

ALLEGATIONS REGARDING ABANDONING PATIENTS

Since the summer of 2001, the Respondent has stopped going to his offices and stopped treating patients. His phone numbers at those offices have been disconnected. The Board and numerous other podiatrists have received calls and complaints from the Respondent's former patients that they have been unable to receive follow-up care and have been unable to obtain their medical records from the Respondent.

By failing to notify his patients that he is no longer practicing, by failing to make their patient records available to them or to their subsequent providers, and by failing to provide follow-up care to his patients and/or

arrange appropriate referrals to other providers, the Respondent has abandoned his patients, in violation of the Act.

(St. Ex. 2 at 2-10)

2. The Maryland Board charged Dr. Rabb on or about October 30, 2001, with violations of the Maryland Podiatry Act, Maryland Code Annotated, H.O. § 16-311(a), including the following: fraudulently or deceptively obtaining or attempting to obtain a license in violation of § 16-311(a)(1); abandonment of a patient in violation of § 16-311(a)(4); providing professional services while under the influence of alcohol in violation of § 16-311(a)(5); impairment of the ability to perform podiatric services in violation of § 16-311(a)(6); submitting a false statement to collect a fee in violation of § 16-311(a)(12); behaving “fraudulently, immorally or unprofessionally in the practice of podiatry” and/or being “professionally or mentally incompetent” in violation of § 16-311(a)(17); violating any Board rules or regulations in violation of § 16-311(a)(22); and failing to comply with a lawful investigation in violation of § 16-311(a)(27). (St. Ex. 2 at 1-2)

The Maryland Board noted that, under Sections 10.40.08.02(3)(c) and (3)(l) of the Code of Maryland Regulations (COMAR), the term “unprofessional conduct” includes conduct “in the practice of podiatric medicine which evidences moral unfitness to practice the profession” and “[f]ragmentation of a general procedure to increase the reimbursement.” (St. Ex. 2 at 2)

3. On January 10, 2002, an administrative hearing was held on the merits, according to the Maryland Order. The Maryland Board noted that, although Dr. Rabb had “been served with the charges in [this] matter which included the date of the hearing, Dr. Rabb did not appear, and the hearing proceeded without him.” (St. Ex. 2 at 10-11)
4. On August 1, 2006, the Maryland Board issued a final decision titled “Findings of Fact, Conclusions of Law, and Order” [Maryland Order]. (St. Ex. 2 at 1-2) In it, the Maryland Board provided the following summary of testimony:

The State’s witness[es] included John Robert Thomas, Jr., Board investigator, and the Board’s expert, Dr. Joseph Warner. Mr. Thomas testified that Dr. Rabb falsified his license renewal application when he answered no to questions concerning criminal convictions. In an interview, Dr. Rabb admitted to a number of DWI arrests. Mr. Thomas gleaned from employee interviews that Dr. Rabb failed to keep patient appointments, often came to work with the odor of alcohol and the odor of burnt marijuana on his person. That he lied on insurance application forms and that the podiatry assistant was assisting with surgeries, cutting patient nails, and removing sutures. According to Mr. Thomas’ testimony regarding his efforts to locate Dr. Rabb, it appeared that Dr. Rabb abandoned his patients.

Dr. Warner reviewed the original patient complaint, all investigative reports, randomly pulled patient charts, and all records pertaining to Dr. Rabb’s DWI

conviction and subsequent probation, incarceration and alcohol treatment plan. Dr. Warner concluded, after having reviewed the patient charts, that the care provided by Dr. Rabb was “substandard to the accepted standard of care for podiatrists in the State of Maryland.” Record-keeping was inadequate, [and] in some cases there were no records at all, and in others, records were illegible. There was “inappropriate or lack of preoperative work up for patients who are undergoing surgery.² There were inappropriate postoperative care and management of the patient, absence of x-rays and pathological reports. Essentially there was very little, if any, documentation, and the documentation that was provided appeared to be falsified. [Transcript citations omitted]

(St. Ex. 2 at 11-12)

5. In its Order, the Maryland Board set forth the following findings and conclusion:

The Board makes the following Findings of Fact:

1. The Respondent was licensed to practice podiatry [in] Maryland, license number 01257.
2. The Respondent, in December 1999, falsified answers on the Board’s [li]cense renewal application when he answered no to a question regarding criminal arrests and convictions.
3. The Respondent’s patient care and record-keeping [were] below accepted standards for podiatrists in the State of Maryland.
4. The Respondent falsified insurance applications.
5. The Respondent often arrived at his office smelling of alcohol and marijuana.
6. The Respondent abandoned patients.
7. The Respondent allowed a podiatry assistant to assist with surgeries, and to remove sutures.

* * *

*** [T]he Board concludes as a matter of law that the Respondent’s actions, as described above, constitute, in whole or in part, violations of the Maryland Podiatry Act and its regulations as follows: H.O. § 16-311(a) 1, 4, 5, 6, 12, 17, 18, 19, 22, 27 and COMAR 10.40.08.02(3)(c)(l).

(St. Ex. 2 at 12-13)

² The quotation that opens at the beginning of this sentence does not have closing quotation marks. (St. Ex. 2 at 11-12)

6. The Maryland Board ordered that Dr. Rabb's license to practice podiatry in the State of Maryland "shall be and is PERMANENTLY REVOKED." (St. Ex. 2 at 13)

FINDINGS OF FACT

1. On August 1, 2006, the Maryland State Board of Podiatric Medical Examiners issued an Order entitled "Findings of Fact, Conclusions of Law, and Order" [Maryland Order], in which it permanently revoked the license of Willie Calvin Rabb, Jr., D.P.M., to practice podiatric medicine and surgery in the state of Maryland.
2. The Maryland Order included findings that Dr. Rabb had falsified answers on a Maryland license-renewal application, abandoned patients, allowed a podiatry assistant to assist with surgeries and remove sutures, falsified insurance applications, arrived often at his office smelling of alcohol and/or marijuana, and that his patient care and record-keeping were below accepted standards for podiatrists in the state of Maryland.

CONCLUSION OF LAW

The Maryland Order as described above in the Findings of Fact constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that language is used in Ohio Revised Code Section 4731.22(B)(22).

* * * * *

The offenses underlying the Maryland Board's permanent revocation of Dr. Rabb's license were extremely serious, including multiple violations of a kind that pose a direct risk to the public. Based on the number and gravity of violations found by the Maryland Board, the Hearing Examiner recommends that the Board permanently revoke Dr. Rabb's certificate to practice in Ohio. In reaching this conclusion, the Hearing Examiner was mindful that much of the Maryland Order consisted of a recitation of allegations rather than findings. Nonetheless, the Maryland Order—including the summary of evidence, findings of fact, conclusions of law, and order of permanent revocation—warrants the permanent revocation of Dr. Rabb's Ohio certificate.

PROPOSED ORDER

It is hereby ORDERED that:

The certificate of Willie Calvin Rabb, Jr., D.P.M., to practice podiatric medicine and surgery in the State of Ohio is hereby PERMANENTLY REVOKED.

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



Patricia A. Davidson
Hearing Examiner

State Medical Board of Ohio

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

Richard A. Whitehouse, Esq.
Executive Director

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EXCERPT FROM THE DRAFT MINUTES OF DECEMBER 12, 2007

REPORTS AND RECOMMENDATIONS

Dr. Kumar announced that the Board would now consider the Reports and Recommendations appearing on its agenda. He asked whether each member of the Board had received, read, and considered the hearing records, the proposed findings of fact, conclusions of law, and orders, and any objections filed in the matters of: Kimberli Jo Burback; Michael Shane Gainey, M.D.; Russell L. Gaudett; Cynthia Joan Johnson, P.A.; Kandhasamy Kannapiran, MD.; Ali Khan, M.D.; Robert M. Moore, M.T.; Kolli Mohan Prasad, M.D.; Willie Calvin Rabb, Jr., D.P.M.; Mary Ellen Ratcliff; and Robert Rowan Summers, D.O. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Mr. Hairston	- aye
	Dr. Steinbergh	- aye
	Dr. Kumar	- aye

Dr. Kumar 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. Varyani	- aye
	Dr. Buchan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Mr. Hairston	- aye

Dr. Amato - aye
Dr. Steinbergh - aye
Dr. Kumar - aye

Dr. Kumar 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. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

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

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The meeting recessed at 3:50 p.m. When it reconvened at 4:53 p.m., Dr. Amato was absent.

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WILLIE CALVIN RABB, JR., D.P.M.

.....

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. DAVIDSON'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF WILLIE CALVIN RABB, JR., D.P.M. DR. BUCHAN SECONDED THE MOTION.

.....

A vote was taken on Dr. Steinbergh's motion:

ROLL CALL:

Mr. Albert	- abstain
Dr. Egner	- aye
Dr. Talmage	- abstain
Dr. Varyani	- aye
Dr. Buchan	- aye
Dr. Madia	- aye
Mr. Browning	- aye
Mr. Hairston	- abstain
Dr. Steinbergh	- aye
Dr. Kumar	- aye

The motion carried.



State Medical Board of Ohio

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

May 10, 2007

Willie Calvin Rabb, Jr., D.P.M.
13944 Euclid Avenue #105
East Cleveland, OH 44112

Dear Doctor Rabb:

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 podiatric medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) On or about August 1, 2006, the Maryland State Board of Podiatric Medical Examiners [Maryland Board] issued Findings of Fact, Conclusions of Law, and Order [Maryland Order] which permanently revoked your license to practice podiatric medicine and surgery in the state of Maryland. A copy of the Maryland Order is attached hereto and incorporated herein.

The Maryland Order included findings that you falsified answers on the Maryland Board's license renewal application, that your patient care and record keeping was below accepted standards for podiatrists in the state of Maryland, that you falsified insurance applications, that you often arrived at your office smelling of alcohol and marijuana, that you abandoned your patients, and that you allowed a podiatry assistant to assist with surgeries and remove sutures.

The Maryland Order as alleged in paragraph (1) above, constitutes "[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand," as that clause is used in Section 4731.22(B)(22), 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.

Mailed 5-10-07

Willie Calvin Rabb, Jr., D.P.M.

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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 podiatric 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,

A handwritten signature in cursive script, appearing to read "Lance A. Talmage M.D.", written in dark ink.

Lance A. Talmage, M.D.
Secretary

LAT/AMS/flb
Enclosures

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STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
4201 Patterson Avenue • Baltimore, Maryland 21215-2299

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

State Board of Podiatric Medical Examiners
Eva Schwartz, Executive Director

LICENSE VERIFICATION

This is to certify that according to the records of the State of Maryland Board of Podiatric Medical Examiners, the individual named below is hereby licensed accordingly:

NAME: WILLIE RABB JR.

LICENSE TYPE: D.P.M. (Doctor of Podiatric Medicine)

LICENSE NO.: 01257

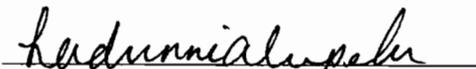
ORIGINAL LICENSURE DATE: 11/26/1997

EXPIRATION DATE: 12/31/2007

OBTAINED BY: STATE EXAMINATION

STATUS: REVOKED

See Attached.


Certified by: Oladunni Akinpelu
Title: Licensing Coordinator
Date Verified: 3/13/07

Requested by: Licensing Board (Ohio)

OHIO STATE MEDICAL BOARD

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IN THE MATTER OF * BEFORE THE MARYLAND
WILLIE RABB, D.P.M. * STATE BOARD OF
Respondent * PODIATRIC MEDICAL EXAMINERS
License Number: 01257 *

* * * * *

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

Pursuant to the Maryland Podiatry Act (the "Act"), Md. Code Ann., Health Occ. ("H.O.") (2005 Replacement Volume) § 16-315(a) the Maryland State Board of Podiatric Medical Examiners (the "Board") hereby renders the following final decision and order.

BACKGROUND

_____ On or about October 30, 2001, the Board charged Willie Rabb, D.P.M. ("Respondent"), license number 01257 under the Act, H.O. §§ 16-101 *et seq.* as follows:

H.O. § 16-311(a)

(a) *In general.* – Subject to the hearing provisions of § 16-313 of this subtitle, the Board, on the affirmative vote of a majority of its members then serving, may ...reprimand any licensee ... impose an administrative penalty ... place any licensee on probation... or suspend or revoke a license ...if the licensee:

- (1) Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or licensee or for another;
- (4) Abandons a patient;
- (5) Provides professional services while:

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- (i) Under the influence of alcohol; or
- (6) Has a condition, illness, or disease that may impair the ability of the individual to perform podiatric services;
- (12) Submits a false statement to collect a fee;
- (17) Behaves fraudulently, immorally, or unprofessionally in the practice of podiatry; Is professionally or mentally incompetent; Violates any provision of this title;
- (22) Violates any rules or regulations adopted by the Board;
- (27) Fails to comply with a lawful investigation conducted by the Board. The Board adopted the following regulations, under Code of Maryland Regulations (COMAR) 10.40.08.02:
 - (3) Unprofessional conduct includes but is not limited to:
 - (c) Conduct in the practice of podiatric medicine which evidences moral unfitness to practice the profession;
 - (l) Fragmentation of a general procedure to increase the reimbursement.

BACKGROUND

On a complaint form, dated May 5, 2000, the Board received a complaint from an ex-employee who alleged that the Respondent: often failed to keep appointments; that he had been jailed for drinking and driving; that he sometimes arrived for work with the smell of alcohol on his breath; that, while retrieving some medical charts and an appointment book from the Respondent's car, the employee found a pipe and a small bag with suspected marijuana on the front seat of the Respondent's car; that an employee assists him on surgery, though she is not certified to do so; and, that he lied

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on insurance applications about not ever being convicted or arrested for driving under the influence.

As a result of the receipt of the complaint, the Board conducted an investigation, which disclosed the following:

ALLEGATIONS REGARDING LICENSURE RENEWAL APPLICATION

On a license renewal form dated December 9, 1999, the Respondent answered "no" to Question Number 6 which asked "[h]ave you pled guilty, nolo contendere (sic), or been convicted of, or received probation before judgment of driving while intoxicated or of a controlled dangerous substance offense?"

However, the Respondent answered this question untruthfully, because on July 30, 1998 and on February 4, 1999, the Respondent was found guilty of driving while intoxicated (DWI) by the District Court of Maryland.

By answering "no" to the above questions, the Respondent violated the Act.

ALLEGATIONS REGARDING PATIENT CARE¹

As part of its investigation, the Board subpoenaed 10 surgical charts from the Respondent. The charts revealed the following overall deficiencies: the Respondent's handwritten progress and operation (op) reports are illegible. All op reports were handwritten on separate pages and not in sequence with the progress notes, leading to the appearance that the reports were written long after the operations took place, and in response to the Board's subpoenas. No pathology reports were present with cases involving the removal of soft tissue masses. Consent forms were often not dated and/or

¹ The statements of Respondent's conduct with respect to the patients identified herein are intended to provide Respondent notice of the alleged charges. They are not intended as, and do not necessarily represent, a complete description of the evidence, either documentary or testimonial, to be offered against Respondent in connection with each patient.

witnessed; some did not describe the procedure to be performed. Some surgeries did not have operative reports. The Respondent failed to conduct an appropriate or adequate history of the patients and often failed to try a conservative approach or discuss alternatives to surgery. The Respondent often failed to obtain pre-op x-rays or post-op x-rays. When the Respondent obtained x-rays, there was no discussion in his records about his impressions or assessments. The Respondent failed to conduct a comprehensive pre-op work-up, and order specific tests, when indicated, such as blood work, urinalysis, and chest x-rays or EKGs, for surgical patients². Specific deficiencies follow:

A. Patient A's³ first visit to the Respondent occurred on October 9, 1998. Prior to that, Patient A had seen the previous owner of the clinic on October 16, 1995.

Despite the lapse in treatment, the Respondent failed to take a detailed history from Patient A, who was seventy-five when she presented to the Respondent.

On August 17, 1999, the Respondent performed a hammertoe surgery on Patient A's left foot. The usual and customary period for removal of sutures is 10 to 14 days, post-op. The Respondent waited for 21 days before he removed Patient A's sutures. The Respondent failed to conduct a pre-op work-up on this elderly patient. The Respondent failed to take pre-op or post-op x-rays.

B. Patient B, who last saw the Respondent's predecessor in September 1997, presented to the Respondent on May 27, 1999. On July 22, 1999, Patient B signed a

² Laboratory studies may be necessary for surgical candidates based on physical findings as established from the medical history. EKGs are standard for any surgical candidate over 40 years of age. Chest x-rays should be done at the discretion of the doctor, but are necessary for those surgical candidates who are heavy smokers.

³ Patient names are confidential, but will be disclosed to the Respondent by contacting the Administrative Prosecutor.

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Consent form for surgery, which was not witnessed. The Respondent failed to write a progress note for that appointment. On July 27, 1999, the Respondent performed a bunionectomy of the big toe, right foot, arthroplasty of the second toe, right foot, and a resection of a painful nerve, right foot. The Respondent failed to record a diagnosis or to discuss the need for surgery or its alternatives. Even though Patient B was to have anesthesia, the Respondent failed to take a history, failed to do a pre-op work-up, or do pre-op or post-op x-rays of Patient B. The Respondent also failed to submit the neuroma material to a pathology laboratory.

C. Patient C presented to the Respondent as a new patient on February 5, 2000. The Respondent failed to take an adequate history of the patient. The Respondent billed for an injection on that first visit, but because his notes are illegible, it is impossible to determine where or why the injection took place. The Respondent failed to date the Consent form. The Respondent failed to discuss alternatives to surgery. The Respondent performed a hammertoe surgery on Patient C on February 17, 2000. Even though Patient C was undergoing anesthesia, the Respondent failed to do a pre-op work-up of Patient C. The Respondent took an x-ray on February 5, 2000, but failed to interpret or assess it. The Respondent failed to take a post-op x-ray.

D. Patient D had been seen by the Respondent's predecessor in August 1994. Patient D presented to the Respondent on June 16, 1999. Despite the gap in services, the Respondent failed to take an adequate history of Patient D. On July 23, 1999, the Respondent performed an ostectomy for a heel spur on Patient D. The Respondent's op report, written, as usual, on a sheet separate from the progress notes, is dated July 23, 2000. The Respondent's progress notes and op report are illegible.

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Under the November 1, 1999 entry, another entry appears which is either undated or dated September 25th. On October 5, 1999, the Respondent sent Patient D for a nerve conduction study. The Respondent failed to include any interpretation or discussion about the results of that study into his progress notes. The Respondent took pre-op x-rays, but failed to interpret them. The Respondent failed to take post-op x-rays.

E. Patient E presented to Respondent as a new patient on August 23, 1999. The Respondent failed to take an appropriate history. The Respondent operated on a tumor on Patient E on October 18, 1999. The Consent form is undated and un-witnessed. Although the Respondent removed soft tissue mass, he failed to obtain a pathology report. The Respondent took pre-op x-rays of Patient E, but failed to take post-op ones. The Respondent billed for hammertoe surgery and for a tenectomy, which is fragmentation.

F. Patient F was last seen by the Respondent's predecessor in March 1997. Patient F presented to the Respondent as a new patient on March 2, 2000. Despite the gap in care, the Respondent failed to take an appropriate history. Four days later, the Respondent performed hammertoe surgery on Patient F, without taking pre-op x-rays. The Respondent also failed to take post-op x-rays. The Respondent billed for two hammertoe surgeries, but the separate op report only noted surgery on the second toe.

G. Patient G's last visit with the Respondent's predecessor was in August 1997. Patient G presented to the Respondent on July 14, 1998. The Respondent failed to update Patient G's history. On December 1, 1998, the Respondent took an x-ray of Patient G, but did not assess same. On December 7, 1998, the Respondent performed bone surgery on Patient G, but failed to do a pre-op work-up. The Respondent failed to

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provide a note for the date of surgery, and failed to do post-op x-rays. The Consent for this surgery is un-witnessed.

H. On February 4, 2000, Patient H presented to the Respondent as a new patient. The Respondent took x-rays of Patient H, but failed to document an assessment of the x-rays. Without trying or discussing alternative/conservative treatments, the Respondent operated on Patient H on February 8, 2000. However, the Respondent failed to record a note regarding the surgery in his progress notes. The Consent signed and dated by the patient as February 8, 2000, was un-witnessed. The Consent states that the operation was for removal of a soft tissue mass on the right foot and removal of a bone spur on the big toe of the left foot. The Respondent wrote a separate op report, without placing the patient's name on the second page of the report. The report is dated February 8, 2000.

The Respondent billed for an ostectomy, which is a more expensive procedure involving the metatarsal, on February 8, 2000. The Respondent up coded. Even though the Respondent claims to have removed a soft tissue mass, he failed to send it to a pathology lab. The Respondent billed for a pre-op x-ray of one foot, but failed to obtain a post-op x-ray.

On February 9, 2000, the Respondent billed for the identical procedures billed on February 8, 2000. The Respondent failed to record any Consent, office visit, notes, or op report for February 9, 2000. The Respondent double-billed.

I. Patient I was last seen by the Respondent's predecessor in January 1996. Patient I presented to the Respondent on August 27, 1999. Despite the gap in visits, the Respondent failed to update Patient's history. On August 30, 1999, the Respondent

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excised a mass on Patient I. The Respondent failed to send the excised matter to a pathology lab. The Respondent failed to obtain consent for this surgery. On November 5, 1999, the Respondent removed a soft tissue mass on Patient's right foot. The Respondent failed to obtain Consent for this surgery, which required anesthesia. The Respondent failed to write an op report or to send the mass to a pathology lab. The Respondent also failed to do a pre-op work-up.

J. On March 7, 2000, Patient J presented as a new patient to the Respondent. Patient J had a painful deformity on the fifth toe of both feet. Patient J had filled out a questionnaire which indicated that she smoked 20-30 cigarettes a day. The Respondent failed to do a pre-op work-up with this heavy smoker, before performing surgery on her on March 12, 2000, under anesthesia. The anesthetist records that anesthesia was given on March 12, 2000, and Patient J signed Consent to it on that date. The Respondent's nearly illegible handwritten op report indicates that surgery took place on March 12, 2000. However, Patient J's insurer okayed the surgery for March 13, 2000, and Patient J signed a Consent form for the surgery, dated March 13, 2000. The Consent form was un-witnessed. The Respondent billed for hammertoe surgery conducted on the 13th. The Respondent failed to write any progress notes at all for Patient J, from her first visit to her last.

The Respondent took pre-op x-rays of Patient J, but failed to provide an assessment of them. The Respondent failed to obtain post-op x-rays. The Respondent failed to send the specimen to the pathology lab.

As set forth above, the Respondent violated the Act and regulations thereunder.

ALLEGATIONS REGARDING VIOLATIONS OF THE TITLE

During the course of the investigation, the Respondent stopped going to his Glen Burnie and Essex offices and appeared to have moved from his home. The Respondent failed to notify the Board of his change of address, as required. By failing to notify the Board of his change of address, the Respondent violated the Act.

ALLEGATIONS REGARDING ALCOHOL ABUSE AND IMPAIRMENT

As set forth in paragraph five hereof, in 1998 and 1999, the Respondent was convicted of driving while intoxicated. Furthermore, on April 15, 2001, the Respondent was again arrested for driving on a revoked license, exceeding the maximum speed limit, by going 100 in a 55 miles per hour zone, speed greater than reasonable, and DWI/DUI. As a result of the first DWI charge, the Respondent was placed on probation until October 13, 2001: a condition of probation is that he is not to drink any alcoholic beverages. The Respondent admitted to the Board's investigator that he had drunk a "few beers" on April 15, 2001, the date of his latest DWI arrest.

The Complainant informed the Board that she received a phone call from the Respondent, stating that he was in jail. The Respondent asked the Complainant to bail him out, which bond was \$7500. The Complainant further stated that the Respondent comes to work with the smell of alcohol on his breath and with his clothes smelling of "pot" (marijuana).

The Respondent is currently undergoing substance abuse treatment on an outpatient basis, as a part of his probation, but continues to drink alcohol.

Practicing podiatry while under the influence of drugs or alcohol is a violation of the Act and regulations thereunder.

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ALLEGATIONS REGARDING FAILURE TO COOPERATE WITH

A LAWFUL BOARD INVESTIGATION

During the course of the Board's investigation, the Board subpoenaed an additional patient file. The Respondent received the subpoena on June 13, 2001, and promised the Board on several occasions thereafter that he would forward the file to the Board. The Respondent has failed to forward said file. Failing to cooperate with a lawful Board investigation is a violation of the Act.

ALLEGATIONS REGARDING ABANDONING PATIENTS

Since the summer of 2001, the Respondent has stopped going to his offices and stopped treating patients. His phone numbers at those offices have been disconnected. The Board and numerous other podiatrists have received calls and complaints from the Respondent's former patients that they have been unable to receive follow-up care and have been unable to obtain their medical records from the Respondent.

By failing to notify his patients that he is no longer practicing, by failing to make their patient records available to them or to their subsequent providers, and by failing to provide follow-up care to his patients and/or to arrange appropriate referrals to other providers, the Respondent has abandoned his patients, in violation of the Act.

Pursuant to Pursuant to H.O. § 16-313 and the Maryland Administrative Procedure Act, Md. Code Ann., State Gov't § 10-226(c)(1)(ii) a hearing on the merits took place on January 10, 2002. Constituting a quorum were the following Board members: Charles Avent, Dr. Dennis Weber, Dr. Brian Kashan, Dr. Judith Cappelo, Dr. Ira Deming, Ernestine Jones Jolivet. Dr. Jim Christina, Board Vice President, presided. Roberta Gill, Assistant Attorney General represented the State. In spite of having been served

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with the charges in matter which included the date of the hearing, Dr. Rabb did not appear, and the hearing proceeded without him.

SUMMARY OF WITNESS TESTIMONY

_____The State's witness included John Robert Thomas, Jr., Board investigator, and the Board's expert, Dr. Joseph Warner. Mr. Thomas testified that Dr. Rabb falsified his license renewal application when he answered no to questions concerning criminal convictions. In an interview, Dr. Rabb admitted to a number of DWI arrests. Mr. Thomas gleaned from employee interviews that Dr. Rabb failed to keep patient appointments, often came to work with the odor of alcohol and the odor of burnt marijuana on his person. That he lied on insurance application forms and that the podiatry assistant was assisting with surgeries, cutting patient nails, and removing sutures. According to Mr. Thomas testimony regarding his efforts to locate Dr. Rabb, it appeared that Dr. Rabb abandoned his patients.

Dr. Warner reviewed the original patient complaint, all investigative reports, randomly pulled patient charts, and all records pertaining to Dr. Rabb's DWI conviction and subsequent probation, incarceration and alcohol treatment plan. Dr. Warner concluded, after having reviewed the patient charts that the care provided by Dr. Rabb was "substandard to the accepted standard of care for podiatrists in the State of Maryland." (T. 40 4-7). Record keeping was inadequate, in some cases there were no records at all, and in others, records were illegible. There was "inappropriate or lack of preoperative work up for patients who are undergoing surgery. There was inappropriate postoperative care and management of he patient, absence of x-rays and pathological

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reports. Essentially there was very little, if any, documentation, and the documentation that was provided appeared to be falsified. (T. 40 14-18).

FINDINGS OF FACT

_____The Board makes the following Findings of Fact:

1. The Respondent was licensed to practice podiatry Maryland, license number 01257.
2. The Respondent, in December 1999, falsified answers on the Board's incense renewal application when he answered no to a question regarding criminal arrests and convictions.
3. The Respondent's patient care and record keeping was below accepted standards for podiatrists in the State of Maryland.
4. The Respondent falsified insurance applications.
5. The Respondent often arrived at his office smelling of alcohol and marijuana.
6. The Respondent abandoned patients.
7. The respondent allowed a podiatry assistant to assist with surgeries, and to remove sutures.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, and Conclusions of Law, the Board concludes as a matter of law that the Respondent's actions, as described above, constitute, in whole or in part, violations of the Maryland Podiatry Act and its regulations as follows: H.O. § 16-311(a) 1, 4, 5, 6, 12, 17, 18, 19, 22, 27 and, COMAR 10.40.08.02(3)(l).

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ORDER

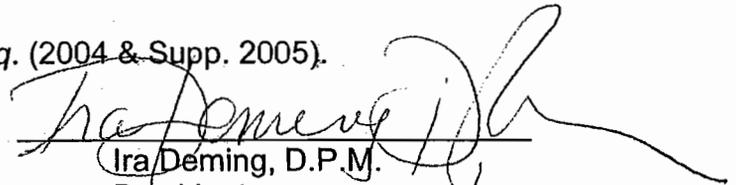
Based on the foregoing Findings of Fact and Conclusions of Law, it is, this
1st day of August, 2006, pursuant to the authority vested in the Maryland State
Board of Podiatric Medical Examiners by Md. Code Ann., Health Occ. Article, § 16-
311(a), hereby

ORDERED that, the Respondent's license to practice podiatry in this State
shall be and is **PERMANENTLY REVOKED**; and it is further

ORDERED that the Respondent shall be responsible for all hearing costs
incurred by the Board; and it further

ORDERED that this document is a public record, pursuant to Md.
Code Ann., State Gov't Article, § 10-611 *et seq.* (2004 & Supp. 2005).

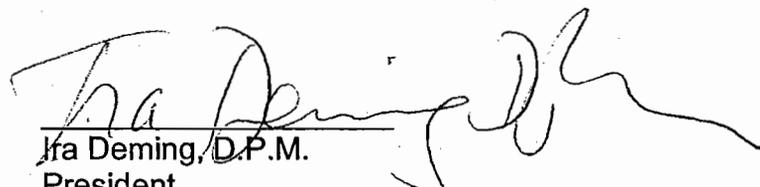
August 1, 2006
Date


Ira Deming, D.P.M.
President

NOTICE OF RIGHT OF APPEAL

In accordance with Md. Code Ann., Health Occ. Article, § 4-319, you have a right to
take a direct judicial appeal. A petition for appeal shall be filed within thirty days of your
receipt of this Findings of Fact, Conclusions of Law and Order and shall be made as
provided for judicial review of a final decision in the Maryland Administrative Procedure
Act, Md. Code Ann., State Gov't Article, §§ 10-201 *et seq.*, and Title 7 Chapter 200 of
the Maryland Rules.

August 1, 2006
Date


Ira Deming, D.P.M.
President

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