



March 10, 2004

MINUTES

THE STATE MEDICAL BOARD OF OHIO

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Anquetette Sloan, President, called the meeting to order at 1:00 p.m., at the Vern Riffe Center for Government and the Arts, 77 S. High St., Columbus, Ohio 43215, Room #1932, with the following members present: Patricia J. Davidson, M.D. Vice-President; Lance A. Talmage, M.D., Secretary; Raymond J. Albert, Supervising Member; Carol L. Egner, M.D.; Anant R. Bhati, M.D.; David S. Buchan, D.P.M.; Deepak Kumar, M.D.; Andrew F. Robbins, Jr., M.D., Anand G. Garg, M.D., and Anita M. Steinbergh, D.O. The following joined the meeting at a later time: R. Gregory Browning, Ph.D.

Also present were: Thomas A. Dilling, Executive Director; William J. Schmidt, Assistant Executive Director; Diann K. Thompson, Assistant Executive Director; Mark Wayda, Chief of Executive Staff; Lauren Lubow, Senior Executive Staff Attorney; Shannon F. Baldwin, Executive Staff Attorney; Lori S. Gilbert, Chief Enforcement Attorney; Mark R. Blackmer, Marcie P. Burrow, Sally J. Debolt, David P. Katko, Rebecca J. Marshall, Karen H. Mortland, Kathleen S. Peterson, and Charles Woodbeck, Enforcement Attorneys; Sheryl L. Maxfield, Rebecca J. Albers, Kyle C. Wilcox, and Gregory A. Perry, Assistant Attorneys General; Eileen M. Schmidt, Executive Assistant to the Director; Joan K. Wehrle, Coordinator for Assessment and Development; Danielle Bickers, Compliance Officer; Barbara Jacobs, Public Services Administrator; Jacqueline A. Moore, Disciplinary Information Assistant.

EXECUTIVE SESSION

DR. GARG MOVED THAT THE BOARD DECLARE EXECUTIVE SESSION TO CONFER WITH THE ATTORNEY GENERAL'S REPRESENTATIVES ON MATTERS OF PENDING OR IMMINENT COURT ACTION. DR. STEINBERGH SECONDED THE MOTION. A vote was taken:

VOTE:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

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Pursuant to Section 121.22(G)(3), Revised Code, the Board went into executive session.

Mr. Browning joined the meeting during the executive session.

The following joined the meeting after the executive session: R. Gregory Porter, Chief Hearing Examiner; Sharon W. Murphy and Siobhan R. Clovis, Hearing Examiners.

MINUTES REVIEW

DR. BHATI MOVED TO APPROVE THE MINUTES OF FEBRUARY 11-12, 2004. MR. BROWNING SECONDED THE MOTION. A vote was taken

VOTE:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- abstain

The motion carried.

REPORTS AND RECOMMENDATIONS

Ms. Sloan announced that the Board would now consider the findings and orders appearing on the Board's agenda. She asked whether each member of the Board had received, read, and considered the hearing record, the proposed findings, conclusions, and order, and any objections filed in the matters of: Teodoro C. Navarro, M.D.; Erdulfo Paz Paat, M.D.; German V. Prada, M.D.; Francisco I. Regueyra, M.D.; and John Michael Schechter, M.D. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye

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Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye
Ms. Sloan	- aye

Ms. Sloan asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

Ms. Sloan noted that, in accordance with the provision in Section 4731.22(F)(2), Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters.

Ms. Sloan stated that if there were no objections, the Chair would dispense with the reading of the proposed findings of fact, conclusions and orders in the above matters. No objections were voiced by Board members present.

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

TEODORO C. NAVARRO, M.D.

Ms. Sloan directed the Board's attention to the matter of Teodoro C. Navarro, M.D. She advised that no objections were filed to Hearing Examiner Murphy's Report and Recommendation.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF TEODORO C. NAVARRO, M.D. DR. ROBBINS SECONDED THE MOTION.

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Ms. Sloan stated that she would now entertain discussion in the above matter.

Dr. Steinbergh stated that this is a licensure issue. Dr. Navarro doesn't hold a current license from any other state, and he hasn't passed an examination, as required in the law that would permit the Board to grant him a license. The Proposed Order is appropriate, and the Board should deny his application for a license to practice medicine and surgery in Ohio.

Dr. Steinbergh continued that her read of this case is that Dr. Navarro is on track to complete the CME requirements that would allow him to reinstate his Michigan license. She stated that Dr. Navarro's best chance would be to get his Michigan license reinstated. She noted that the Proposed Order isn't a permanent denial, and Dr. Navarro will be eligible to apply for licensure again after he meets Ohio's licensure requirements.

Dr. Buchan agreed, stating that the Conclusions are clear and well stated.

Dr. Bhati stated that it's a matter of meeting Ohio's licensure requirements, and, currently, Dr. Navarro does not.

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

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

The motion carried.

ERDULFO PAZ PAAT, M.D.

Ms. Sloan directed the Board's attention to the matter of Erdulfo Paz Paat, M.D. She advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

Ms. Sloan continued that materials included with the objections are being construed as a request to submit additional evidence. The Assistant Attorney General has filed his memorandum in opposition to admission of the additional evidence. Ms. Sloan asked if the Board wished to accept the additional evidence.

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Dr. Bhati stated that, if the information could be of assistance to the Board in its deliberations, it should accept it.

DR. STEINBERGH MOVED TO ADMIT THE ADDITIONAL EVIDENCE FILED BY DR. PAAT. DR. ROBBINS SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye
	Ms. Sloan	- aye

The motion carried.

The materials will be admitted to the record.

Ms. Sloan advised that a request to address the Board has been timely filed on behalf of Dr. Paat. Five minutes would be allowed for that address.

Dr. Paat was accompanied by his attorney, James M. McGovern.

Mr. McGovern stated that he believes that the Report and Recommendation ignores and/or disregards strong mitigating evidence explaining why Dr. Paat pled “no contest.” Mr. McGovern urged the Board to not disregard the evidence that’s present in this case. He advised that Dr. Paat is a foreign-born doctor, and he has some language or communication difficulties, as the Board may see when it hears from him.

Mr. McGovern stated that Dr. Paat is very nervous about being here, given what is at stake.

Mr. McGovern stated that, based upon that fact, he has urged Dr. Paat to write down his thoughts and read from them, as necessary.

Dr. Paat thanked the Board members. He stated that he must begin by informing the Board that he is frightened by this process and by the thought of losing his license. He was born in the Philippines and came to the United States in 1968. He worked hard to earn his medical degree and to build his professional practice. He is proud to say that all of his patients like and respect him. He believes that that is because he spends extra time with them, explaining their illnesses and answering their questions about the diagnosis and his treatment.

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Dr. Paat stated that, until this time, he had never been the subject of any complaint. Hoping that his remorse would bring a lighter sanction than the severe one that was proposed, he apologizes to Patient 1 and to the Board, but he cannot apologize for something he did not do. Dr. Paat stated that he did touch the patient's breasts as part of the heart and lung examination. In that regard, his biggest mistake was not rehooking her bra after inspecting the skin rash on her back and her side, and not explaining to her what was going on. Dr. Paat stated that he believes that this patient was uncomfortable during the examination and perhaps misunderstood what occurred. For that, he stated that he sincerely apologizes to Patient 1.

Dr. Paat stated that his goal in participating in this hearing has been to explain why he pled "no contest" for the misdemeanor charge, rather than going to trial. He is hopeful that each Board member will try to place him or herself into his shoes and try to understand why he offered the plea of "no contest" rather than defend himself at a trial. Unfortunately, he chose the path of least resistance; however, knowing what he knows now about how this Board would react to the finding of guilt that resulted from his "no contest" plea, he never would have offered the plea. Dr. Paat stated that he would have fought the charges. He would have found a way to pay his attorney to defend him during his trial. Dr. Paat stated that his only hope now is that this Board will recognize that this is an isolated incident, and that it boils down to "he said/she said."

Dr. Paat asked that the Board, under the circumstances, allow him to keep his license. If the Board wants him to be evaluated so that the Board can feel confident that he's not a threat or danger to the public, he is willing to do so. He now has a female medical assistant with him all of the time during his examination of female patients, and he will continue to do so for as long as he is in practice.

Dr. Paat again asked that the Board allow him to keep his license.

Ms. Sloan asked whether the Assistant Attorney General wished to respond.

Ms. Albers indicated that this case was handled by Assistant Attorney General Dominic J. Chieffo, who is unable to appear before the Board due to a family funeral. She stated that she would read remarks that Mr. Chieffo prepared:

I did not decide to request a permanent revocation of the certificate of Dr. Paat until contemplating my closing remarks at the hearing. As the Hearing Officer states in his very exhaustive report, this is a difficult and depressing case. The competency of Dr. Paat, his personality, or his mannerisms are not the issues, nor is his plea of "no contest" or "nolo contendere," or the definition of "nolo contendere." The issue is the judicial finding of guilt of a misdemeanor involving moral turpitude, committed in the course of his medical practice. This is coupled with the fact that he was represented by counsel in the criminal proceedings, that he voluntarily, knowingly and intelligently entered the plea, and that he stipulated to a finding of guilt.

In spite of all the foregoing, there's a lack of remorse, as indicated by his denial in the hearing of the very conduct of which he was found guilty, as well as by the criminal

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court-ordered letter of apology that bears no resemblance whatsoever to an apology for his underlying conduct.

When considering the consistency of the victim's statements to the police department, her testimony at the hearing, her lack of any motive for personal gain, the embarrassment of having to come forward, the testimony of five of his patients that he never unfastened or asked permission to unfasten their bras – as pointed out in the objections, each case must be considered on its own merits – and in this case, because of the facts that have been outlined, the recommendation of permanent revocation is appropriate. Thank you.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF ERDULFO PAZ PAAT, M.D. DR. EGNER SECONDED THE MOTION.

Ms. Sloan stated that she would now entertain discussion in the above matter.

Dr. Egner stated that this is a physician who pled “no contest” and was therefore found guilty of attempted sexual imposition. Dr. Egner stated that this was the overriding fact of the whole case. The Court fined Dr. Paat, he had a suspended jail sentence, and he did have legal representation. The patient says that Dr. Paat auscultated her back, came around to the front and, without looking at her or lifting her shirt, he placed his hands under her sweater and fondled her breasts. The patient had come into his office complaining of an earache and a rash and, after the doctor's exam, he diagnosed otitis media and herpes zoster. Dr. Egner stated that she believes this is very significant. This wasn't just a rash. The patient obviously didn't know the seriousness of that when she came in.

Dr. Egner stated that the testimony and exhibits offered at hearing revealed to her the following. Dr. Paat first came to know this patient after she was placed under his care from a previous ER visit. She added that she found that his records from the hospitalization were very thorough. Dr. Paat's admission and discharge summaries were excellent and very detailed. His office records were also very complete, and his office procedures of how he handles phone calls are detailed, giving the message and the time. His office staff seems to be as thorough as he is. Dr. Egner stated that she believes Dr. Paat's exam in the office was appropriate. It was recorded on the chart that the patient had a tattoo on her right chest wall, as well as an old scar. He notes normal lung sounds and an old scar in the epigastric area. Dr. Egner stated that the tattoo was not mentioned in the hospital record of her physical exam. Dr. Egner stated that she would have to conclude that Dr. Paat did not go back and look at an old record and put that information in his record. Dr. Egner stated that to find those findings, Dr. Paat would have had to lift up her sweater. He could not have known those things without having looked. This is in conflict with the patient's testimony. It seems unreasonable how he would have known these things if he had never lifted her shirt.

Dr. Egner stated that she wants to address the issue of Dr. Paat's unhooking the patient's bra. Dr. Paat stated that he normally asks the patient for permission. Dr. Egner stated that, in thinking about this particular issue, she thought about it in terms of her own office practice. All patients in her office are asked to unhook their bras themselves prior to the exam; but she would estimate that about 25 percent of

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her patients forget to do that, even though they have just been told. Generally, when this is discovered and she's ready to do the physical exam, Dr. Egner stated that she often unhooks the patient's bra. She volunteers to do this just about the same time she does it. In this particular instance, she doesn't see that there is a difference between having a male or female doctor do that. She doesn't think that who unhooks the bra is such a grave issue. Dr. Egner stated that some Board members may take exception to that, but she has to look at what her own day goes like, too, and for her, this is not a big issue.

Dr. Egner stated that the patient's testimony was very detailed and clear about the incident, but other parts of her testimony are disjointed on details such as how many times she's been married. The patient stated that she was married two times; and, yet, as the questions become more specific, she's been married three times. The patient stated that she had taken Paxil in the past when living in Toledo, but her depression cleared upon moving to Cleveland and now takes no antidepressants. Yet her record shows that she's been prescribed Celexa.

Dr. Egner stated that Dr. Paat has testified as to why he pled "no contest." He wanted to avoid the publicity, prolonging the ordeal, and he did not know that there would be further consequences, such as those from the Medical Board. While this could have been the case, the Board cannot ignore his plea and his guilty conviction. His letter of apology is consistent with his denial that the incident took place as the patient perceived it.

Dr. Egner stated that these were basically the things with which she really wrestled in trying to make a decision as to what the Board should do with his license.

Dr. Egner continued that, prior to giving her conclusions and recommendations in the case, she would also like to comment on the objections and their attachments submitted by Dr. Paat's attorney. She stated that the objections were excessive in their volume. She stated that she doesn't ever remember receiving objections of that size in the past. She found them unnecessary and burdensome. She added that she takes exception at the notion that Mr. Porter and the members of the Board need a dissertation and definition of the meaning of "no contest." She stated that the Hearing Examiners, as well as the Board, understand this very well. She added that she does not understand the purpose of the case summaries for the entire year of 2003 and 2004 to this date. Then there were four cases reviewed as analogous, but they're not. These cases all involved consensual involvement or were more about sexual boundary issues. These cases were clear, in that the doctors admitted what happened and were cooperative, remorseful and amenable to discipline. Dr. Egner stated that, if anything, after reading the objections, she was more questioning of her initial conclusions of what had really happened with the doctor and the patient, and that, perhaps, her own conclusions were not correct.

Dr. Egner stated that the patient may very well have misunderstood what was going on, and hence she believes there is the need for a course dealing with professional behavior and effective physician/patient communication.

Dr. Egner stated that she brings up these issues because she is not in favor of permanent revocation. She stated that there are too many mitigating circumstances. The Board must decide how much weight it wants

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to give to the conviction, which is conclusive evidence. Dr Egner stated that a suspension and education would be necessary and appropriate considering all of the facts of the case.

DR. EGNER MOVED TO DELETE THE PARAGRAPH IMMEDIATELY PRECEDING THE PROPOSED ORDER IN THE REPORT AND RECOMMENDATION IN THE MATTER OF ERDULFO PAZ PAAT, M.D., WHICH BEGINS WITH THE WORDS, "THIS BOARD HAS IN THE PAST DETERMINED...." DR. EGNER FURTHER MOVED THAT THE PROPOSED ORDER IN THE MATTER OF ERDULFO PAZ PAAT, M.D., BE AMENDED TO READ AS FOLLOWS:

It is hereby ORDERED that:

- A. **SUSPENSION OF CERTIFICATE:** The certificate of Erdulfo Paz Paat, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for ninety days.
- B. **PROBATIONARY CONDITIONS:** Upon reinstatement, Dr. Paat's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years:
 1. **Obey the Law:** Dr. Paat shall obey all federal, state, and local laws, all rules governing the practice of medicine and surgery in Ohio, and all terms of probation imposed by the Parma Municipal Court.
 2. **Quarterly Declarations:** Dr. Paat shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on the first day of the third month following the month in which this Order becomes effective, provided that if the effective date is on or after the 16th day of the month, the first quarterly declaration must be received in the Board's offices on the first day of the fourth month following. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
 3. **Appearances:** Dr. Paat shall appear in person for quarterly interviews before the Board or its designated representative during the third month following the effective date of this Order. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
 4. **Education Program:** Within one year of the effective date of this Order, or as otherwise approved by the Board, Dr. Paat shall provide acceptable

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- documentation of satisfactory completion of an education program, to be approved in advance by the Board or its designee. The education program shall be related to professional behavior and effective physician-patient communication. The exact number of hours and the specific content of the program shall be determined by the Board or its designee. This program shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education acquisition period(s) in which the program is completed.
5. **Third-Party Presence During Exam/Treatment**: Dr. Paat shall have a third party present while examining or treating female patients.
 6. **Absence from Ohio**: In the event that Dr. Paat should leave Ohio for three continuous months, or reside or practice outside the State, Dr. Paat must notify the Board in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of this period under the Order, unless otherwise determined by the Board in instances where the Board can be assured that probationary monitoring is otherwise being performed.
 7. **Violation of Probation; Discretionary Sanction Imposed**: If Dr. Paat violates probation in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
 8. **Tolling of Probationary Period while Out of Compliance**: In the event Dr. Paat is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period.
- C. **TERMINATION OF PROBATION**: Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Paat's certificate will be fully restored.
- D. **REQUIRED REPORTING BY LICENSEE TO EMPLOYERS AND HOSPITALS**: Within thirty days of the effective date of this Order, Dr. Paat shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Paat shall provide a copy of this Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments.
- E. **REQUIRED REPORTING BY LICENSEE TO OTHER STATE LICENSING**

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AUTHORITIES: Within thirty days of the effective date of this Order, Dr. Paat shall provide a copy of this Order by certified mail, return receipt requested, to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license. Dr. Paat shall also provide a copy of this Order by certified mail, return receipt requested, at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement or restoration of any professional license. Further, Dr. Paat shall provide this Board with a copy of the return receipt as proof of notification within thirty days of receiving that return receipt.

EFFECTIVE DATE OF ORDER: This Order shall become effective immediately upon mailing of notification of approval by the Board.

Dr. Egner stated that this was a very difficult case for her. She stated that she, as well as all of the other Board members, take these kinds of case very seriously, and a lot of thought goes into them, both for the physician and the patient. Her proposed amendment would make her feel comfortable in Dr. Paat's continuing to practice, and that the public is protected.

DR. STEINBERGH SECONDED THE MOTION.

Dr. Steinbergh stated that she supports the proposed amended order. Her feelings about Dr. Paat were similar to Dr. Egner's with the exception of a couple of things; however, in toto, she agrees with the assessment and with the proposed amended order. Dr. Steinbergh stated that she took into account the patient's thoughts and the physician's thoughts. She added that she thinks that all physicians who examine patients know there can sometimes be miscommunication and, perhaps, unintended consequences. On the other hand, the Board has a case before it where the physician was found guilty and the misdemeanor conviction has to be addressed without question.

Dr. Steinbergh stated that she didn't feel that this case was about money. The patient wanted an apology from Dr. Paat, and she wanted to be certain that this didn't happen to anyone else. Dr. Steinbergh stated that she took those thoughts into account. The Court made a judgment as to what occurred, and she thinks that, with the proposed amended order requiring the presence of a third party when examining female patients, the Board knows that this kind of thing will not happen again. She does believe that Dr. Paat is remorseful about this particular incident. Dr. Steinbergh stated that she believes that Dr. Paat should have communicated better with the patient and should have perhaps done things differently in his physical examination of the patient, but he's a very experienced physician and the concept of how he approached the patient and so forth was very reasonable.

Dr. Steinbergh continued that she does believe that there is a difference between a female examining a female and a male examining a female. She added that, although she certainly understands Dr. Egner's comments, she personally does not undress a person, regardless of his or her gender, in her examination room. She requests that they be undressed. She stated that she frequently comes into the room and the patient is not undressed. Depending upon the type of examination, she's been known to tell the patient that

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she would need to examine the patient's back or whatever the part of the body is, and the patient will need to be undressed. She will explain to what extent the patient needs to be undressed, and then she will walk back out of the room. Dr. Steinbergh stated that there are other circumstances, such as a person being in for a respiratory infection, when the gown is on and a bra is on, and physicians know that any type of cloth on top of the skin can cause sounds that sound similar to chest rales, that is, dry or sometimes wet sounds, depending upon the condition, and it can interfere with the proper auscultation of the chest. Dr. Steinbergh stated that, that being true, if she finds that that is interfering with it, she does tell the patient that she will need to have the bra off, and she will ask if the patient needs help. That gives the patient time to say "yes," or "go ahead and help me." She doesn't hesitate then to help the patient with that. Dr. Steinbergh stated that she does think that that's critical in the respect of the patient.

Dr. Steinbergh stated that she absolutely concurs with the proposed amendment to the Proposed Order. She recognized the need for a course specifically addressing the subject of professional behavior and effective physician/patient communication. She added that the Board may need to work in terms of helping Dr. Paat find an appropriate course; or the Board might require certain readings in certain areas to which the Board could direct him, and then bring Dr. Paat before a small committee of the Board, who would then simply have a conversation and verbally discuss with Dr. Paat the contents of these readings and feel comfortable that Dr. Paat understands and that, in effect, would be a course, if there is no such course available to him.

Dr. Steinbergh stated that she does agree with the proposed suspension due to Dr. Paat's conviction of a misdemeanor of the fourth degree.

Dr. Robbins stated that he also agrees with the amendment on the table, but he feels a little differently about a couple of things. He thinks that a male physician's unhooking a patient's bra is inappropriate and cannot be excused. He stated that the way Dr. Steinbergh has described is the appropriate way to handle the situation. Dr. Robbins stated that, although this case does involve a conviction, permanent revocation is excessive. He advised that he agonized over this case, and the thing that bothers him even now is the "he said/she said" aspect of this case. Dr. Robbins stated that he would feel better if there was an admission of what occurred, and an indication that Dr. Paat understands the seriousness of this case. Dr. Robbins stated that, despite that, the amendment makes a lot of sense, especially with the mitigating factors of this case, including the number of other patients that came forward and that there were no other incidents in this physician's past.

Dr. Kumar also agreed with the proposed amendment. Dr. Kumar stated that he would like to make some comments about this incident that have not yet been made. The patient claims that Dr. Paat touched her breast in the initial examination after an endoscopy was done. Dr. Kumar stated that he has a problem with accepting that, and his gut feeling is somehow or other the patient got the concept that someone was doing something to her, and that carried forward in a future examination. Dr. Kumar stated that he has had experience as a chief of staff in investigating patients filing complaints, one particular one talking about the fact that during the examination the people in the room were making fun of her breasts. As the investigation came out, essentially what happened was that a female physician, in discussing the patient's diverticulosis, used the words, "how big ticks she has." That was misconstrued and misrepresented.

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Dr. Kumar stated that what happened under anesthesia or under sedation in that charge should not be construed in this case.

Dr. Kumar stated that he totally supports this amended order.

Dr. Buchan stated that, essentially, he's in agreement with his colleagues. He commended Dr. Egner for her review of this case and for taking the lead on this case. It was difficult, but Dr. Egner articulated his feelings quite well. Dr. Buchan stated that he sensed that Dr. Paat had some issues in communication, and he believes that there were some cultural influences here. He commented that Dr. Paat may have felt that a "no contest" plea meant that it might just go away. Dr. Buchan stated that he felt that the Board should exercise some leniency in this case, and the proposed amendment does just that. The 90-day suspension is appropriate action for the misdemeanor conviction, and is along the same lines he thought the Board should be on this case prior to today.

Dr. Bhati stated that Dr. Egner did a great job in analyzing and dissecting this case in a very proper fashion. The only thing he would want to add is that there was an attempt made to look for more victims of this physician, and none were found. He asked the Board to keep in mind that this physician has been in practice for 30 years. If something had gone wrong, a lot of people would have jumped on it and said yes. None were found.

Dr. Bhati stated that he believes the physician in this case. He added that he believes Dr. Paat had very poor legal advice to plead "no contest." Dr. Bhati stated that he wishes that Dr. Paat had had better advice so that he would have understood the consequences of his plea. The Board has seen this kind of situation in the past, when the physician doesn't understand that a "no contest" plea will lead him down a lot of other alleys in which he would not wish to be. Dr. Bhati stated that he wishes attorneys would do a better job than they have done.

Dr. Bhati continued that the patient had shingles. It was important for the physician to examine the chest. It would have been below minimal standards had he not. Dr. Paat did the right thing. Dr. Bhati stated that he doesn't see much problem in this case except the fact that there is a conviction against this doctor about which the Board must do something. Dr. Bhati asked whether the Board would gain much by a 90-day suspension in this case. He stated that he doesn't think it will. He would rather have a stayed suspension in this case. Dr. Bhati stated that Dr. Paat is not a danger to his patients. He's been in practice for 30 years. Dr. Bhati asked Dr. Egner to stay the 90-day suspension.

Dr. Steinbergh disagreed with the suggestion that the suspension be stayed. She stated that there has to be some punishment for the finding of guilt of sexual imposition. It's important for the patient to know and feel confident that the Board has considered this case and that Dr. Paat is being punished, which means that Dr. Paat's professional life won't ever be quite the same. Dr. Steinbergh stated that she wants the patient to feel that this has been appropriately addressed, and that the Board is not saying that none of this happened. There were two people in that room, each one of them would know what occurred. The Board is disciplining according to the Court's finding of guilt and because of the Board's review of the record. She believes that the patient will be satisfied now that the case is done. Dr. Steinbergh stated that the

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proposed amendment is an appropriate discipline for this kind of finding.

Dr. Bhati stated that the question is whether or not the Board believes something went wrong. Yes, the Board has convicted Dr. Paat and some punishment is necessary. But at this stage, does the Board believe that Dr. Paat did something wrong. Dr. Bhati stated that he's willing to believe that Dr. Paat didn't. He added that he believes Dr. Paat's examination was very appropriate. As far as opening the bra is concerned, Dr. Paat asked the patient to open the bra.

Dr. Steinbergh stated that, according to the patient, he did not. Dr. Paat does not remember if he asked.

Dr. Bhati stated that the patient obviously has a lot of other problematic factors, which makes one not believe everything that she said. It could have totally been a question of misinterpretation, misunderstanding between the two people. If this guy was a bad doctor or a sexual abuser, the Board would have seen a lot more.

Dr. Egner stated that the Board should not lose sight of the fact that Dr. Paat was found guilty in a court. There were things that could have been done better and that were done wrong. Dr. Egner stated that she doesn't believe that the patient came up with this just totally in her imagination. That's the piece of the education course that will help Dr. Paat in the future. Dr. Paat has been found guilty of sexual imposition by the court. Dr. Egner stated that, for that, she does believe he needs a 90-day suspension. Dr. Egner stated that if she felt that absolutely nothing had occurred and there was no reason for this, she would dismiss it. She doesn't feel that way at all. Dr. Egner stated that she feels very strongly about keeping the suspension at 90 days.

A vote was taken on Dr. Egner's motion to amend:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- nay
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF ERDULFO PAZ PAAT, M.D. DR. BHATI SECONDED THE MOTION. A vote was taken:

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Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- nay
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

GERMAN V. PRADA, M.D.

Ms. Sloan directed the Board's attention to the matter of German V. Prada, M.D. She advised that objections were filed to Hearing Examiner Murphy's Report and Recommendation and were previously distributed to Board members.

Ms. Sloan continued that a request to address the Board has been timely filed on behalf of Dr. Prada. Five minutes would be allowed for that address.

Dr. Prada was accompanied to the meeting by his attorney, Eric J. Plinke.

Mr. Plinke stated that he has filed objections to the Report and Recommendations and has therefore made his position known to the Board. He stated that he would reserve the remainder of the time for Dr. Prada to address the Board.

Dr. Prada stated that he is calling today for the holy presence of God almighty to enlighten hearts and to help him in this very difficult moment. Only God and his conscience know the well-intended purpose of his actions and the ill intention that came about. Dr. Prada stated that his intention was to help; the way it was carried out was terribly wrong, and the interpretation of it was even worse. It was a terrible mistake. He stated that he cannot possibly convey his regret and remorse.

Dr. Prada stated that he is 72 years old. He has been in Dayton almost 30 years, and he has been caring for hundreds of patients to whom he has given happiness, a return to life, dignity, faith in themselves and the strength to keep on living. They undoubtedly will suffer.

Dr. Prada stated that he came to this country about 33 years ago looking for the pursuit of the American dream. This mistake on one patient has shattered this dream and turned it into a more terrible nightmare. The punishment for this mistake will impact hundreds of his patients who have been receiving care from

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him for 15, 20, and some of them more years. They undoubtedly will suffer.

Dr. Prada stated that he hopes that the Board considers this matter today with enlightened hearts, and consider what he has said today. Dr. Prada stated that he wants to gravely apologize for his conduct that brought him before the Board today, and for the cost this conduct has had on the patient and all of the patients he swore to help and to serve.

Ms. Sloan asked whether the Assistant Attorney General wished to respond.

Mr. Perry stated that the violations in this case are pretty simple; Dr. Prada was convicted of committing a misdemeanor in the course of practice and which also involved moral turpitude. That is based on his “no contest” plea to a sexual imposition charge. Mr. Perry stated that a “no contest” plea means that, while not admitting to his guilt in the legal sense of the word, he was admitting to all of the factual allegations that were made against him, mainly that he had engaged in sexual contact with a patient for purposes of his own sexual gratification.

Mr. Perry continued that, to have a crime actually occur, you have to have a combination of two elements at the same time: the guilty act and the guilty mind. To commit a crime you have to commit a guilty act while possessing a guilty mind. He added that Dr. Prada would have the Board believe that, while he may have committed a guilty act, he didn’t have a guilty mind. He meant well, had good intentions. Mr. Perry stated that the acts Dr. Prada committed just can’t be done with good intentions. The two ideas are mutually exclusive.

Mr. Perry stated that he was at the hearing, and he talked to Dr. Prada more than anyone on the day of the hearing. Mr. Perry stated that he really does think that Dr. Prada feels bad about what happened, but that doesn’t change the facts. This was not a boundary violation; this was an assault. This was a patient, and he took something from her that can never be given back. Dr. Prada violated her trust as a patient and her dignity as a person. The patient was ill, and she came to Dr. Prada. He was a doctor, she was seeking treatment, and look what she got. She became the victim of a sex offense. Will she ever go to the doctor again? Who could blame her if she doesn’t? Mr. Perry stated that Dr. Prada didn’t use a gun or a knife. He didn’t make any threats of brute physical force. That’s the whole point. Dr. Prada didn’t have to do those things – he was the doctor, she was the patient. She trusted him and was very vulnerable. She never saw it coming until it was over, and look how she reacted.

Mr. Perry continued that, at the hearing, Dr. Prada was given every opportunity to explain how he thought that fondling a patient’s breasts and buttocks and telling her how beautiful she was would make her feel better. He couldn’t do it then and he can’t do it now, but he wants the Board to believe that he had good intentions. Mr. Perry stated that there are a lot of Latin phrases in the law, and he generally tries to avoid them, but there is one that seems especially appropriate in this case: *res ipsa loquitur*, and it literally means “the act speaks for itself.” Dr. Prada’s actions do not speak of trying to make a person feel better about themselves. They speak of him trying to satisfy his own sexual desire.

Mr. Perry stated that he’s not trying to say that this is a revocation case, but he does believe that the

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suspension should be significantly longer. Dr. Prada is still unable to tell the Board why he did what he did. That places any future patients at risk. Mr. Perry stated that he does believe that it would be helpful if Dr. Prada did a forensic sex offender evaluation and a risk assessment by someone who is a professional in this business to tell the Board if there is any risk to the public due to his background and behavior, and he should be required to follow up on any recommendations from that assessment and evaluation.

MR. BROWNING MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF GERMAN V. PRADA, M.D. DR. STEINBERGH SECONDED THE MOTION.

Ms. Sloan stated that she would now entertain discussion in the above matter.

Dr. Egner stated that Dr. Prada is a psychiatrist who admits to touching his patient's breasts and buttocks on the outside of her clothing. This was done in the process of treating her for her depression and low self esteem. Dr. Egner stated that, as Mr. Perry indicated, the Board might question how this represents treatment.

Dr. Egner stated that she believes that all of the issues that need to be addressed have been addressed. She stated that she has a few changes to the Proposed Order that she would like the Board to consider. She noted that Dr. Prada was found guilty of sexual imposition, referring to the sexual contact. Sexual intent is an element of his conviction; therefore, just as in the last case, the Board must consider and weigh this against Dr. Prada's testimony in explaining why he did it. Dr. Egner stated that there are certainly ethical issues that need to be addressed. Dr. Prada was stepping over personal boundaries. Anyone who did this act would be stepping over boundaries. This wasn't just the case of a physician doing it. Anyone doing these kinds of acts would be found inappropriate and unethical. Dr. Egner stated that this needs to be addressed by a course in ethics.

Dr. Egner stated that she believes that Dr. Prada would also benefit from the same type of educational program that the Board discussed in the last case. This is a course on communication and on the physician/patient relationship.

Dr. Egner stated that it is very evident when you read the testimony from the hearing, and it's confirmed from Dr. Prada's appearance today, that this has affected Dr. Prada quite a bit. Dr. Egner stated that she is concerned about how this whole episode has affected him in terms of his going back into practice. Dr. Egner stated that she would like Dr. Prada to be evaluated by two other psychiatrists. This is not a minimal standards type of evaluation, but an evaluation to confirm that Dr. Prada has not been so affected by this process that he can't resume practice. Because of that, the proposed suspension time in her proposal is a minimum of 90 days. There will have to be some room in there so that he has time to do the required courses.

DR. EGNER MOVED THAT THE PROPOSED ORDER IN THE MATTER OF GERMAN V. PRADA, M.D., BE AMENDED AS FOLLOWS:

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1. BY SUBSTITUTING THE FOLLOWING FOR PARAGRAPH A:
 - A. **SUSPENSION OF CERTIFICATE:** The certificate of German V. Prada, M.D., to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than ninety days.

2. BY ADDING THE FOLLOWING AS PARAGRAPH B AND REDESIGNATING EXISTING PARAGRAPH B AS PARAGRAPH C:
 - B. **CONDITIONS FOR REINSTATEMENT/RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. Prada's certificate to practice medicine and surgery until all of the following conditions have been met:
 1. **Application for Reinstatement or Restoration:** Dr. Prada shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
 2. **Psychiatric Reports Evidencing Fitness to Practice; Recommended Limitations:** At the time Dr. Prada submits his application for reinstatement or restoration, Dr. Prada shall provide the Board with written reports of evaluation by two psychiatrists acceptable to the Board indicating that Dr. Prada's ability to practice has been assessed and that he has been found capable of practicing in accordance with acceptable and prevailing standards of care. Such evaluations shall have been performed within sixty days prior to Dr. Prada's application for reinstatement or restoration. The reports of evaluation shall describe with particularity the bases for the determination that Dr. Prada has been found capable of practicing according to acceptable and prevailing standards of care and shall include any recommended limitations upon his practice.
 3. **Additional Evidence of Fitness to Resume Practice:** In the event that Dr. Prada has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222 of the Revised Code to required additional evidence of his fitness to resume practice.

3. BY ADDING THE FOLLOWING AS SUBPARAGRAPH C.4. AND ADJUSTING ALL SUBSEQUENT PARAGRAPH NUMBERS ACCORDINGLY:
 4. **Education Program:** Within one year of the effective date of this Order, or as otherwise approved by the Board, Dr. Prada shall provide acceptable documentation of satisfactory completion of an education program, to be approved in advance by the Board or its designee. The education program shall be related to professional behavior and effective physician-patient communication. The exact number of hours and the specific content of the program shall be determined by the Board or its designee. This program shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical

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Education acquisition period(s) in which the program is completed.

Dr. Buchan asked whether the proposed education is in addition to the ethics course required by the Proposed Order or in lieu of it.

Dr. Egner stated that it is in addition. She stated that she believes the facts of this case are substantially different from the previous case, and that it involves ethical issues as well as his communication and relationship that he has with his patients.

Dr. Bhati asked Mr. Dilling whether the Board is within its rights for a psychiatric evaluation for this physician.

Mr. Dilling stated that he thinks that it is.

Mr. Dilling at this time asked that someone second Dr. Egner's motion to amend.

DR. STEINBERGH SECONDED THE MOTION.

Dr. Robbins stated that he believes the proposed amendment is well thought out and was pretty much what he was considering.

Dr. Bhati also spoke in support of the proposed amendment, commenting that Dr. Egner did an excellent job.

Dr. Steinbergh stated that it's important to note that, because Dr. Prada is a psychiatrist, the Board cannot ask him to have a third party present during his examination patients.

Dr. Egner agreed, stating that in terms of the specialty, there is a distinction when the Board sees these kinds of issues with psychiatrists as opposed to other medical specialties where the Board can put an observer in the room to make sure that these things don't happen. In terms of psychiatry, it's a big issue. The Board lacks a big arm of monitoring.

Dr. Steinbergh stated that she agrees with the proposed amendment to the Proposed Order. Having appropriate evaluation prior to his resumption of practice will allow the Board to feel confident that, because of this issue and the emotional response that the Board has seen from this physician, the physician will be able to provide appropriate psychiatric care.

Dr. Buchan stated that he is troubled by this because, if the Board looks at the analogy of what a general surgeon might do to put himself before us, this fellow stepped way outside what he does as a professional. He's a psychiatrist. Patients come to Dr. Prada with problems and part of his tools and healing effort is communication skills. Dr. Buchan expressed worry over Dr. Prada's being so far outside the box. He added that the educational requirement softens his thoughts a little bit, as does the psychiatric evaluation evaluating Dr. Prada's fitness to practice. Dr. Buchan stated that he still has concerns about Dr. Prada's

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genuine tools and skills in dealing with people. If the general surgeon used a saw when he should have used a scalpel, he would worry about that physician's fitness to practice. In this case, Dr. Prada went outside a reasonable boundary in his world of psychiatric care. Dr. Buchan stated that he does believe Dr. Egner's amendment puts safeguards in place.

Dr. Egner agreed with Dr. Buchan. She added that she wished this was a minimal standards case, and that she really wished that she had been able to see this patient's record; but it's not a minimal standards case, so the Board has to deal with what it has. Dr. Prada has a guilty conviction on his record.

Mr. Browning asked what the difference is between attempted sexual imposition and sexual imposition.

Mr. Dilling stated that he can't answer that question without looking at the actual statute.

Mr. Browning stated that his assumption is that sexual imposition is a more significant offense than attempted sexual imposition. The last case was attempted. This case is sexual imposition. The last case he was in conceptual agreement with what happened, but thought that the Board can't retry cases and the guy was convicted and the Board needed to treat it accordingly, and he felt 90 days was too short a period of time. In this case, given the difference between the two cases, he believes that even more so. While he doesn't think that time in and of itself is significant, he thinks it sends the wrong message when a patient gets involved in sexual imposition on the part of the physician and the Board responds by taking the physician out for 90 days. It doesn't seem like it squares. Mr. Browning stated that he would oppose a 90-day suspension, and suggested a minimum 6-month suspension.

Dr. Buchan stated that this is different in that the proposed 90-days is a minimal suspension. He stated that he takes some comfort in knowing that this amended order is harsher, and he is okay with it as it stands. Dr. Prada won't be able to practice until he completes the reinstatement requirements.

Dr. Bhati stated that it's important to take Mr. Browning's concerns into consideration. He added that he would be willing to support a six-month suspension.

Dr. Steinbergh suggested an indefinite suspension period of at least six months.

Dr. Bhati asked whether Dr. Egner would agree to this.

Dr. Egner stated that she doesn't have strong feelings about this. Practically speaking, it could take Dr. Prada six months to do all of the things that he has to do.

DR. EGNER AND DR. STEINBERGH AGREED TO AMEND THEIR MOTION TO IMPOSE A MINIMUM SIX-MONTH SUSPENSION.

Dr. Buchan spoke against a six-month suspension. He stated that he thinks that the point is made and Dr. Prada's fitness to practice will be determined based upon the original amendment.

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Mr. Dilling asked Dr. Egner and Dr. Steinbergh whether they would agree to use the terminology of “180 days” rather than six months, in keeping with model language currently being used by the Board.

DR. EGNER AND DR. STEINBERGH AGREED TO AMEND THEIR MOTION TO IMPOSE A MINIMUM 180-DAY SUSPENSION.

A vote was taken on Dr. Egner’s motion to amend:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- nay
	Dr. Kumar	- nay
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. MURPHY’S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF GERMAN V. PRADA, M.D. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- nay
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

FRANCISCO I. REGUEYRA, M.D.

Ms. Sloan directed the Board’s attention to the matter of Francisco I. Regueyra, M.D. She advised that

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objections were filed to Hearing Examiner Murphy's Report and Recommendation and were previously distributed to Board members. She noted that Dr. Garg did not serve as Secretary on this case and may participate in discussion and voting.

Ms. Sloan continued that a request to address the Board has been timely filed on behalf of Dr. Regueyra. Five minutes would be allowed for that address.

Dr. Regueyra was accompanied by his attorney, Thomas D. Pigott.

Mr. Pigott stated that on October 8, 2003, the Board approved Dr. Regueyra's request for restoration of his license, contingent upon his taking and passing the SPEX. Mr. Pigott stated that he filed a request for hearing on this matter, and he would like to explain why.

Mr. Pigott stated that, at first glance, that looks like a very reasonable recommendation by the Board, but Dr. Regueyra is trying to get his license back for financial reasons that were not of his making. A fraud was committed on Dr. Regueyra and now he has to go back to work to pay for his home and everything else. The difficulty with the SPEX examination is that it is an all-encompassing exam. Dr. Regueyra was a general surgeon and vascular surgeon for his career. To pass a test that tests his knowledge of psychiatry and other practices, without adequate study time, would not have been the proper thing for him.

Mr. Pigott continued that, after the hearing, Ms. Murphy provided the Board with a Proposed Order, granting a limited and restricted license with five limitations attached. The Board, of course, has the authority under State law to make that recommendation and approve that. Mr. Pigott stated that he would like to state that the doctor has agreed to those limitations, as has his perspective employer, which was a great extent of the hearing examination. The reason they filed written objections was to get a proposed addition to Ms. Murphy's Proposed Order before the Board. That addition would state that the doctor would be allowed, at some point, upon his successful passing of the SPEX – because he fully intends to take the time to study for that exam and pass it – to have the limitations and restrictions in the Proposed Order lifted. He noted that the result would be no different than the Board's original proposed order.

Mr. Pigott thanked Ms. Murphy for the time that she invested in the hearing. He does think that they have received a very favorable recommendation from Ms. Murphy. The reason they received that recommendation was not on his ability as counsel to Dr. Regueyra, but only upon Dr. Regueyra. Mr. Pigott commented that the one thing he has come to know about Dr. Regueyra is that surgery is Dr. Regueyra's lifelong passion and love. With that said, it hurt Dr. Regueyra to retire from the practice of surgery. Mr. Pigott stated that, getting to know Dr. Regueyra, he has found that he is wise enough and caring enough to know that that's no longer a possibility for him, due to his age. The one thing Dr. Regueyra kept referring to prior to the hearing and at the hearing, which he thought was very important and showed the type of doctor he is, was that his overriding concern was for his patients. Dr. Regueyra told him that early in his career he took an oath to "do no harm." Mr. Pigott stated that, throughout his counsel to Dr. Regueyra, that was the one theme that Dr. Regueyra kept portraying to him. Dr. Regueyra's thought was that the Board doesn't want him to have a license because it fears he will go back to the practice of surgery, and he can't. Dr. Regueyra has indicated that he won't return to surgery, he wouldn't

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do that to another human. Mr. Pigott stated that that's very important for the Board to know.

Mr. Pigott asked that the Board approve Ms. Murphy's recommendation, along with the attachment filed with the objections.

Dr. Regueyra thanked the Board for allowing him to appear before it. He added that he wants to give special thanks to Ms. Peri Klinger, a person who has helped him to no end. He stated that he doesn't know her except from talking on the phone, but she has been great, and he wishes some day he could meet her face to face.

Dr. Regueyra stated that he cannot practice surgery any more for one reason and one reason alone: he has arthritis and cannot move his hands like he used to. He has to take medications for that. He cannot go as fast as he used to anymore. If he does that, he would hurt a patient, and he would never in his life hurt a patient. One thing he does have is his brain, and he can teach. Dr. Regueyra stated that he taught for years at the Medical College of Ohio at St. Vincent, and that he can do. He can pass what he knows to the boys and girls that he taught for so many years. He wants to teach again. Unfortunately, "they" took all of his money away, and he has to go back to work, and he will be 70 in three months. He has to go back to work. He's currently living on the money he got from properties he sold. He sold his Florida condo, where he was very happy. He could fish every day of his life, and that's what he wanted to do, and play golf. But that cannot be done, so he wants to teach. That's all he wants to do, nothing else.

Dr. Regueyra stated that one thing he wants to make very clear. He understands that the law that says that you must pass an examination if you've been out of the practice of medicine for two years. He stated that his license expired in April 2000, but he never left medicine. He continued to teach under the direction of Dr. Gerald Stark, his boss. He became an assistant director on the surgical rotation. He taught students, he taught surgical residents how to operate in the classroom. He ran medical conferences and took care of all of the medical students and residents until July 1, 2001. Dr. Regueyra stated that he thought that he would never practice medicine again; he was very happy, going to Florida. Unfortunately, they called him and he had to come back and he learned that he only had \$1,900 left in the bank. Dr. Regueyra said that some of the Board members know what happened to the company that held his pension plan. Many doctors lost their pensions. That's why he wants to go back to teaching. He wants to teach so he can maintain his family and his wife.

Ms. Sloan asked whether the Assistant Attorney General wished to respond.

Ms. Albers stated that pursuant to 4731.222, the Board is authorized to ensure that the public is protected by imposing certain requirements on a physician when he or she returns to practice after two years out-of-practice. Ms. Albers stated that the Report and Recommendation sets out very well what Dr. Regueyra will be doing in his practice, and she supports the Report and Recommendation, as long as he is limited to this practice until such time as he passes the SPEX. That way the public will be protected.

DR. BHATI MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF FRANCISCO I. REGUEYRA,

M.D. DR. STEINBERGH SECONDED THE MOTION.

Ms. Sloan stated that she would now entertain discussion in the above matter.

Dr. Steinbergh stated that she has a couple of questions about the Proposed Order. She stated that she understands why Dr. Regueyra wants to have a license, and she's not opposed to that. She noted that it is appropriate that Dr. Regueyra be restricted from performing surgery. The Proposed Order also requires him to be supervised by a licensed physician at all times during which actual patients are being treated. Dr. Steinbergh stated that she assumes, then, that Dr. Regueyra is not doing the treating, but that during the teaching of the residents and so forth, he'll be teaching physical examination. She asked whether that is correct.

Dr. Regueyra stated that it is.

Dr. Steinbergh asked for assurance that Dr. Regueyra would not be making any medical decisions.

Dr. Regueyra stated that he would not. The physician supervising him would be making the medical decisions.

Dr. Steinbergh stated that she's not sure how a credentialing body is going to approve him for staff privileges with a restricted license and with a restricted D.E.A. She asked whether he will be getting staff privileges at the hospital.

Dr. Regueyra stated that he will not. He will be only on the teaching staff.

Dr. Steinbergh stated that Dr. Regueyra has requested that the Board remove any restrictions from his license at such time as he passes the SPEX. She stated that the Board generally requires the SPEX to be taken and passed within six months of the Order. She asked whether the Board can go outside that policy.

Mr. Dilling stated that there is nothing that would restrict the Board from doing so.

Dr. Steinbergh stated that she would always restrict Dr. Regueyra from performing surgery.

Dr. Regueyra agreed.

Dr. Steinbergh asked whether his request is, if Dr. Regueyra does pass the SPEX, the Board shall then remove from his certificate all restrictions and limitations as to the extent, scope, and type of practice herein prescribed. She stated that she would disagree with that. She would always want his license to be restricted from practicing surgery. Dr. Steinbergh added that she does believe that Dr. Regueyra is ethically bound to not return to surgery.

Dr. Regueyra stated that he believes very strongly in ethics.

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Dr. Steinbergh stated that, once the Board issues a license, it has less control over what a physician does. Her concept of permanently restricting him from practicing surgery is her only comment on that.

Dr. Regueyra stated that he still hopes that, with God's help, the individuals that took his money will go to jail, that he'll get some of his money back, and that someday he can retire again.

Dr. Bhati stated that this gentleman has been chairman of the department and chief of surgery; he knows his limitations. He has done a fantastic job so far, and the Board has not had any complaints about this gentleman. Now he wants to get back to teaching. Dr. Bhati stated that, obviously, Dr. Regueyra is a passionate, caring, loving surgical man who wants to do something. Dr. Bhati stated that the Proposed Order is an excellent way of accomplishing this. As far as the question of having somebody passing the SPEX, he would be entitled to use that as a full license, and the Board would have no way to restrict him. However, when he first came to the Board, he asked if he could go out and do neurosurgery. He was told he could do that, but he would be compared with neurosurgeons' skills. If Dr. Regueyra does any surgery, he would be held to the same standard regular general surgeons are. Dr. Bhati stated that, because of that, he doesn't have any problem with what Dr. Regueyra is requesting.

DR. BHATI MOVED TO AMEND THE PROPOSED ORDER TO INCLUDE THE FOLLOWING LANGUAGE:

If at anytime after the effective date of this Order, Dr. Regueyra takes and successfully passes the Special Purpose Examination (SPEX), and provides proper documentation of passage thereof to the Board or its designee, the above restrictions shall be lifted from Dr. Regueyra's certificate to practice medicine and surgery in Ohio.

DR. BUCHAN BHATI SECONDED THE MOTION.

Dr. Egner commented that she was one of Dr. Regueyra's medical students at the Medical College of Ohio at Toledo. She stated that one thing she did remember about Dr. Regueyra was that he demanded that you follow rules explicitly, and he will therefore understand why the Board is going to follow its rules. The Board has to go from the time Dr. Regueyra gave up his license, even if he did continue to teach, and so he has been without a license for more than two years.

Dr. Egner spoke against Dr. Steinbergh's suggestion that Dr. Regueyra be forever restricted from practicing surgery. She noted that Dr. Regueyra just testified before the Board that he would never practice surgery, and she's pretty sure that there's not a hospital that will allow him to practice surgery.

Dr. Bhati suggested that it would also be acceptable for Dr. Regueyra to pass his specialty board examinations.

Dr. Davidson stated that he would need an unrestricted license to take that.

Dr. Kumar stated that he absolutely agrees with the comments made. The understanding is, however, that

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Dr. Regueyra will work in accordance with the position description designed for him by the Mercy Health Partners. Dr. Kumar expressed concern that the position description might be changed, and the way the Proposed Order is written, the Board would be accepting it. He suggested amending the language in Paragraph 1 of the Proposed Order to indicate that Dr. Regueyra can only work under the position description on file with the Board on this date.

DR. BHATI AGREED TO ACCEPT DR. KUMAR'S SUGGESTION AS PART OF HIS PROPOSED AMENDMENT. DR. BUCHAN, AS SECOND, AGREED. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER, AS AMENDED, IN THE MATTER OF FRANCISCO I. REGUEYRA, M.D. DR. GARG SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

Mr. Dilling at this time noted that Dr. Regueyra expressed a wish to meet Ms. Klinger of the Board's staff. He advised Dr. Regueyra that Ms. Klinger is present in the room, and directed him to where she was

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sitting.

JOHN MICHAEL SCHECHTER, M.D.

Ms. Sloan directed the Board's attention to the matter of John Michael Schechter, M.D. She advised that objections were filed to Hearing Examiner Murphy's Report and Recommendation and were previously distributed to Board members.

Ms. Sloan continued that a request to address the Board has been timely filed on behalf of Dr. Schechter. Five minutes would be allowed for that address.

Dr. Schechter was accompanied by his attorney, Eric J. Plinke.

Mr. Plinke stated that he has filed objections in this case, and he knows that the Board members have read them. He stated that he will turn the remainder of his time over to Dr. Schechter.

Dr. Schechter stated that he is before the Board because of mistakes he made that represented his clear incompetence as a physician. It was an incompetence that set forth a spiral of events for which he is profoundly ashamed and sorry. His incompetence contributed to substantial pain for his family and to the patient whose trust he violated, and this incompetence nearly led to his own demise.

Dr. Schechter stated that, over the past weeks, in anticipation of what the Board's decision might be, he's had to say goodbye to a great many people, including people to whom he was a mentor, role model and trusted physician, thereby widening this circle of pain that he's caused. He added that, although his incompetence was limited to one single patient, and he knows the thousands of others he's treated appropriately and compassionately can in no way cancel out the substantial hurt that he's caused, he does come before the Board asking for another chance to practice medicine.

Dr. Schechter stated that in the years that have passed since his acknowledgment of this incident, he has learned a great many things that have, ironically, made him a better doctor. One of the most profound elements of these difficult lessons was the strength and determination that his wife's forgiveness has given him. She saw goodness in him that he had long since buried. She has stood by him every step of the way, through the civil proceedings, the newspaper articles, through the Board hearing and through the prospect of unemployment and financial ruin. She has helped him turn his life around, back to the path of what is right.

Dr. Schechter advised that, beginning with his admission to Dr. McGraw, he has done everything to right the significant wrongs he has committed. These steps included beginning work with Dr. Levine, closing his private practice and changing his clinical focus, cooperating with Mr. Thompson in issuing a statement to the Board, and discussing his situation frankly with his supervisors and departmental chairman. Dr. Schechter stated that it feels good to be on the right road. He added that the Board may decide that he no longer has a place in medicine, but he has become comfortable again with his place in life.

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Dr. Schechter stated that he believes that he has a place in medicine. He stated that he spoke frankly with his superiors early on, and they chose to support him, allow him to teach, treat patients and chair committees. These people were convinced that he was no danger. Since his acknowledgment, he has shown himself to be a competent, safe and compassionate teacher and physician. These qualities have been recognized by others, as he was recently recognized by the medical school as an outstanding member of the clinical faculty, and also shared a service award with two other doctors for his inpatient work from his county mental health society.

Dr. Schechter stated that, as a result of his experiences, and as he testified at his hearing, he is determined to go out into the professional community and assist with the program of primary prevention. Many learn about boundary violations and dangers too late, and this is borne out by the incidence data. He had his first experience with teaching about this, albeit informally, a week ago Friday, when he met with the psychiatric residents. They were very concerned and interested in understanding his difficulties, and their exchanges cemented his belief that physicians today are not prepared to deal with some of these intimately difficult and personal predicaments.

Dr. Schechter stated that in the past years he has taken significant steps toward rehabilitation, and demonstrated, he believes, that he is a salvageable physician. During this time he has treated hundreds of patients with excellent results. He added that throughout this time he has carried himself in a way of which the Board could be proud. He has the confidence of Dr. Stephen Levine, an expert in the field, who endorsed him without question. Dr. Schechter stated that he has the support of colleagues and supervisors, who continue to have faith in his abilities and confidence in his safety as a physician.

Dr. Schechter asked that the Board consider all of the factors and allow him some day to request reinstatement from the Board. He stated that he can assure the Board that in the long run he would prove that the Board had made the correct decision.

Ms. Sloan asked whether the Assistant Attorney General wished to respond.

Mr. Wilcox stated that both he and Mr. Perry would address the Board on this case.

Mr. Wilcox stated that Dr. Schechter has attempted in his objections to compare his case to other cases this Board has considered for boundary violations or sexual relations with patients; however, as the Board is well aware, each case is examined individually, and there is no standard discipline in these types of cases. Mr. Wilcox stated that he thinks that permanent revocation is absolutely necessary in this case. Dr. Schechter physically and mentally abused this patient. This was a very vulnerable patient with a horrible past that included years of sexual abuse by her father. Dr. Schechter used this patient as his personal sex toy. He admittedly allowed her to perform exhibitionist sexual acts for him on at least 36 different occasions. Mr. Wilcox stated that Dr. Schechter encouraged this behavior by telling the patient that she could do whatever she wanted, as long as she remained in the chair. Dr. Schechter could have easily ended this behavior by simply telling the patient that such behavior was unacceptable, and that, if she continued it, he would no longer treat her. Dr. Schechter didn't do that, and that's the crux of the issue. He didn't want her to stop. Dr. Schechter knowingly abused this patient for months.

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Mr. Wilcox stated that Dr. Schechter has attempted to marginalize his conduct in that it was only two episodes of sexual conduct with the patient and, therefore, harm was minimal. Dr. Schechter allowed this patient to masturbate in his presence on at least 36 occasions. He then had sex with this patient, knowing that it would cost him his career and his license to practice. He then emotionally abused her, attempting for months to cover up his acts, only deepening the damage he did to this patient. Additionally, in an argument outside of his office, Dr. Schechter physically slapped this patient.

Mr. Wilcox stated that Dr. Schechter should never be allowed to put any other patient in such danger. Mr. Wilcox concluded that he thinks that permanent revocation is the only appropriate penalty in this matter.

Mr. Perry stated that he would have to agree with everything that Mr. Wilcox said. He added that the Report and Recommendation itself is very thorough, very well written, and lays out all of the facts very clearly for the Board. He added that there are a couple of issues that he would like to address and that he would like the Board to keep in mind.

Mr. Perry stated that the first is Dr. Schechter's claim that he was technically incompetent to deal with the issues that a person like Patient 1 presented. Mr. Perry stated that that is totally irrelevant in this case. This case isn't here because Dr. Schechter didn't have the ability to make this person get better. It's here because, whatever his ability level, he should have stopped this atrocity from ever happening.

Mr. Perry stated that Dr. Schechter claims that he has learned a lesson from his experience in this case. This was not a gray area. There was no judgment call here. The rule against having sex with a patient is as black and white as black and white can be. In fact, in the medical profession, it's not only prohibited, it's condemned. The risk of patient harm is unmistakable, and that's not something that Dr. Schechter needed to learn. He already knew that. It shouldn't have taken any special ability or expertise on his part just to say, "no, we're not going there."

Mr. Perry stated that revocation in this case is the Board's only option. Mr. Perry remarked that Dr. Schechter is saying now that revocation is too harsh, but that isn't what he was saying when this happened. After the first incident, when he touched Patient 1's underwear, he said, literally, "I could lose my license for this," and then he had sex with her. He knew what would happen if anybody ever found out, and that's proven by all of the efforts he made to conceal this. He asked her to promise never to tell. He locked the door to his office. Afterwards, he continued to treat her, even though he had totally lost control of the treatment environment. He didn't ask for help from a colleague when he knew that that's what he needed. He sought treatment for depression for himself, but didn't tell his own doctor why he was so depressed.

Mr. Perry stated that Dr. Schechter's medical records didn't accurately reflect what actually went on in treatment. Mr. Perry directed the Board to the extortionate threats that Dr. Schechter made to his own patient, saying that if she told anybody, he would kill himself or he'd expose the compromising photos that he had of her. Dr. Schechter told the patient that if she told her psychologist, he would deny it. He would say that she was delusional and the psychologist would believe him. In fact, that's what he did do. Dr. Schechter lied to a colleague, his own patient's primary treatment provider. Mr. Perry stated that Dr.

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Schechter did all these things to cover himself because he didn't want the Board to find out. He knew what would happen if the Board found out.

Mr. Perry stated that when he says that revocation is the only answer here, that's not his decision, and that wasn't Sharon Murphy's decision. Mr. Perry added that it's not even the Board's decision. It was Dr. Schechter's decision. Dr. Schechter knew that that is what would happen if the Board found out, but he was willing to take that risk, and the Board needs to revoke his license.

DR. BHATI MOVED TO APPROVE AND CONFIRM MS. MURPHY'S PROPOSED FINDINGS OF FACT, CONCLUSIONS, AND ORDER IN THE MATTER OF JOHN MICHAEL SCHECHTER, M.D. DR. STEINBERGH SECONDED THE MOTION.

Ms. Sloan stated that she would now entertain discussion in the above matter.

Dr. Steinbergh stated that this case was probably the most difficult, most egregious she has had to read in the 11 years she's been on the Board. The Board has read the record and had time to give thought to it, and listening to what has been said today, she has to say that she's pleased to know that Dr. Schechter has handled his personal life to his satisfaction. She added, however, that Dr. Schechter needs to know that the Board's mission is one of public protection, and there are certain acts so egregious by physicians, so severe, that this Board cannot accept those acts. It's absolutely intolerable. There was so much harm to this patient, and there were so many chances not to harm this patient, and he continued with it.

Dr. Steinbergh stated that Mr. Wilcox' reply today absolutely reflects her thoughts in this case. There is no question in her mind that this license has to be permanently revoked.

Dr. Robbins agreed with Dr. Steinbergh and stated that the Assistant Attorneys General put it very well. These instances of 'whatever happens in the chair, as long as she stays in the chair,' are just atrocious, and in his mind this wasn't psychotherapy. This was a peeping Tom. There's no place in medicine for something like this, and permanent revocation is the only penalty.

Dr. Bhati stated that the whole thing described in the Report and Recommendation and by the two Assistant Attorneys General speaks on its own. Imagine 36 counts of masturbation sitting in the office, going for months having sex. What else can go wrong here? Dr. Bhati stated that it has to be permanent revocation in plain, simple form, and nothing else.

Dr. Egner also spoke in agreement. She stated that there aren't many times before this Board where there is a single patient involved and the Board has revoked a license. The thing considered when that happens is that the action itself is so egregious that it doesn't matter that it is just one patient. This was definitely one patient over many, many times in many years, so, in a sense, although it's a single patient, it's not necessarily a single act.

Dr. Egner continued that the Board has to take into consideration Dr. Schechter's specialty, psychiatry. She stated that she likens it, many times, to impairment cases when anesthesiologists are involved. The

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Board sees them in a little different light than it does the other specialties because they have such easy access to drugs. It makes their situation a little different from some of the other specialties. In the same sense, a sexual abuse case in relation to psychiatry is the worst situation that you can have. The Board doesn't have a way to monitor him when he is alone with patients. There is no such thing as a third party in a room with a psychiatrist. That in itself limits the Board's ability to know that this won't happen again.

Dr. Egner stated that, for herself, the issue of whether or not it would happen again is not an issue because everything that happened was so terrible. Dr. Schechter took advantage of this patient's mental illness. He told her that no one would believe her. He told her that he might kill himself. Dr. Egner stated that the permanent harm that Dr. Schechter did to this patient is unbelievable to her when he had a situation that he easily could have remedied early on. This patient did not come to Dr. Schechter on her own. She was sent as a referral from a psychologist, who was giving her therapy. When she started to show her transference of affection, there's no excuse for Dr. Schechter's not calling that psychologist to let her know what was going on with this patient. Dr. Egner stated that the very start was the very bad decision that he made, and then it just got worse from there.

Dr. Egner stated that there are very few cases where the Board can say that this alone tells the Board that the physician cannot practice medicine. It's unfortunate, and always sad to see these things happen, but in this case, she's sure in her conviction that it is the right thing to do.

Dr. Buchan stated that to Dr. Schechter's credit, he appreciated Dr. Schechter's disclosure. Dr. Buchan stated that the Board is so used to seeing records full of conflicting reports and lies and deceit. Dr. Schechter makes no mistake about what he did. Dr. Buchan stated that he hopes that this is the beginning of a better life for Dr. Schechter, noting that it wasn't working so well before. Dr. Buchan stated that he will vote for revocation in this case, but he hopes that Dr. Schechter continues to stay on track.

Mr. Browning stated that, from a consumer perspective, if the Board didn't revoke this license, he doesn't know a case where it could. This was beyond any standard of decency, and it goes way beyond incompetence, in his judgment, for Dr. Schechter to knowingly pursue that course of action. Mr. Browning stated that the Board is compelled to vote to permanently revoke. He also agrees with Dr. Buchan that this is a tragedy for the doctor and the patient. Hopefully, Dr. Schechter can find a better way going forward, but the Board has to revoke.

Mr. Dilling asked to clarify the record to note that the Proposed Order is for permanent revocation as opposed to revocation.

Board members indicated that they understood that.

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

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

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Dr. Bhati	- aye
Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Garg	- abstain
Dr. Steinbergh	- aye

The motion carried.

Dr. Talmage left the meeting at this time.

PROPOSED FINDINGS AND PROPOSED ORDERS

EMILIO ALDO ESPINOSA, M.D.

Ms. Sloan advised that, by letter of December 10, 2003, the Board notified Dr. Espinosa that it proposed to take disciplinary action against his license to practice medicine and surgery in the state of Ohio based on allegations that Dr. Espinosa had failed to respond to a random audit of his continuing medical education for the 2000 – 2002 CME acquisition period. The notice was mailed to Dr. Espinosa's address of record and proper service was documented. No hearing request has been received from Dr. Espinosa and more than thirty days have elapsed since the mailing of the notice. The matter was reviewed by Hearing Examiner Murphy, who prepared a Proposed Findings and Proposed Order, and is now before the Board for final disposition.

DR. STEINBERGH MOVED TO FIND THAT THERE IS RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE TO SUPPORT THE ALLEGATIONS AS SET FORTH IN THE DECEMBER 10, 2003 NOTICE OF OPPORTUNITY FOR HEARING IN THE MATTER OF EMILIO ALDO ESPINOSA, M.D., AND TO ADOPT THE PROPOSED FINDINGS AND PROPOSED ORDER. DR. BUCHAN SECONDED THE MOTION.

Ms. Sloan stated that she would now entertain discussion in the above matter.

Dr. Steinbergh stated that Dr. Espinosa has not responded appropriately to the CME audit. The Proposed Findings and Proposed Order, a copy of which shall be maintained in the exhibits section of this journal, outline the facts. The summary of evidence and Proposed Findings are appropriate. Dr. Steinbergh at this time reviewed the Proposed Order.

Dr. Kumar asked what purpose is served to both reprimand and suspend a certificate.

Dr. Steinbergh stated that Dr. Espinosa has not responded to the CME audit.

Dr. Kumar stated that the Board could just suspend his license.

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Dr. Steinbergh stated that for years the Board did a variety of things in CME cases. Now its actions are rather standard that the Board reprimand. The suspension has to do with his failure to respond to the CME. Had he responded and not met his CME requirements, he would have been reprimanded and then had further CME audit requirements.

Dr. Kumar suggested that a reprimand is superficial here.

Dr. Egner stated that she thought that the statute changed.

Dr. Bhati stated that the Board used to suspend for one month, even if the physician completed the CME and submitted it late. In this case, the physician didn't respond to the audit notices, and the Board doesn't really know his status. The standard in taking care of these cases is issuing a reprimand, imposing a \$5,000 fine, and imposing conditions for future audit.

Dr. Steinbergh stated that Dr. Kumar's question is whether it is redundant to reprimand and suspend.

Dr. Kumar stated that that is correct.

Dr. Robbins stated that he doesn't think it is redundant. Dr. Espinosa violated CME laws and because of that he's being reprimanded and fined. Now, because he didn't respond to the CME audit, he's being suspended.

Dr. Egner stated that the Board doesn't know that Dr. Espinosa violated CME because he didn't respond to the audit. She stated that it may be redundant, but she doesn't have a problem with it. She added that, since a reprimand doesn't harm Dr. Espinosa further than the suspension would, she doesn't see a problem with it.

Dr. Kumar stated that to him it appears to be redundant, but he's okay with it.

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

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

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The motion carried.

CONWAY THOREAU MCLEAN, D.P.M.

Ms. Sloan advised that, by letter of May 14, 2003, the Board notified Dr. McLean that it proposed to deny his application for a certificate to practice podiatric medicine and surgery in Ohio, for the reasons contained in the letter, a copy of which shall be maintained in the exhibits section of this Journal. The notice was mailed to Dr. McLean's address of record, as well as to other addresses contained in the record. No service was obtained. Subsequently, the notice of opportunity for hearing was published in the *Chicago Tribune* on August 16, August 23, and August 30, 2003. On October 1, 2003, a copy of the proof of publication was sent to Dr. McLean's last address of record. No hearing request has been received from Dr. McLean and more than thirty days have elapsed since the third publication of the notice. The matter was reviewed by Hearing Examiner Murphy, who prepared a Proposed Findings and Proposed Order, and is now before the Board for final disposition.

DR. ROBBINS MOVED TO FIND THAT THERE IS RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE TO SUPPORT THE ALLEGATIONS AS SET FORTH IN THE MAY 14, 2003 NOTICE OF OPPORTUNITY FOR HEARING IN THE MATTER OF DR. MCLEAN, AND TO ADOPT THE PROPOSED FINDINGS AND PROPOSED ORDER. DR. BUCHAN SECONDED THE MOTION.

Dr. Buchan stated that Dr. McLean has prior actions in Iowa, Wisconsin and Illinois, and he proceeded to lie or misrepresent himself on Ohio's application. Clearly, Dr. McLean has no business in the state of Ohio, and Dr. Buchan agrees with the Proposed Order of denial.

Dr. Steinbergh noted that the Proposed Finding and Proposed Order indicates that the notice of opportunity for hearing was mailed in May 2002. She questioned whether it was really May 2003.

Dr. Bhati stated that it should be 2003.

Mr. Dilling stated that the letter was mailed in May 2003.

A vote was taken on Dr. Robbins' motion:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain

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Dr. Steinbergh - aye

The motion carried.

FINDINGS, ORDERS AND JOURNAL ENTRIES

JUDY E. GRISHABER, D.O.

Ms. Sloan advised that, by letter of January 7, 2004, the Board notified Dr. Grishaber that it proposed to approve her application for restoration of her certificate to practice osteopathic medicine and surgery provided that she take and pass the SPEX or the pediatric recertification examination. The notice was mailed to Dr. Grishaber's address of record and proper service was documented. No hearing request has been received from Dr. Grishaber and more than 30 days have elapsed since the mailing of that notice. This matter is now before the Board for final disposition.

DR. STEINBERGH MOVED TO FIND THAT THERE IS RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE TO SUPPORT THE ALLEGATIONS AS SET FORTH IN THE JANUARY 7, 2004 NOTICE OF OPPORTUNITY FOR HEARING IN THE MATTER OF DR. GRISHABER AND TO ENTER AN ORDER APPROVING DR. GRISHABER'S REQUEST FOR RESTORATION OF HER CERTIFICATE TO PRACTICE OSTEOPATHIC MEDICINE AND SURGERY, SUBJECT TO HER PASSING THE SPEX OR THE PEDIATRIC RECERTIFICATION EXAMINATION. DR. ROBBINS SECONDED THE MOTION.

Ms. Sloan stated that she would now entertain discussion in the above matter.

Dr. Steinbergh asked whether the Board shouldn't require Dr. Grishaber to pass the recertification exam of the American Board of Pathology, rather than in pediatrics. Dr. Steinbergh stated that the documentation indicates that Dr. Grishaber no longer practices pediatrics. Her last board certification was by the American Board of Pathology in blood banking and transfusion medicine in 1991. Dr. Grishaber lists that as her specialty, and is, in fact, going to be working in the blood banking area of medicine.

Dr. Bhati stated that the Board of Pathology does not have a recertification exam.

Ms. Rieve advised that Dr. Grishaber has already taken and passed the SPEX.

Dr. Steinbergh stated that that takes care of that issue.

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

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye

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Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye

The motion carried.

Dr. Talmage returned to the meeting at this time.

SHAGUFTA A. KHAN, M.D.

Ms. Sloan advised that, by letter of December 29, 2003, the Board notified Dr. Khan that it proposed to approve her application for a certificate to practice medicine and surgery, provided that she take and pass the SPEX or specialty board recertification examination. The notice was mailed to Dr. Khan's address of record and proper service was documented. No hearing request has been received from Dr. Khan and more than 30 days have elapsed since the mailing of that notice. This matter is now before the Board for final disposition.

DR. KUMAR MOVED TO FIND THAT THERE IS RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE TO SUPPORT THE ALLEGATIONS AS SET FORTH IN DECEMBER 29, 2003 NOTICE OF OPPORTUNITY FOR HEARING IN THE MATTER OF DR. KHAN, AND TO ENTER AN ORDER APPROVING DR. KHAN'S REQUEST FOR A CERTIFICATE TO PRACTICE MEDICINE AND SURGERY, SUBJECT TO HER PASSING THE SPEX OR HER SPECIALTY BOARD RECERTIFICATION EXAMINATION. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

Dr. Kumar stated that the Board asked Dr. Khan to pass the SPEX or specialty board examination for

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restoration of his license. That is the Board's standard procedure.

Dr. Bhati noted that Dr. Khan has not responded to the Board's notice of opportunity for hearing.

KATHRYN RIEDEL, M.D.

Ms. Sloan advised that, by letter of December 29, 2003, the Board notified Dr. Riedel that it proposed to approve her application for a certificate to practice medicine and surgery, provided that she take and pass the SPEX or a specialty board recertification examination. The notice was sent to Dr. Riedel's address of record, and proper service was documented. No hearing request has been received from Dr. Riedel, and more than 30 days have elapsed since the mailing of that notice. The matter is presented at this time for final disposition.

DR. BHATI MOVED TO FIND THAT THERE IS RELIABLE, PROBATIVE AND SUBSTANTIAL EVIDENCE TO SUPPORT THE ALLEGATIONS AS SET FORTH IN THE DECEMBER 29, 2003 NOTICE OF OPPORTUNITY FOR HEARING IN THE MATTER OF DR. RIEDEL, AND TO ENTER AN ORDER APPROVING DR. RIEDEL'S REQUEST FOR A CERTIFICATE TO PRACTICE MEDICINE AND SURGERY, SUBJECT TO HER PASSING THE SPEX OR THE SPECIALTY BOARD RECERTIFICATION EXAMINATION. MR. BROWNING SECONDED THE MOTION.

Dr. Bhati stated that this is the standard Order. Dr. Riedel hasn't practiced medicine for more than two years, and she didn't respond to the Board's notice of opportunity for hearing.

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

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

CITATIONS, PROPOSED DENIALS AND ORDERS OF SUMMARY SUSPENSION

Ms. Sloan advised that during this first group of notices, Dr. Garg served as Secretary and may not vote.

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ROY MERLE HUTCHINSON, M.D. - LETTER OF PROPOSED DENIAL

At this time the Board read and considered the letter of proposed denial in the above matter, a copy of which shall be maintained in the exhibits section of this Journal.

DR. BHATI MOVED TO SEND THE LETTER OF PROPOSED DENIAL TO DR. HUTCHINSON. DR. KUMAR BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

CHEUNG S. SHIN, M.D. - CITATION LETTER

At this time the Board read and considered the proposed citation letter in the above matter, a copy of which shall be maintained in the exhibits section of this Journal.

DR. BHATI MOVED TO SEND THE CITATION LETTER TO DR. SHIN. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

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The motion carried.

PETER STEVEN STANOS, D.O. - CITATION LETTER

At this time the Board read and considered the proposed citation letter in the above matter, a copy of which shall be maintained in the exhibits section of this Journal.

DR. KUMAR MOVED TO SEND THE CITATION LETTER TO DR. STANOS. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

BRUCE J. MCSURDY, M.D. - CITATION LETTER

At this time the Board read and considered the proposed citation letter in the above matter, a copy of which shall be maintained in the exhibits section of this Journal.

Ms. Sloan advised that Dr. Garg did not serve as Secretary on this case and may vote.

DR. BUCHAN MOVED TO SEND THE CITATION LETTER TO DR. MCSURDY. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye

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Dr. Garg - aye
 Dr. Steinbergh - aye

The motion carried.

ROBERT R. BRIGHTWELL, D.O. ORDER OF SUMMARY SUSPENSION AND NOTICE OF OPPORTUNITY FOR HEARING

At this time the Board read and considered the proposed Order of Summary Suspension and Notice of Opportunity For Hearing in the above matter, a copy of which shall be maintained in the exhibits section of this Journal.

DR. BUCHAN MOVED TO APPROVE THE ORDER OF SUMMARY SUSPENSION AND TO SEND THE NOTICE OF OPPORTUNITY FOR HEARING TO DR. BRIGHTWELL. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- abstain
	Ms. Sloan	- aye

The motion carried.

RATIFICATION OF CONSENT AGREEMENTS

STEPHEN L. DICKSON, JR., M.D.

Dr. Kumar stated that he has a problem with this Consent Agreement. He noted that this case involved wrong-site surgery or procedure by a physician who was a resident. An action was taken in Florida, and Ohio is bootstrapping that action with this Consent Agreement. The Agreement calls for a simple reprimand, and it's not attaching anything else to what the Florida action would be. He suggested placing Dr. Dickson on probation until he has completely satisfied the Florida requirements.

Dr. Steinbergh stated that she believes Dr. Dickson has already satisfied the Florida requirements. The question she had was how long the reporting requirement in this Consent Agreement was supposed to last – a year or forever. Dr. Steinbergh stated that Dr. Dickson was a resident at the time of the surgery that was

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the basis for the Florida action, and to her everything fell in line. He fulfilled the Florida Board Order, having done everything he was required to do. She doesn't see that anything more is needed for this young man.

Dr. Kumar stated that he doesn't see where he has completed his Florida requirements.

Mr. Dilling stated that, if he doesn't fulfill his Florida requirements, there's an active assumption that Florida will do something about that. If Florida does something about that, it will trigger an action in Ohio, based upon that failure. There is a regulatory body to which this Board is deferring to follow up. He stated that what Dr. Kumar is saying is not unreasonable, but he thinks that that is the safeguard that the Board has right now.

Dr. Kumar stated that, with that explanation, he is okay with this.

DR. BHATI MOVED TO RATIFY THE PROPOSED CONSENT AGREEMENT WITH DR. DICKSON. DR. STEINBERGH SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

LYNNE ELLEN ZEGIOB CHECK, M.D.

DR. BHATI MOVED TO RATIFY THE PROPOSED CONSENT AGREEMENT WITH DR. CHECK. MR. BROWNING SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye

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Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Garg	- abstain
Dr. Steinbergh	- aye

The motion carried.

JAMES M. ROSSELIT, JR., D.O.

DR. BHATI MOVED TO RATIFY THE PROPOSED CONSENT AGREEMENT WITH DR. ROSSELIT. DR. ROBBINS SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

The motion carried.

PATRICIA A. SEILER, M.D.

DR. STEINBERGH MOVED TO RATIFY THE PROPOSED CONSENT AGREEMENT WITH DR. SEILER. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- abstain
	Dr. Egner	- aye
	Dr. Talmage	- abstain
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- abstain
	Dr. Steinbergh	- aye

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The motion carried.

ADMINISTRATIVE REPORT

At this time Mr. Dilling introduced Siobhan R. Clovis to the Board, explaining that Ms. Clovis is the Board's new Hearing Examiner.

Mr. Dilling then presented a ten-year service pin to Ms. Gilbert, honoring her years of service to the State of Ohio.

PERSONAL APPEARANCES

RORY J. FRIEDMAN, D.P.M.

Dr. Friedman appeared before the Board pursuant to his request for release from the terms of the Board's Order of October 10, 2001.

In response to Dr. Kumar's questions, Dr. Friedman advised that he is before the Board because in 1990 he had an inappropriate relationship with an employee, whom he happened to treat as well. He advised that he got married a year ago and is doing well now. He is very careful to keep his self discipline and to keep appropriate relationships.

DR. KUMAR MOVED TO RELEASE DR. FRIEDMAN FROM THE TERMS OF THE BOARD'S ORDER OF OCTOBER 10, 2001. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

Dr. Steinbergh left the meeting at this time.

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MITCHELL W. LEVENTHAL, M.D.

Dr. Leventhal appeared before the Board pursuant to his request for release from the terms of his March 14, 2001 Consent Agreement. If approved, release from probation would become effective March 14, 2004.

In response to Dr. Buchan's questions, Dr. Leventhal stated that he is doing well. He's made a commitment, and he realizes that his drinking was leading him down a path that was destructive to his moral and spiritual values. Dr. Leventhal stated that he stopped drinking six years ago, and he stopped smoking four years ago. Dr. Leventhal stated that his belief that his spiritual values were at stake is critical to maintaining his sobriety. If he starts drinking again, he thinks he will sacrifice his spiritual and moral values. It's only a matter of time. That, along with continuing the program of A.A. and continued drug screens, will keep him sober. Dr. Leventhal stated that he intends to continue with his drug screens because the faculty was a little unsettled when it learned that his probation was coming to an end. He talked with Dr. Collins and decided that for another year or so he would continue drug screening. He added that after six years, it's part of his life. He attends two to three meetings a week, one in Costa Rica, and he will continue.

DR. BHATI MOVED TO RELEASE DR. LEVENTHAL, EFFECTIVE MARCH 14, 2004, FROM THE TERMS OF HIS MARCH 14, 2001 CONSENT AGREEMENT. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye

The motion carried.

GUANG LIANG, ACUPUNCTURIST

Mr. Liang appeared before the Board pursuant to his request for release from the terms of his March 14, 2001 Consent Agreement. If approved, release from probation would become effective March 14, 2004. Ms. Sloan explained that Mr. Liang's wife would be acting as translator and answering the questions for Mr. Liang.

In response to Dr. Kumar's questions, Ms. Liang stated that Mr. Liang is doing well now. The practice is

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going well. She stated that they practice traditional Chinese acupuncture, and she described the method of acupuncture they use. They use it for all kinds of illnesses. She stated that Chinese medicine always talks about the Ying/Yang balance.

Dr. Kumar asked whether they provide acupuncture for operative anesthesia.

Ms. Liang stated that they do not.

In response to Dr. Garg's questions, Ms. Liang stated that the Chinese training in acupuncture took five years. In China, acupuncturists are called "Dr.", but not here.

Dr. Egner asked whether most of Mr. Liang's patients are Chinese. Ms. Liang stated that 90% are American.

Dr. Egner commented that Ms. Liang is speaking for Mr. Liang because he can't speak much English.

Mr. Liang stated that he can speak a little bit, but not a lot.

Ms. Liang stated that Mr. Liang does understand. She added that treating the patient is not only talking about how the patient feels. They have to see the patient's face, the tongue and eye, and check the pulse.

Dr. Egner asked whether Mr. Liang feels that he can adequately communicate with the patients, or whether his wife interprets for him during the patient's treatment.

Ms. Liang stated that she always sees the patient first to find out what the situation is, and to tell them what they want to know, and what they should expect when they come in for acupuncture. She doesn't just leave Mr. Liang at the office; she always stays with him.

DR. KUMAR MOVED TO RELEASE MR. LIANG, EFFECTIVE MARCH 14, 2004, FROM THE TERMS OF HIS MARCH 14, 2001 CONSENT AGREEMENT. DR. BUCHAN SECONDED THE MOTION.

Dr. Egner asked whether patients are charged by visit or by complete treatment.

Ms. Liang stated that they usually charge \$70 for the first visit, and \$50 for subsequent visits. Insurance doesn't pay for this and it's hard for the patient to pay a lot. The most common ailment they see is back pain. The number of visits it takes to help a problem often depends upon age. The energy is stronger in young people, and the channel opens easier. It will take longer for weak patients.

In response to Dr. Garg's questions, Ms. Liang stated that if a young person gets back pain from just twisting it or something like that, a couple of treatments will be all right. She stated that the human body is like a car. With a brand new car, repairs are easier. After a car is driven so many years, it takes longer time.

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In response to Dr. Kumar's questions, Ms. Liang stated that 80% of the patients feel a difference after the first couple treatments.

Dr. Garg asked whether it matters what is causing the back pain. He asked whether the patients are checked out before treatment.

Ms. Liang stated that they have to know whether the back pain is caused by diabetes, a general weakness, an age weakness, or was injured. It depends on the situation, but they still take care of it through a certain channel that goes directly to the problem. Doctors refer the patients to them for the back pain.

Dr. Garg asked whether acupuncture will help diabetic pain.

Ms. Liang stated that it will, but this doesn't mean that she can treat the diabetes.

A vote was taken on Dr. Kumar's motion to release:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

MICHAEL S. MIKHAIL, M.D.

Dr. Mikhail made his initial appearance before the Board, pursuant to the terms of the Board's Order of November 12, 2003.

In response to Dr. Kumar's questions, Dr. Mikhail stated that his wife suffers from multiple medical problems, and that is what brought him to the Board in the beginning. She will face several operations. She is currently being managed by several different physicians at the Cleveland Clinic.

Dr. Kumar noted that Dr. Mikhail had advised the Board that he was teaching other physicians about the restrictions on prescribing for family members. He asked whether Dr. Mikhail has continued with that.

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Dr. Mikhail stated that he thinks that he has been talking with a lot of physicians, but his counsel, Mr. John Irwin, had given five sessions of meetings with the medical staff so far. Dr. Mikhail stated that, to be honest with the Board, he has to admit that he was ignorant about the Board's rules and regulations. Physicians who have been practicing for more than 20 years might lose sight of knowing the rules and regulations. He stated that he thinks he has been doing well with his teaching sessions. He added that he's asked some pharmacists to come to educate the staff, as well.

Dr. Kumar noted that Dr. Mikhail had a very short suspension. He asked whether that helped Dr. Mikhail understand the gravity of what he did.

Dr. Mikhail stated that suspension is probably the most painful experience any physician can encounter. He stated that he was the sole physician provider for the whole county. Besides the community suffering, he suffered. It was very painful and is still very painful. Dr. Mikhail stated that he's learned from his experience and will go forward. He stated that he thinks the experience has made him a better physician and a better person, and a lot of people have benefited from his pain and experience. Now they know that documentation is an extremely important issue in practicing medicine. Dr. Mikhail stated that some day in the future he will appreciate what happened to him.

In response to Dr. Steinbergh's questions, Dr. Mikhail stated that he gave Ms. Bickers information about prescribing and recordkeeping courses he wishes to attend. Both courses are offered by Case Western Reserve University. They will be offered in May and in June.

Dr. Garg stated that the Board has approved these courses before.

DR. GARG MOVED TO CONTINUE DR. MIKHAIL UNDER THE TERMS OF THE BOARD'S ORDER OF NOVEMBER 12, 2003, AND THE BOARD'S POLICY OF DECEMBER 9, 1998, WITH FUTURE APPEARANCES BEFORE THE BOARD SECRETARY OR DESIGNEE. DR. GARG FURTHER MOVED TO APPROVE CASE WESTERN RESERVE UNIVERSITY'S CONTROLLED SUBSTANCES PRESCRIBING AND MEDICAL RECORDS COURSES, IN FULFILLMENT OF PARAGRAPHS (B) (4) & (5) OF THE BOARD'S ORDER. DR. ROBBINS SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

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The motion carried.

KOLLI PRASAD, M.D.

Dr. Prasad made his initial appearance before the Board, pursuant to the terms of the Board's Order of February 11, 1998.

Mr. Albert stated that Dr. Prasad has been with the Board for six years and will be for another eight years because of a relapse. Mr. Albert stated that he thinks that Dr. Prasad is maintaining his sobriety, but the problem he's had over the years is in complying with the Consent Agreement. Mr. Albert stated that he thinks that the Board has Dr. Prasad's attention now. He wants to do what is right and get away from the consent agreement.

In response to Dr. Steinbergh's questions, Dr. Prasad stated that he is doing very well. He thanked the Board members for keeping him where he is. He has matured as a person. Before he only knew medicine, now he knows how to live a normal life, too. As far as compliance, Dr. Prasad stated that he was compliant with every single step, but sometimes, because of the multiple sources from which he had to get information, he was late. What happened this time was that there was something bad going on in the family. He had to take care of it and is still taking care of it. He realizes that it is his responsibility to make certain things are received by the Board in a timely fashion.

Dr. Egner asked whether Dr. Prasad is going back to work.

Dr. Prasad stated that he is planning to return to work in April. He will be working for one week a month for three months. He's not going to work full time, but will be doing locum tenens work.

Mr. Albert noted that Dr. Ted Parran is Dr. Prasad's supervising physician.

Dr. Steinbergh asked who is monitoring the films.

Dr. Prasad stated that Dr. Raval was his monitoring physician, but he's not currently working with Dr. Raval. When he starts working with someone else, he will ask the Board for approval of that individual. Right now he's not working.

In response to Dr. Egner's questions, Dr. Prasad stated that he will read everything, including x-rays, mammograms, CT scans, and MRIs.

Dr. Egner noted that Dr. Prasad has been out of practice for six years. She asked how he kept up with radiology.

Dr. Prasad stated that it's tough to keep up in radiology, there's so much going on. He spends an hour every day looking at what's going on around. He's had the basic knowledge for the last 25 years.

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Dr. Buchan asked about interventional radiology.

Dr. Prasad stated that he's not planning on doing interventional procedures during the first year because he needs time to retrain. He'll follow another physician for three months in the hospital.

In response to Dr. Garg's questions, Dr. Prasad stated that he won't be doing arteriograms, and similar things. He'll be working in an office practice, outside the hospital. It will not involve any real interventional procedures such as he did before.

Dr. Kumar asked whether Dr. Prasad has attended any of the national society meetings, such as the American College of Radiology, to keep informed of what is going on in the specialty.

Dr. Prasad stated that there are so many changes that, unless he practices what he learns, it doesn't stay.

Dr. Davidson asked whether Dr. Prasad has taken the SPEX.

Dr. Prasad stated that he has.

Dr. Garg advised Dr. Prasad that he believes that the Board members are concerned because when a physician is out of the profession for long, he or she will get very rusty. That's why members are concerned about whether or not he has kept up with whatever is going on in radiology. He suggested that Dr. Prasad attend some focused radiology meetings, whether at radiologic clinics or associations.

Dr. Prasad stated that he plans to go to three to four conferences. He stated that if he goes to a conference now and doesn't practice what he learns for two years, it's gone.

Dr. Kumar stated that that's the way you keep up. Things won't change dramatically that way. There's always a sequential change. He disagrees that it would disappear from Dr. Prasad's mind, even though he's not practicing. He'd still have the didactic information. The Board is suggesting that he go to some of these conferences to make himself more versed in what is going on today.

In response to Dr. Robbins' questions, Dr. Prasad stated that his oldest child is 25 years old, and his youngest will be graduating from Ohio State University this June.

DR. BHATI MOVED TO CONTINUE DR. PRASAD UNDER THE TERMS OF THE BOARD'S ORDER OF FEBRUARY 11, 1998, AND THE BOARD'S POLICY OF DECEMBER 9, 1998, WITH FUTURE APPEARANCES BEFORE THE BOARD SECRETARY OR DESIGNEE. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

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

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Dr. Bhati	- aye
Dr. Buchan	- aye
Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye

The motion carried.

PROBATIONARY REPORTS

Ms. Sloan referred the Board to the Compliance Staff's reports of conferences with probationers on January 12 and January 13, 2004. He noted that all probationers are in compliance.

DR. BHATI MOVED TO ACCEPT THE COMPLIANCE STAFF'S REPORTS OF CONFERENCES WITH RICHARD G. DAY, M.D.; JAMES H. GRAY, JR., D.O.; THOMAS A. HUNTER, P.A.; TIMOTHY S. KRESS, M.D.; MICHAEL J. O'BRIEN, D.O.; ANTHONY G. POLITO, D.P.M.; RAMACHANDRA K. PUDUPAKKAM, M.D.; AKI S. PURYEAR, M.D.; MARY H. RABB, D.O.; STEVEN J. SHOR, M.D.; ROBERT D. SMARSCH, D.O.; ROBERT R. SUMMERS, D.O.; JEFFREY W. WINHOLT, M.D.; AND VIRGINIA C. WOODROW, M.D. MR. BROWNING SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

PROBATIONARY REPORTS AND PROBATIONARY REQUESTS

PETER FRAGATOS, M.D.

Dr. Fragatos' requests for approval of the staff's report of his office conference and approval of a treating

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mental health professional were presented to the Board for consideration at this time.

DR. STEINBERGH MOVED TO ACCEPT THE COMPLIANCE STAFF'S REPORT OF A CONFERENCE [it's singular above] WITH DR. FRAGATOS ON FEBRUARY 10, 2004. DR. STEINBERGH FURTHER MOVED TO APPROVE JOHN SHEN, Ph.D., TO SERVE AS DR. FRAGATOS' TREATING MENTAL HEALTH PROFESSIONAL. MR. BROWNING SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

THOMAS A. RANIERI, M.D.

Dr. Ranieri's requests for approval of the staff's report of his office conference and reductions in his appearance and drug screen schedules were presented to the Board for consideration at this time.

DR. STEINBERGH MOVED TO ACCEPT THE COMPLIANCE STAFF'S REPORT OF A CONFERENCE WITH DR. RANIERI ON FEBRUARY 10, 2004. DR. STEINBERGH FURTHER MOVED TO REDUCE DR. RANIERI'S APPEARANCE SCHEDULE FROM EVERY THREE MONTHS TO EVERY SIX MONTHS, AND HIS DRUG SCREEN REQUIREMENT FROM ONCE A WEEK TO TWICE PER MONTH. DR. GARG SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye

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Dr. Steinbergh - aye

The motion carried.

JOSEPH S. SCHEIDLER, D.O.

Dr. Scheidler's requests for approval of the staff's report of his office conference and reductions in his appearance and drug screen schedules were presented to the Board for consideration at this time.

DR. BUCHAN MOVED TO ACCEPT THE COMPLIANCE STAFF'S REPORT OF A CONFERENCE WITH DR. SCHEIDLER ON FEBRUARY 10, 2004. DR. BUCHAN FURTHER MOVED TO REDUCE DR. RANIERI'S APPEARANCE SCHEDULE FROM EVERY THREE MONTHS TO EVERY SIX MONTHS, AND HIS DRUG SCREEN REQUIREMENT FROM ONCE A WEEK TO TWICE PER MONTH. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

JOHN R. TRUMBO, M.D.

Dr. Trumbo's requests for: approval of the staff's report of his office conference and an increase in work hours were presented to the Board for consideration at this time.

DR. STEINBERGH MOVED TO ACCEPT THE COMPLIANCE STAFF'S REPORT OF A CONFERENCE WITH DR. TRUMBO ON JANUARY 9, 2004. DR. STEINBERGH FURTHER MOVED TO INCREASE DR. TRUMBO'S WORK HOURS TO 45 PER WEEK. DR. GARG SECONDED THE MOTION. A vote was taken:

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

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Dr. Buchan	- aye
Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye

The motion carried.

PROBATIONARY REQUESTS

DANIEL H. BRUMFIELD, M.D.

Dr. Brumfield's request for approval of a monitoring physician was presented to the Board for consideration at this time.

DR. STEINBERGH MOVED TO APPROVE ROBERT E. KNEISLEY, M.D., TO SERVE AS DR. BRUMFIELD'S MONITORING PHYSICIAN, WITH TEN CHARTS TO BE REVIEWED PER MONTH. DR. GARG SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

VICKIE M. FLOWERS, M.T.

Ms. Flowers' request for approval of an ethics course was presented to the Board for consideration at this time.

DR. STEINBERGH MOVED TO APPROVE CUYAHOGA COMMUNITY COLLEGE'S COURSE, *ETHICS FOR HEALTHCARE PROFESSIONALS*, IN FULFILLMENT OF PARAGRAPH 9 OF MS. FLOWERS' NOVEMBER 12, 2003 CONSENT AGREEMENT. DR.

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BUCHAN SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

ROBERT S. REEVES, JR., M.D.

Dr. Reeves' requests for approval of a treating psychiatrist and a monitoring physician and his request for reinstatement of his license, which was suspended by Board Order of February 11, 2004, were presented to the Board for consideration at this time.

DR. STEINBERGH MOVED TO APPROVE GREGORY B. COLLINS, M.D., TO SERVE AS DR. REEVES' TREATING PSYCHIATRIST AND SUPERVISING PHYSICIAN AND CHARLES L. VALONE, M.D., TO SERVE AS DR. REEVES' MONITORING PHYSICIAN, WITH TEN CHARTS REVIEWED PER MONTH. DR. STEINBERGH MOVED THAT THE APPLICATION FOR THE REINSTATEMENT OF THE LICENSE OF ROBERT S. REEVES, JR., M.D., BE APPROVED, SUBJECT TO THE PROBATIONARY TERMS AND LIMITATIONS OF THE FEBRUARY 11, 2004 BOARD ORDER. DR. GARG SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

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The motion carried.

LICENSURE

PHYSICIAN ASSISTANT APPLICANTS

At this time the Board considered applications for registration as physician assistants.

DR. STEINBERGH MOVED TO APPROVE THE APPLICANTS LISTED IN LICENSURE EXHIBIT (A) FOR REGISTRATION AS PHYSICIAN ASSISTANTS, CONTINGENT UPON ALL REQUESTED DOCUMENTS BEING RECEIVED AND APPROVED IN ACCEPTANCE WITH LICENSURE PROTOCOLS. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

P.A. UTILIZATION PLANS

At this time the Board reviewed P.A. Utilization Plans submitted for consideration.

DR. STEINBERGH MOVED TO APPROVE THE P.A. UTILIZATION PLANS OF DAYTON LUNG & SLEEP MEDICINE, INC.; GARY GERARD, M.D.; MEMORIAL HOSPITAL OF UNION COUNTY; TALLO & ASSOCIATES; AND UNIVERSITY CARDIOLOGY, INC., CONTINGENT UPON ALL REQUESTED DOCUMENTS BEING RECEIVED AND APPROVED IN ACCEPTANCE WITH LICENSURE PROTOCOLS, INCLUDING IN THE CASE OF UNIVERSITY CARDIOLOGY, INC., VERIFICATION THAT THE P.A. WILL SEE NO MORE THAN 25 PATIENTS PER DAY. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

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

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Dr. Buchan	- aye
Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Davidson	- aye
Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye

The motion carried.

PHYSICIAN LICENSURE APPLICANTS

At this time the Board considered applications for licensure as doctors of medicine and surgery, doctors of osteopathic medicine and surgery and doctors of podiatric medicine and surgery.

DR. BUCHAN MOVED TO APPROVE THE APPLICANTS LISTED IN LICENSURE EXHIBIT (B) FOR ENDORSEMENT LICENSURE, CONTINGENT UPON ALL REQUESTED DOCUMENTS BEING RECEIVED AND APPROVED IN ACCEPTANCE WITH LICENSURE PROTOCOLS. DR. DAVIDSON SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

PHYSICIAN ASSISTANT APPLICANTS

At this time the Board considered additional applications for registration as physician assistants.

DR. GARG MOVED TO APPROVE THE APPLICANTS LISTED IN LICENSURE EXHIBIT (C) FOR REGISTRATION AS PHYSICIAN ASSISTANTS, CONTINGENT UPON ALL REQUESTED DOCUMENTS BEING RECEIVED AND APPROVED IN ACCEPTANCE WITH LICENSURE PROTOCOLS. DR. BHATI SECONDED THE MOTION. A vote was taken:

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Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

ADMINISTRATIVE REPORT

Mr. Dilling referred the Board to his written report, a copy of which shall be maintained in the exhibits section of this journal. He noted that Dr. Garg and Mr. Albert have been selected by the Federation of State Medical Boards as co-recipients of the John H. Clark Leadership Award, in recognition of their contributions to the Medical Board and their leadership and commitment in advancing the public good in the field of medical licensure and discipline.

Mr. Dilling referred to Attachment B of his report, which indicates that Board members attending the Federation meeting will be Mr. Albert, Dr. Davidson, Dr. Garg, Dr. Egner, Dr. Kumar, Dr. Steinbergh and Dr. Talmage. He asked that the Board authorize him and Ms. Wehrle to attend the Administrators in Medicine (AIM) meeting on Wednesday, April 28, in addition to the Federation annual meeting.

MR. ALBERT MOVED TO AUTHORIZE MR. DILLING AND MS. WEHRLE TO ATTEND BOTH THE AIM AND FEDERATION MEETINGS. MR. BROWNING SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

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The motion carried.

Mr. Dilling at this time reminded Board members to file their Financial Disclosure Statements with the Ohio Ethics Commission by April 15.

REPORTS OF ASSIGNED COMMITTEES

QUALITY ASSURANCE COMMITTEE

No report this month.

PRESCRIBING COMMITTEE

Dr. Davidson stated that she reported to the Committee on current activities of the Committee on Prescriptive Governance. Also, the Committee discussed the draft report of the Compassionate Care Task Force, which will probably be approved in some final form on Friday, March 12. The final report will be highlighted in the Board's next newsletter.

Dr. Davidson left the meeting at this time.

LICENSURE COMMITTEE

Dr. Garg stated that the Committee discussed a report by the Federation's Special Committee on Maintenance of Licensure. He asked Ms. Wehrle to address the Board on this topic.

Ms. Wehrle stated that the report will be e-mailed to Board members. She stated that it is an interim report asking the House of Delegates to adopt the policy that it is part of a Medical Board's responsibility to ensure the continuing competence of physicians at the time of relicensure. This will be the first of a multi-part strategy on how to implement that policy decision, and is being provided for the Board's information. She added that it will give Board members a "heads up" of what will be a very hot topic at the Federation meeting.

Mr. Dilling stated that it won't be adopted until next year. This is just a half-way point report.

Jose Antonio Cancelas, M.D.

Dr. Garg stated that the Committee also reviewed Dr. Cancelas' application for medical licensure. He noted that Dr. Cancelas is a graduate of a Spanish medical school. His main interest is in research, and he has been hired by the University of Cincinnati to do stem cell research. Dr. Cancelas has requested the Board to consider his previous training and experience as being equivalent to 24 months of graduate medical education through the second year level. Dr. Garg stated that Dr. Cancelas has completed one year of a research fellowship in hematology at Children's Hospital in Cincinnati.

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Dr. Garg stated that the Committee didn't feel that there was enough information to find equivalency in this case. He added that the Committee did discuss the possibility of going to the Legislature and asking for an administrative license for those in situations such as this. However, in this case, the Committee recommends that the Board propose to deny on the basis that Dr. Cancelas has not completed 24 months of graduate medical education through the second year level or its equivalent in previous training and experience.

Dr. Bhati stated that Dr. Cancelas' CV contains almost 43 papers he published in international journals. Obviously, this physician has done extensive work with stem cells, and he was highly sought in this country. Dr. Bhati stated that there will be other states standing in line to get this physician. He suggested that the Board might give him a license restricted to doing only research, because that is what Dr. Cancelas will be doing here. He agreed, however, that Dr. Cancelas does not meet the requirements for licensure.

Dr. Garg stated that the Committee discussed this case extensively, and recognized that Dr. Cancelas has had a very distinguished career and has a very strong CV. He noted that Dr. Cancelas has very high USMLE scores for someone who has been out of medical school for fifteen years. He's a very brilliant person.

Dr. Steinbergh asked whether Dr. Cancelas has a Ph.D.

Dr. Garg stated that he does.

Dr. Steinbergh asked why he would need a medical license to do research.

Dr. Bhati stated that it's clinical research and he will be involved with patients.

Dr. Garg asked Dr. Bhati whether he knows what Dr. Cancelas' fellowship involved.

Dr. Bhati stated that he did not.

Dr. Garg stated that the staff asked Dr. Cancelas that question, and his response did not give any idea that there was any clinical work involved. It was mostly research.

Dr. Robbins asked whether the Board could give Dr. Cancelas a restricted license.

Dr. Bhati stated that he was hoping that the Board could do that.

Dr. Egner stated that she went along with this in the Committee, but she wants to change her mind. She stated that the Board has seen cases like this before who are the brains of medicine. For his job, he needs a license.

Dr. Garg stated that if the Board restricts his license, that starts a precedence.

Dr. Egner suggested that the Board has done that before.

Dr. Garg stated that it has not for initial licensure.

Dr. Buchan stated that he's sensitive to Dr. Cancelas' brilliance, but the Board licenses physicians, not scientists. Dr. Cancelas does not have the clinical training that would make Dr. Buchan comfortable with approving Dr. Cancelas for a license in this state. If the Board deviates from that tack, that is a major change in the Board's philosophy.

Dr. Garg asked whether the Board can legally grant Dr. Cancelas a license.

Mr. Dilling stated that the Board has the discretion to determine the equivalency through the second year level of graduate medical education.

Dr. Garg stated that the Board has found equivalency for members of the Royal College of Surgeons, whether in England, Edinburgh, Australia, South Africa or Canada. Similarly, this gentleman has his hematology boards from Spain, and he has a Ph.D. Dr. Garg stated that he would personally not be against it, but the Board should keep in mind that there will be others asking for equivalency. He stated that the Board has denied licensure to individuals who have published 200 papers.

Dr. Steinbergh stated that the Board has denied a lot of licenses for applicants who intend to do research.

Mr. Dilling stated that one of the things the Board has done is get the person more involved in answering questions and get some support to help the Board understand how it can find equivalency. He stated that if the Board denies Dr. Cancelas a license today, he could request a hearing and get the information the Board is looking for relative to the clinical aspect of the research he has done. Mr. Dilling suggested that it might be faster to ask Dr. Cancelas some specific questions.

Dr. Garg stated that the Board already asked him those questions.

Ms. Rieve stated that she asked Dr. Cancelas to explain his current duties, his duties in the clinical fellowship. Usually when the staff asks those questions, they learn how much patient care the applicant did. In this case, it was very clear that it was more research based because he's doing stem cell research so he doesn't work with patients in that way. He works with the product.

Dr. Bhati stated that he would like to keep Dr. Cancelas in Ohio, and he suggested that he appear before the Chair of the Licensure Committee.

Dr. Garg stated that he thinks that it's too big an issue. If the Board creates a precedence, it should be as a result of an appearance before the full Board and not just the Chair of the Committee. It doesn't have to be through the hearing process.

Dr. Kumar asked whether Dr. Cancelas would be satisfied having a limited license.

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Mr. Dilling stated that Dr. Cancelas wants to be able to take his boards. In order to take his boards, he needs an unrestricted license. If the Board restricts his license, it would be potentially playing with his opportunity to take his board examinations.

Dr. Egner asked whether he wants to take his boards.

Ms. Rieve stated that she asked whether he has applied to take them.

Dr. Egner stated that he has not.

Dr. Kumar stated that Dr. Cancelas is asking for an unrestricted license, and the Board is discussing granting him a restricted license. That does not meet what he is trying to obtain, so it's a moot point even to grant a restricted license.

Mr. Dilling stated that the problem is, to give him a restricted or unrestricted license, the Board has to first answer the question as to whether or not Dr. Cancelas has demonstrated an equivalency through the second year level. If he has, then you don't want to grant him an unrestricted license.

Dr. Steinbergh stated that he doesn't have the equivalency.

Dr. Garg stated that the Board has not talked with him. If it does talk with him, it might determine that he meets equivalency. The Board could ask him what his residency was like, what his internship was like, what kind of work he did, what he has done since. Was there any clinical work involved in the fellowship? Dr. Garg stated that Dr. Cancelas teaches students, but mostly what he has done is research related.

Dr. Robbins asked whether there is any way to craft something so that Dr. Cancelas can do what he wants to do at the University of Cincinnati and let him go to his specialty boards? If they say he's not eligible, he's not eligible.

Dr. Kumar stated that he needs an unrestricted license to take his specialty boards.

Dr. Robbins stated that this Board can't give it to him, but he'd put it back on the specialty boards.

Ms. Rieve advised that eligibility for specialty boards has been considered equivalent. Another entity has said that this person has the training to take the boards, which implies the person's expertise. In this case, Dr. Cancelas may not have gone to the specialty boards at all to find out if he's eligible.

Dr. Steinbergh stated that the last time Dr. Cancelas had any clinical training was in 1990 – 1993, when he was a resident in hematology in Spain. He indicates it was 100% clinical. Since then, all the positions he's held have been research oriented and non-clinical in their application.

Mr. Dilling stated that he doesn't understand the difference in terminology between graduate medical

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education that's done in an ECGME accredited residency versus a fellowship. The statutes pertaining to training certificates mention them both in the same realm. He completed a fellowship in Cincinnati. Mr. Dilling stated that he believes that the Board can ask Dr. Cancelas some questions and learn something about this. It could focus the questions a little bit. Looking at Dr. Cancelas' résumé, and he lists 100% research under "clinical" for these fellowships. He suggested that he sit down with the licensure staff and contact the University of Cincinnati and explain what the Board is looking for so that it can get the necessary information prior to Dr. Cancelas appearing before the Board. This will be more expedient than denying licensure.

Dr. Garg stated that what Mr. Dilling suggested is fine. Perhaps, with that information and an appearance before the full Board, it will help to convince those who are hesitant about granting a license. He added, though, that if the Board grants Dr. Cancelas a license, it will be setting a precedent. The Board won't be able to limit it to just this individual.

Mr. Dilling stated that no one is questioning that. He just feels that the staff may not have given the Board all of the information it needs. He added that staff did everything it was supposed to do, but this is one of those things where he would like to take it a step further to help the process.

Dr. Garg stated that, according to the Board's guidelines, everything was done before the matter was brought to Committee. He stated that he thinks the information is there. He added that he thinks Dr. Cancelas has been truthful about this. He's not trying to say that he also did some clinical work under the fellowship.

Dr. Steinbergh suggested that, since Dr. Cancelas passed the USMLE recently, the Board might require him to pass a clinical skills exam.

Ms. Rieve stated that he did that as part of his ECFMG.

Mr. Dilling stated that the licensure process is two-fold. It's based on passing the USMLE and doing the education. They balance one another out; they're checks on each other in the system. You have to have both. Dr. Cancelas has done the one part, which makes you feel better about him, but the test in itself is not the be-all and end-all, it's also the education you get. That's the second part that the Board is trying to answer.

DR. GARG MOVED TO TABLE DR. CANCELAS' APPLICATION TO ALLOW STAFF TO OBTAIN FURTHER INFORMATION FOR PRESENTATION IN APRIL. DR. STEINBERGH SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye

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Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye

The motion carried.

LEGISLATIVE LIAISON & RULES COMMITTEE

Mr. Browning referred to Mr. Wayda's memorandum, a copy of which shall be maintained in the exhibits section of this journal. He noted that the only item needing action is Rule 4731-1-05, the massage therapy scope of practice rule.

DR. BHATI MOVED TO AUTHORIZE STAFF TO REFILE RULE 4731-1-05, WITH THE AMENDED LANGUAGE, WITH JCARR. DR. BUCHAN SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

LIMITED BRANCH & ALTERNATIVE MEDICINE COMMITTEE

Dr. Buchan advised that the Committee reviewed three applications for certificates of good standing, and recommend approval of all.

DR. GARG MOVED TO GRANT CERTIFICATES OF GOOD STANDING TO: RISING SPIRIT INSTITUTE OF NATURAL HEALTH, ATLANTA, GEORGIA; THE LOUISVILLE SCHOOL OF MASSAGE, LOUISVILLE, KENTUCKY; AND TROCAIRE COLLEGE, BUFFALO, NEW YORK. MR. BROWNING SECONDED THE MOTION. A vote was taken:

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

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Dr. Talmage	- aye
Dr. Bhati	- aye
Dr. Buchan	- aye
Dr. Kumar	- aye
Mr. Browning	- aye
Dr. Robbins	- aye
Dr. Garg	- aye
Dr. Steinbergh	- aye

The motion carried.

P.A. COMMITTEE

Dr. Talmage stated that he would like to present as a group those P.A. supplemental utilization plans that the Committee recommends for approval. He indicated that the Committee recommends approval of the requests of Cardiology One, Jewish Hospital of Cincinnati, MedCosmetix, LLC, and Southwest General Health Center. He commented that there is precedent for approval of these applications.

Dr. Kumar stated that the Committee did say that the procedures requested by Southwest General Health Center should be performed by P.A.s on adults only.

DR. GARG MOVED TO APPROVE THE FOLLOWING P.A. SUPPLEMENTAL UTILIZATION PLANS: CARDIOLOGY ONE'S REQUEST FOR THE P.A. TO PERFORM NONINVASIVE CARDIOVASCULAR STUDIES; JEWISH HOSPITAL OF CINCINNATI'S REQUEST FOR THE P.A. TO PERFORM CENTRAL LINE INSERTION TO INCLUDE PICC LINES; MEDCOSMETIX, LLC'S REQUEST FOR THE P.A. TO PERFORM APPLICATION OF LIGHT-BASED MEDICAL DEVICES FOR THE PURPOSE OF HAIR REMOVAL; AND SOUTHWEST GENERAL HEALTH CENTER'S REQUEST FOR THE P.A. TO PERFORM RADIAL ARTERY HARVESTING ON ADULTS ONLY. DR. BHATI SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

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Dr. Talmage stated that the Committee recommends denial of the supplemental plans submitted by Far Oaks Orthopedists and Akron Radiology, primarily on the basis of complexity and potential complications from both the process and the medication being injected.

Dr. Buchan stated that there was discussion of the possible complications, which include everything from skin atrophy to intertendinous injection, which could include tendon rupture if inappropriately performed. Intra-articular injections in large joints can lead to softening of the cartilage. Dr. Buchan stated that all of these complications and concerns would suggest that these procedures should be performed by experts.

Dr. Buchan continued that, in regard to surgical intervention, the Board realizes that failed results with multiple steroid injections leads to the operating room. With that in mind, the Committee wants to make sure that these injections are appropriately rendered by experts so that if surgery is indicated, it's for all the right reasons.

DR. GARG MOVED TO PROPOSE TO DENY THE FOLLOWING P.A. UTILIZATION PLANS ON THE BASIS THAT THE PROCEDURES REQUESTED ARE COMPLEX AND CARRY A HIGH POTENTIAL FOR COMPLICATIONS: FAR OAKS ORTHOPEDISTS' REQUESTS FOR ITS P.A.S TO PERFORM: CORTISONE INJECTION INTO THE HIP FOR GREATER TROCHANTERIC BURSITIS AND TENDONITIS; INJECTION INTO THE ANKLE FOR PERONEAL TENDONITIS AND THE FEET FOR GREAT TOE AND MORTON'S NEUROMA; CORTISONE INJECTION INTO THE MEDIAL AND LATERAL EPICONDYLE OF THE ELBOWS; CORTISONE INJECTION INTO THE HANDS FOR GANGLION CYSTS AND TRIGGER FINGER; AND INJECTION INTO THE KNEE FOR BOTH TRAUMATIC EFFUSIONS AND ARTHRITIC EFFUSIONS; AND AKRON RADIOLOGY'S REQUEST FOR ITS P.A.S TO PERFORM: HIP INJECTION. DR. STEINBERGH SECONDED THE MOTION.

A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Robbins	- aye
	Dr. Garg	- aye
	Dr. Steinbergh	- aye

The motion carried.

DR. GARG MOVED TO ADJOURN. DR. BHATI SECONDED THE MOTION. All members voted aye.
The motion carried.

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Thereupon at 5:50 p.m. the March 10, 2004 session of the State Medical Board of Ohio was duly adjourned.

We hereby attest that these are the true and accurate approved minutes of the State Medical Board of Ohio, meeting on March 10, 2004, as approved on April 14, 2004.



Anquetette Sloan, President



Anand G. Garg, M.D., Secretary

(SEAL)



March 11, 2004

MINUTES**THE STATE MEDICAL BOARD OF OHIO****March 11, 2004**

Anquetette Sloan, President, called the meeting to order at 8:10 a.m., at the Vern Riffe Center for Government and the Arts, 77 S. High St., Columbus, Ohio 43215, Room #1932, with the following members present:, Patricia J. Davidson, M.D., Vice-President; Lance A. Talmage, M.D., Secretary; Raymond J. Albert, Supervising Member; Anant R. Bhati, M.D.; David S. Buchan, D.P.M.; Deepak Kumar, M.D.; R. Gregory Browning, Ph.D.; Andrew F. Robbins, Jr., M.D., and Anita M. Steinbergh, D.O. The following joined the meeting at a later time: Carol L. Egner, M.D. The following did not attend the meeting: Anand G. Garg, M.D.

Also present were: Thomas A. Dilling, Executive Director; William J. Schmidt, Assistant Executive Director; Diann K. Thompson, Assistant Executive Director; Terrill D. McLaughlin, Assistant Director, Investigations; Mark Wayda, Chief of Executive Staff; Lauren Lubow, Senior Executive Staff Attorney; Shannon F. Baldwin, Executive Staff Attorney; Lori S. Gilbert, Chief Enforcement Coordinator; Mark R. Blackmer, Marcie P. Burrow, Sally J. Debolt, David P. Katko, Rebecca J. Marshall, Karen H. Mortland, and Kathleen S. Peterson, Enforcement Coordinators; Rebecca J. Albers, Kyle C. Wilcox, and Gregory A. Perry, Assistant Attorneys General; R. Gregory Porter, Chief Hearing Examiner; Sharon W. Murphy and Siobhan R. Clovis, Hearing Examiners; Eileen M. Schmidt, Executive Assistant to the Director; Joan K. Wehrle, Coordinator for Assessment and Development; Danielle Bickers, Compliance Officer; Barbara Jacobs, Public Services Administrator; Jacqueline A. Moore and Annette Jones, Disciplinary Information Assistants.

EXECUTIVE SESSION

DR. STEINBERGH MOVED THAT THE BOARD DECLARE EXECUTIVE SESSION TO CONFER WITH THE ATTORNEY GENERAL'S REPRESENTATIVES ON MATTERS OF PENDING OR IMMINENT COURT ACTION. DR. ROBBINS SECONDED THE MOTION. A vote was taken:

Vote:	Mr. Albert	- aye
	Dr. Talmage	- aye
	Dr. Bhati	- aye
	Dr. Buchan	- aye
	Dr. Kumar	- aye
	Mr. Browning	- aye
	Dr. Davidson	- aye
	Dr. Robbins	- aye
	Dr. Steinbergh	- aye

The motion carried.

Pursuant to Sections 121.22(G) (3), Revised Code, the Board went into executive session.

Dr. Egner joined the meeting following the executive session.

BOARD DISCUSSION OF IMPAIRMENT ISSUES

Mr. Schmidt stated that, at its February meeting, the Impairment Committee discussed the seemingly increasing issue of anesthesiologists who become impaired, sometimes on anesthesia drugs, and the question of whether or not they should return to anesthesia practice. The Committee wanted a presentation on that and Mr. Albert requested that Craig T. Pratt, M.D., be contacted to make such a presentation.

Mr. Schmidt at this time introduced the panel members: Mr. Schmidt advised that Dr. Pratt has a long history of working in the addiction field, as well as in psychiatry. He has the additional advantage of having started his career in anesthesiology. Dr. Pratt has training in internal medicine and anesthesiology. Life circumstances dictated that he make a career change, and he went into addiction medicine and has served as Medical Director at Shepherd Hill, a Board-approved treatment provider. Dr. Pratt then did a psychiatric residency at Harding Hospital and currently works at Twin Valley Behavioral Health Care.

Edna M. Jones, M.D., trained in family medicine in the 1980s. She also practices addiction medicine and at this point is Medical Director at The Woods at Parkside. Richard N. Whitney, M.D., originally trained and worked in emergency medicine. Dr. Whitney got interested in addiction medicine and did a fellowship in it. Dr. Whitney has been the Medical Director at Shepherd Hill Hospital.

Mr. Schmidt stated that the fourth panelist, who had not yet arrived, is Theodore V. Parran, Jr., M.D. Dr. Parran trained at Johns Hopkins University School of Medicine in internal medicine. He developed an interest in addiction medicine and switched over to that and is currently an internist and addictionist. Dr. Parran is on the faculty at Case Western Reserve University, where he's an associate professor and Medical Director of C.M.E. He is the Director of several C.M.E. courses to which the Board has sent many doctors. Dr. Parran is also the Associate Medical Director of Rosary Hall.

Mr. Schmidt stated that the Impairment Committee asked Dr. Pratt about anesthesiologists and under what circumstances they should return to the practice. Mr. Schmidt stated Dr. Pratt started talking and you could see the enthusiasm building in several of the Committee members who, with all of their educational background, did not have a whole lot of prior exposure to the topic of addiction medicine. There was a real fascination with the discussion of genetic loading and a real interest in some of the things that Dr. Pratt said about how the Board can assist in the recovery process through the direction it provides recovering probationers. Mr. Schmidt paraphrased Dr. Pratt's basic points as "say what you mean and mean what you say." Mr. Schmidt stated that what he believes he heard Dr. Pratt say was that the Board needs to give good guideposts to people.

Mr. Schmidt stated that after the meeting there was a lot of enthusiasm to have a more general discussion at a Board meeting of some of the topics, and the Board decided to devote the Thursday of its March or April meeting to the topic of addiction and the treatment of impaired and recovering practitioners. Mr. Schmidt stated that the Board was fortunate in being able to get all four panelists for this meeting. He stressed that the Board was looking for people who actually are active in providing treatment in this area to serve on the panel, and that's how the four panelists were selected.

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Mr. Schmidt thanked the panel members for being here this morning.

Mr. Schmidt asked that Board members feel free to explore areas where they really have questions about the topics discussed.

Mr. Schmidt stated that he believes the Board would benefit to hear how “say what you mean and mean what you say” applies to anesthesiologists, as well as to others the Board monitors generally. The Board has heard that the relapse rate for chemical dependency is 80% or higher, whereas the relapse rate for physicians, attorneys and others who have careers they don’t want to give up tends to be exceedingly low. Mr. Schmidt asked Dr. Pratt to give the Board his thoughts about “say what you mean and mean what you say” concerning anesthesiologists and the Board’s licensees generally.

Dr. Pratt noted that Stan Sateren, M.D., is also present.

Mr. Schmidt introduced Dr. Sateren, advising that he is the Director of Ohio Physicians Effectiveness Program (OPEP). Dr. Sateren has made presentations to the Board in the recent past. The Board does a lot of work with OPEP and has a very good working relationship with OPEP. Mr. Schmidt advised that also present from OPEP are Ed Poczekaj and Barry Farrier.

Dr. Pratt stated that he went to Twin Valley during a life transition point moreover to work and heal from a variety of physical and life changes he underwent. He went there with no agenda, which was the first time in his life that he went anywhere with no agenda. It’s been nice because he can now comment on a lot of things he said in the past rather than feel like he has to preach about things he said in the past.

Dr. Pratt stated that he wrote a lot of things back in the 1980s, after he did his career/teacher fellowship at DePaul Rehabilitation Hospital, and he’s reviewed a lot of those things and they haven’t changed a whole lot. He added that there are fundamentals of addiction that everyone needs to get a grasp on but on which people seem to have a consistently difficult time getting a grasp. Dr. Pratt commented that psychiatrists haven’t been all that helpful in simplifying matters when it comes to addiction. He added that he thinks that psychiatrists have complicated it more than everything else.

Dr. Pratt continued that, for him, one of the fundamentals of addiction that he would put at the top of the list is that addiction is one with many manifestations. The chemical is the manifestation of the addiction physiology that is active. Frequently, when he asks somebody if he or she has a family history of addiction, they’ll say “no. Mom and dad never drank, they never used drugs.” He’ll ask if they smoked, and they will say that they did. Many children who grow up in smoking families manifest addiction later in life, but not necessarily with tobacco. They’ll manifest it with marijuana, alcohol, and a variety of other substances of use.

Dr. Pratt stated that he doesn’t use a lot of pejorative terminology because he thinks that confuses things. People get confused with what is addiction versus what is abuse. He’s often said that social drinking is when you go into a bar, order a beer, and take it to a back booth and have a conversation with it. Drug abuse is when you chase a marijuana cigarette around the living room and beat it silly with a baseball bat. The substances are nothing more than the manifestation of a physiologic state of being in an individual that

is determined by their genetic background. There's not an addictionist on the planet who doesn't realize, if they're paying even a modicum of attention, that the more addiction genetic loading in the family tree, the more you have addiction come down Mom's side of the family and Dad's side of the family, the earlier these kids usually begin, the more intense is their use, the quicker they get out of control, the earlier they have consequences. The more diluting of addiction genetics in the tree tends to delay the manifestation of active addiction.

Dr. Pratt stated that what creates some of the differences is that, naturally, different people have different personality styles. A personality is defined by one's social history. You determine personality disorders by the pattern of their social history. How were they in school? How were they in their marital life? How were they in their interpersonal life? How were they at work? How were they in the military? How were they in medical school and so forth and so on. You can begin to determine various different personality patterns.

Dr. Pratt advised that the ones to which the Board needs to pay the most attention are the personality disorders known as "Cluster B" personality disorders. Generally, there is no addictive personality. Addiction does begin to mold people into certain personality styles, and that's called regression. Generally speaking, someone who is actively involved in their addiction does not mature and grow and develop a healthy personality structure. They tend to arrest. What may be appropriate behavior in an adolescent, is inappropriate behavior in an adult. Some of the disruptive physicians you see, what you really see is somebody who is engaged in a variety of adolescent behavior that is inappropriate for the set and the context of the environmental exposure, whether it be in the operating room or on the floor. So the personality picture comes into play.

Concerning what is in "Cluster B," Dr. Pratt stated that it is the borderline personality disorder, the antisocial personality disorder, narcissistic personality disorder and histrionic personality disorder. Dr. Pratt stated that currently he is struggling with a consult for one of the other Boards of a healthcare practitioner who has a histrionic personality disorder, is profoundly somatic and has found an individual who is aligned because this other individual also has a personality disorder, and has this person on high doses of opioids, and they have colluded. Dr. Pratt stated that what happens often in the community is that personality disorders match up and marry. If you have a borderline personality disordered patient, it's not unusual to have a narcissistic personality disordered spouse at home. If you have a histrionic personality disordered patient, it's not unusual to have a narcissistic or antisocial spouse at home. Generally speaking, these people try to fill the voids that they don't have in their own personality structure with someone else. Generally speaking, you are now talking about family problems that begin to arise in the context of treating these physicians.

Dr. Pratt stated that when you look at an impaired physician, first of all you have to get a good sense of their history. It's not just a matter of what drugs the person is using, to a degree, but it's also a question of what you can predict in terms of their general outcome if they get treatment and get into recovery. If you have an anesthesiologist who is using Fentanyl, and that's all he's using, that's rather easy to address. The anesthesiologist goes to treatment, goes on Naltrexone, he has certain expectations of therapy and recovery activity, and that can be a fairly cut and dried scenario. But if you have an anesthesiologist who's not only doing Fentanyl but is getting drunk every night, he has then taken the chemical that he uses outside of the operating room, which makes things a little bit more complicated. Now you have another tier you have to

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address. If you have an anesthesiologist who's using Fentanyl, getting drunk every night at home and also going to the street for his marijuana and cocaine, you have another boundary that has been transgressed that needs to be addressed in the treatment process, and it's going to complicate matters because you have people who are then no longer relying on their sources from just the channel that you might be interested in, which would be in the OR, depriving the patient, per se, if that's what's going on, of opioids. You then have another source that needs to be addressed in the home environment, and another source that needs to be addressed relative to their street activity.

Dr. Pratt stated that he is convinced that people who go to the street are more likely to have a variety of personality disorder disturbances than people who confine their use to what might be regarded in their mind as a legitimate supply source. In other words, a physician using the wares of his or her trade, in the mind of an impaired person, has a bit of a different flare than somebody who just says, "well, screw the hospital, I'll just go to my dealer down the street." So you're dealing with a degree of antisocial behavior that says "the rules don't really apply to me, I'm a little bit different." Dr. Pratt stated that it's that "I'm a little bit different" that begins to confuse the Board when they go to set limits and apply the "say what you mean, mean what you say" activity to their contract.

Dr. Pratt stated that the reason he's said that the Board needs to be very, very clear about how many strikes and you're out is that, he would guess, that the physicians who repeatedly present themselves to the Board in "relapse" mode are ones who are disturbed at another level other than just addiction. Trying to find those physicians who are disturbed at another level is what he believes oftentimes makes the Board's work more complicated.

Dr. Pratt stated that when he says addiction is one and the chemical is the manifestation, the physiology is the same. Generally speaking, the physiology of addiction is pretty much the same across all chemicals. Now they have different target points that will give different drug effects, but that which drives craving, that which drives the return to the drug, is the same process. Different people, however, have different experiences with different drugs that they choose and will then go seek that experience, but that which drives the seeking is what you need to pay attention to. It's the craving, the drug-seeking, the acquisition that is all driven by the same neurophysiologic process.

Dr. Steinbergh referred to Dr. Pratt's comment about those who relapse perhaps being disturbed at a different level, and asked whether he's talking about someone who is chemically dependent and perhaps has a second psychiatric diagnosis.

Dr. Pratt stated that in psychiatry they have five axes they talk about. Axis 1 disorders are generally those disorders that can be addressed biologically with antidepressants, antipsychotics, and so forth. Schizophrenia, Major depressive disorder, and bipolar disorder would be Axis 1 diagnoses. One of the struggles in addiction medicine is that psychiatrists seem to think that everybody who has addiction is bipolar these days, and they begin passing out medications to treat that which can't be treated with medication. Addiction when it is active looks a lot like active bipolar disorder, so, consequently, we've lost our ability to give these people time to let their chemistry settle down to see what they really are. There is a high comorbidity of mood disorders and addiction. Generally speaking, the genetic loading that contributes to the addiction neurophysiology is a similar genetic loading that contributes to mood disturbances. Dr. Pratt stated that he thinks that it's a safe bet that women who grow up in alcohol-

disturbed homes are much more likely to have a mood disturbance than men. There are hormonal and genetic reasons for that, too.

Dr. Pratt continued that Axis 2 disorders are the personality disorders. Generally, if someone is in treatment, or in a monitored environment for two to three months, and he doesn't mean that they have to go off to Atlanta or Shepherd Hill for that long a time, but generally, if they're in a good monitored scenario, they're seeing the therapist, psychiatrist or addictionist and they're getting good follow-up, you can begin to tell when their moods aren't coming around as they should. Then you can begin to see that this is someone who might warrant an antidepressant. The anxiety disorders get a little bit more complicated, but, generally speaking, most anxiety disorders are also treated with antidepressants and respond quite well. You avoid the benzodiazepine reactivation of addiction problem.

Dr. Pratt stated that Axis 2 disorders are the ones that get a bit more complicated, and they're what actually make addiction very, very difficult to treat because these are, by definition, patterns of behavior that tend to be recalcitrant to intervention. Generally speaking, if you have a physician who has elements of a personality disorder, the question is, as they remain sober, do those elements begin to resolve. Do they begin to establish more stable relationships? Do they begin to realize the responsibility they have to continue in the self-treatment process? Are they more conscientious than the person who is monitoring them. When you've seen people come to the Board who have come prepared, who have their drug screens and their therapists' reports, they tend to generate a sense of genuine vulnerability, they very much want the Board to know that they're in recovery versus those people who are kind of vague and kind of nebulous and kind of unsure, you get the sense that they really haven't changed their life much, but they're just not using – those are the kind of folks the red flag should stay up. Generally speaking, Dr. Pratt would be one of those people who have not necessarily been antagonistic to the five-year plan, because he thinks that it takes a good five years for a lot of structural changes to begin to happen in people's personality organization. For those people in the room who are in recovery, he believes that they would all say that it takes a long time to begin to alter those old patterns of behavior. Dr. Pratt stated that Axis 1 disorders will generally declare themselves as being present within your first year of recovery. You'll know if somebody has more than just active addiction.

Dr. Pratt commented that psychiatrists will say all the time that the person is only using to self-medicate his underlying mood disorder. Dr. Pratt stated that he doesn't like that because it provides a rationalization, not only for ongoing use, but it provides a minimization of a fundamental problem, which is the addiction. He usually sort of just tells folks that they really don't have just one problem, but they have two. They have addiction and a co-occurring anxiety disorder, mood disorder, what have you.

Dr. Pratt stated that he doesn't think that it is any secret that he is recovering, and 20 years came up last November. What he would say is that he was introduced to Fentanyl through a panic attack. The panic disorder preceded active addiction, but coming down both sides of his parents' family tree was a great deal of alcoholism. Dr. Pratt commented that he doesn't usually say "alcoholism" any more, he usually says "addiction as manifest by alcohol" because he wants to make sure that people are very clear that addiction is one of many manifestations. Both parents smoked; his father died of lung cancer. So the issue is that he had genetic loading for addiction, but he also developed panic disorder. So he didn't have one problem, he had two, and he became very clear about that. He also took a lot of flak when he chose not to go back into the operating room back in the early 1980s, because he was supposed to show that a good recovering

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doctor can do that. He had a problem in that there was no assay for Fentanyl back in 1983. There was no Naltrexone back in 1983. If he had a bad day in the OR and somebody asked if he was using and he said, “no,” he couldn’t prove it. The statistics back then weren’t all that good either. The recovery movement was in an infantile stage, but the awareness in anesthesia departments, the punishment of physicians in recovery, was still sort of a prevalent thing, and he really just worried. That’s why he decided to leave the OR and go retrain. He became a psychiatrist to become a better addictionist, and in the midst of his psychiatry residency, addiction medicine sort of fell apart.

Dr. Pratt continued that Axis 1 disorders will generally manifest themselves within the first year of recovery. Axis 2 disorders, however, by definition are pervasive, and they generally need to be addressed, not through medication management, but through structural changes in their activity and pattern. That means psychotherapy. Dr. Pratt stated that he went through five to seven years in psychotherapy, and that had a lot to do with the general progression in a kid that kind of raised himself in not a very healthy family system.

Dr. Steinbergh stated that that leads her to her second question. She stated that early on Dr. Pratt talked about addiction genetic loading. She asked whether, if you take the child who had one or two parents addicted to something, whether it be smoking or drugs, out of that environment, i.e., adoption at infancy, and put that child into an environment where there is no addiction, what can you expect from that child?

Dr. Pratt stated that you can expect the same thing. Probably 95% of children leaving high school have been exposed to an addiction activating substance.

Dr. Steinbergh asked whether he would expect the manifestations of the birth parents.

Dr. Pratt stated that he would.

Dr. Whitney stated that identical twin studies have shown that. The lifetime incidence does not alter, despite the fact that one of the twins might have been placed in a non-using environment.

Dr. Kumar asked whether there is any specific gene that has been identified.

Dr. Pratt stated that it will be polygenetic. The answer to Dr. Kumar’s question is, “no.” It would be all inferential. Dr. Pratt stated that the worry he has is that this country was probably founded on a good deal of addiction activity. The “geographic cure” was just as real back in 1492 as it is now. Generally speaking, genetic loading moved west. The transcontinental railroad was funded by T. F. Perkins, who had the T. F. Perkins School For the Blind in Boston, where Helen Keller went. He founded that school after he lost his sight after he realized that those big six-masted clipper ships were running opium from Burma around to Taiwan, which was what was responsible for the Chinese opium wars back in the 1800s. When he went blind, he then funded the transcontinental railroad, which was a whole bunch of alcoholics laying track out to California. What’s interesting is that the root word of California is Cali, who is the goddess of the opium plant, and the state flower of California is the California Poppy. So addiction is quite a relevant element to the founding to this country. He remarked that this country has had a number of presidents who have acknowledged active addiction.

Dr. Robbins commented that it's pervasive, and that it would be hard to find people who don't have genetic loading.

Dr. Pratt agreed and stated that people who have addiction tend to also manifest it through sexual activity. So a lot of sick people are procreating out there and creating more genetic loading.

Dr. Robbins asked how far you can go with genetics. Can you go as far as carbohydrate addiction?

Dr. Pratt stated that he draws lines. He noted that PET scans of gamblers look identical to PET scans of chemical users, and there are certain manifestations of sexual activity that could probably fall within the addiction field. Dr. Pratt stated that it's very well known that the president who preceded President Bush had two alcoholic parents, with a mother who ran a brothel. Generally speaking, you don't have that kind of background and not have a great deal of sexual disturbance downstream, irrespective of someone's IQ. That's the problem with addiction. It is not a cerebral cortical process. It's a midbrain subcortical process – that which drives craving, drives the activity. It's kind of like a bowel movement. After someone has had a bowel movement, he feels relieved and he doesn't feel like it's going to happen again, but it's going to happen again. You can be put into psychotherapy, or sent to a meeting every day for the rest of your life, but you're going to have another bowel movement or the urge to have one. However, if someone refrains from having one – and you see this in nursing homes all the time - they become obstipated, and then suddenly they don't complain about having to go to the bathroom. They lay there and begin to lose weight and they begin to die. The bottom line is that they were constipated, then obstipated, and then they no longer had the signal going. Addiction is kind of like that. If you don't respond to the signal over a period of time, the craving begins to wane. In addiction, you don't die if you don't use, but in other primary drive states, you do if you don't respond. If you don't respond to thirst, you die. If you don't respond to hunger, you die. If you don't respond to evacuation needs, you eventually die. That is the distinguishing feature. Addiction is a perversion of a normal drive state. There are neurophysiologic pathways that have been clearly defined. Where the genetics that define that liability are is not entirely clear yet.

Dr. Jones indicated that they have done human genome studies and they are doing studies at the NIH, trying to figure out which chromosomes, which alleles are changed in people with addiction. They're finding similar crossovers with people with mood disorders, eating disorders and things of that nature. To say that you're going to find a gene, it's not going to happen. You're going to find many genes that together increase the genetic loading. In genetic loading, the more you get of those genes, the higher your propensity to manifest addiction.

Mr. Schmidt stated that he would like the panel to focus on Board orders and how the Board should address this. He stated that one thing he believes he heard when discussing the PET scans is that four queens is about the same as a line of cocaine. Should the Board monitor gambling in its probationers? Could that reactivate addiction?

Dr. Pratt asked Dr. Sateren what he thinks about gambling, and whether he's monitoring physicians for whether they're doing any gambling while they are in recovery.

Dr. Sateren stated that currently he is not.

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Dr. Pratt asked Dr. Sateren what he thinks about physicians who are in recovery chemically, but then they're buying up \$5,000 to \$6,000 in lottery tickets and things like that.

Mr. Schmidt stated that the point is that if PET scans are showing the same brain activity from gambling as they show from active drug use, is gambling going to reactivate addiction to drugs.

Dr. Sateren asked, from a Board monitoring prospect, how gambling would harm patients.

Mr. Schmidt stated that what he's driving at is that if the Board has a recovering cocaine addict or a recovery alcoholic, and they have been diagnosed as also being a compulsive gambler, will gambling lead to a reactivation of the addictive process?

Dr. Pratt stated that the question that Dr. Sateren asked was whether it would harm patients. The question he asks, and which he believes the Board struggles with, is what is the right clinical thing to do versus what is the right legal thing to do. Dr. Pratt stated that it's always a difficult negotiation between what is the clinically appropriate way to look at somebody versus what is the legally appropriate way to look at somebody. What is the one drug that is comorbid with gambling, typically? Alcohol. You always have to ask yourself the question, what is the exposure pattern in the pattern of activity that people engage in. There's a much higher incidence of narcissism associated with gambling disorders. So you're also beginning to define personality disorder patterns based on activity because you have to pattern a behavior to get into a gambling mode, that again just says here are some things we need to look at.

Dr. Pratt asked Mr. Schmidt about the monitoring challenges he is struggling with in monitoring these individuals.

Mr. Schmidt stated it's not so much how the Board monitors as it is what it tells people. He remarked that Dr. Pratt told the Committee in February that the Board needs to give the probationer clear guideposts, clear guidance as to what's expected, and that will actually help them in recovery. The Board has long struggled with, for example, imposing stayed revocations. Very frequently when a practitioner is identified as chemically dependent, impaired, they're also identified as having committed felonies to obtain the drugs. Historically, a fairly standard approach to crafting an order in response to that is to impose a permanent revocation, stay that revocation, impose a suspension, followed by the provisions with which the panel is very familiar, go to treatment, get evaluations, go to meetings, etc.

Dr. Pratt asked what the typical ways are that someone garners a felony. Arrest with possession?

Mr. Schmidt stated that the Board considers acts constituting a felony.

Dr. Pratt asked whether diversion for personal use would be considered a felony.

Mr. Schmidt stated that the Board's grounds for discipline include acts constituting a felony. When someone steals a drug, that's a felony. The point is, the Board wrestles with what it should do with these

people when it sees them back when they relapse or there have been cases where the Board has documented that the physician is forging his A.A. meeting signatures, not really attending meetings. Relapse is the most serious one. But there is the desire to emphasize the importance of the Board's Order to our probationers. At the same time, there's that countervailing desire not to give up on somebody. After Dr. Pratt's presentation last month, Board members were questioning whether staying a revocation and then later giving them another chance is really doing the probationer any good and whether the Board is doing its other probationers a disservice by that. He stated that it's a tough question, because you don't want to give up on somebody, and you don't want to be unfair to them.

Dr. Whitney stated that it is a difficult question. Obviously there is a series of punishments or potential punishments or administrative actions that have been taken against physicians and other licensees from supervision to probation to suspension to stayed revocation to revocation. He tries to understand what it would be like to sit on the Board and try to make these decisions. Similarly, when he was looking at item number one on the agenda, as far as "say what you mean and mean what you say," initially his thought was, well, of course because in the field of chemical dependency you always call family members and say, "well, this is your enabling behavior and this is what you have to do in order to get your loved one into treatment and should relapse occur," but at the same time he began realizing that relapse occurs but not every relapse is like every other relapse. Someone who is being monitored, who has been through treatment, who is hit with divorce papers and a malpractice suit on the same day he files bankruptcy, goes out, gets drunk, the next morning calls his sponsor and notifies his monitoring physician, and goes back to A.A., gets a 24-hour chip, gets right back into recovery and follows regulations should probably be treated somewhat differently than an anesthesiologist who is later caught through a drug screen, who minimizes, denies and then later is found out to be diverting and lying about his addiction. That is a full-blown relapse as opposed to a lapse, which is an unfortunate and sudden use of chemicals, followed immediately by proper recovery activities. Dr. Whitney stated that he thinks anyone would agree that these two individuals should be treated somewhat differently.

Dr. Whitney stated that some of the difficulty is understanding the lapse and relapse process for those Board members who don't deal with these individuals on a regular basis. He thinks that having the entire range of possible sanctions available for the individual who had a momentary lapse that is understandable and unfortunate, and who was reevaluated by an addiction specialist who concurs that this was likely a momentary lapse and that the individual should be allowed to return to practice again, versus a full-blown relapse that should be followed by additional sanctions in order to fulfill the Board's obligation, which is to protect the public and make sure that an identified chemically dependent individual is not practicing under the influence of mood-altering drugs. Dr. Whitney stated that he's not sure that he can provide exact guidelines other than the fact that the Board probably is aware, and should be aware, that there are differences in the relapse process. The obvious goal of any treatment provider is to help the individual achieve indefinite, permanent remission of their chemical dependency and absolute and complete chemical abstinence from the moment they enter treatment to the moment they enter the grave, but they also know that at least 15%, and probably upwards of 25%, depending on the study that you read, of even recovering individuals are going to have either a lapse or a relapse, mostly in the first two years of recovery after treatment. Thus the necessity, initially, of the two-year monitoring plan. Dr. Whitney added that most states, and he strongly agrees with this, have extended this to a five-year monitoring program because the vast majority of lapses and relapses, if they're going to occur, are going to occur within the first five years following treatment. This extension to five years will give the public and the Medical Board a great deal of

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reassurance that with an excellent organization like OPEP being involved in the monitoring process, the great majority of lapses and/or relapses are going to be detected early on in the process. Not 100%, but certainly adding additional chemicals such as Fentanyl and Tramadol onto the standard drug screens, once these are identified as being a primary drug of choice or a potential drug of choice, if the drug screens are done randomly, witnessed, proper chain of custody and so forth, the great majority of people who lapse into chemical use are going to be detected.

Dr. Whitney stated that as far as sexual addiction, compulsive gambling, compulsive eating disorders and so forth being relapse triggers for chemical dependence, he stated that he doesn't think that anybody would disagree that these would increase the possibility of relapse occurring. Having been involved personally and professionally with the Texas State Board of Medical Examiners and the Arkansas State Medical Board, as well as the Ohio Medical Board, he can say that, from that perspective, the Ohio Board adheres more to the rule of law than any other Board to which he's been exposed. Dr. Whitney stated that he profoundly respects this Board for doing that. There are very little, if any, arbitrary decisions or personal decisions here. Dr. Whitney stated that he knows that there is an attempt by this Board to go by the rule of law. This is what the law states, these were the violations, these are the prescribed consequences. He commends the Board for doing that. At the same time he recognizes that there is a struggle – is felonious activity necessarily something that must be taken into consideration? Certainly it has to be taken into consideration, but diversion for personal use, while that can be taken as a manifestation of the addiction, certainly diverting for financial gain, essentially being a drug dealer, has got to be taken into consideration as a totally separate, almost certainly personality disordered and separate.

Mr. Schmidt stated that it is. He stated that the felonies that the Board really focuses on as raising the ante, raising the level of response, focus on either the personal gain angle or felonies where patients are harmed. There's the doctor who diverts from the office samples as compared to the doctor who puts on a patient's chart that he gave her so much of the medication when, in fact, the doctor gave the medication to him or herself. The Board will deal with the latter much more harshly than it would the former.

Dr. Davidson asked the panel how it feels about the comment Mr. Schmidt just made.

Dr. Whitney stated that, unfortunately, he feels that if the activity has gone beyond simple self-use, and prescription for self-use and diversion for self-use, to the point where it can and potentially would harm a patient, that has to be taken into consideration and probably dealt with more harshly than an individual who is drinking or solely diverting for their own use. That has gone into the bounds of violating the medical Code of Ethics, and that should be delineated as a separate, and probably harsher, punishment.

Dr. Pratt stated that there are a lot of physicians with addictions who are highly ethical. That's one of the things that needs to be said. What we're trying to differentiate is the unethical more than just addicted physician from the physician that is just manifesting addiction. Unfortunately, addiction doesn't run in good company.

Dr. Jones stated that addiction is a chronic illness. When she looks at addiction, she compares it to other chronic illnesses as a primary care doctor, that she treats for years, the whole patient's life. She will see lapses and full-blown relapses, such as a diabetic who totally goes off her diet, stops her medicines and she sees them in DKA in the ER. That is someone who has quit taking responsibility for her illness, quit

treating it appropriately day by day and has a serious, serious consequence. She doesn't punish those patients. She educates them, steps back and asks what's going on, what led to this, what can be done to prevent this from happening again, what can we learn from this? Of course, those patients obviously don't have the same implication for patient care, but that's how she looks at addiction. It's a chronic illness, it can relapse, but, as Dr. Whitney said, they want to do everything that they can to prevent a relapse and certainly there are degrees of relapse and degrees of total dishonesty where people hide everything and where someone says, "oh my goodness, these things were just overwhelming; I didn't use my support network like I should have. I didn't do X, Y and Z, but I know that I'm going to get much sicker if I don't stop right now." There is some allowance in the Board rules for folks like that.

Dr. Jones stated that she also has trouble looking at the Board monitoring things like gambling and eating, as far as impairment issues. When active, those things are also manifestations of someone's illness and can lead to relapse; but many, many doctors who aren't chemically dependent have compulsive eating disorders or gambling disorders, and they're not being monitored. She asked whether the Board was going to find a physician overweight and tell him or her that it is going to monitor him or her because he or she has manifestations of addiction. Dr. Jones stated that if the Board doesn't do that, it shouldn't do it, either for recovering physicians. She would be very afraid if the Board would tell physicians that it is going to watch if they gamble and turn in their lottery slips.

Mr. Schmidt stated that the reason he brought the question up in the first instance is that Dr. Talmage and Mr. Albert, as well as Ms. Bickers, the rest of the Board and himself, serve a monitoring function, and they are trying to make sure that they are asking the right questions of recovering people. He indicated that they have a fairly good sense of some things that are worth inquiring into. Mr. Schmidt stated that they typically ask about work, family, and a little about social activities; but they never ask if the probationer is out playing cards with the guys on Friday night. He stated that maybe they shouldn't be asking that specific question, but maybe they should be looking at other activities of the probationer. That's why the question arises. It's not to say that if you have a history of chemical dependency, you're not allowed to buy a lottery ticket.

Dr. Jones stated that the monitoring of those types of things, which are not clearly a danger to the public, should be left to the treating physician, the therapist, the people outside the Board. Dr. Jones added that she certainly understands that the Board asks, "how's the rest of your life going," because that tells how recovery is coming and how people are restructuring their lives and doing healthier things.

Mr. Schmidt stated that at the same time the Board has probationers who are done with aftercare, a few, even, who aren't involved with OPEP, but they really don't have much of a network or any network at all once they're beyond their aftercare. The Board has the whole gamut of people it has to monitor, and there are some where there's no one clinical or no one in the advocacy role that's doing that.

Mr. Albert stated that every month somewhere between 35 to 40 probationers come in for conferences. He stated that he, particularly, wants to know whether they have a job, whether they're going back into practice or have been looking for a job. He stated that he's worked with ex-offenders for 25 to 30 years, and he knows that that's the most important thing. Are they able to get malpractice insurance? They ask how the family life is. Mr. Albert stated that sometimes they get in a little deep, but they ask how the family life is, whether they have children, how they're getting along with their kids, what's the relationship

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like with the ex-wife. He commented that there was one doctor who came in and said he didn't have any children, but he and his ex-wife has shared custody of their dog. Mr. Albert stated that these are all important things towards the physician's recovery.

Dr. Jones said that she just means that the Board shouldn't put in writing that the recovering physician can't gamble.

Dr. Whitney stated that an untreated family and severe family dysfunction is one of the prime relapse triggers for any recovering individual, so asking those questions are right on target.

Mr. Albert stated that there are anesthesiologists that the Board took out of practice for four years. The Board still continues to monitor them during that time. It's important to know what they're doing while they are out of practice those four years.

Dr. Steinbergh stated that she believes that all of the Board members recognize that addiction is a chronic illness, and they adhere to the genetic disease model. Because of the Board's mission of public protection and its responsibility to the public, Board members are very pragmatic about certain things. If you take the physician who's spent all of these years of education, to do what he or she wants to do so very badly, and you know those responsibilities are, and you take an addicted physician, put that physician into treatment, under a Board Order monitoring this and that. Sometimes the Board wants to know why a physician can't choose to change his or her behavior so as not to relapse. If they can't, and the Board sees recurrent relapse, at some point the Board feels that it is its responsibility to say, yes, we recognize your disease, but we don't believe that it is consistent with appropriate medical care in the state of Ohio, and therefore we're going to permanently revoke your license, which is very difficult for the Board to do if it accepts that disease model and recognize that that person has a disease. Sometimes that disease is simply inconsistent with the practice of medicine, and the Board struggles then to make a decision on a particular day on how it comes to that point with that physician. Sometimes it's less difficult because there have been so many relapses or egregious types of action that make it a little bit easier for the Board to justify revocation. But that is the Board's struggle, and sometimes she wants to know why a person can't choose. What is so overruling, either in the brain or social manifestations, that won't allow that physician to choose, if he wants to practice medicine, recognize that he can't do both.

Dr. Jones stated that she understands that that's what the Board does, and, quite frankly, she would have a greatly difficult time making that final decision to revoke a license, but at some point you have to say that this isn't working, you're not changing, you're a threat to patients and your license needs to go. Dr. Jones stated that she understands that; she's seen it happen, and she thinks those choices have been very good because of the nature of the physician and the chronic relapses that risk public health. Dr. Jones stated that she has no issue with that.

Dr. Steinbergh stated that she wants to have her question answered. Why is it that they can't take control, take charge.

Dr. Parran stated that the data about the treatment of recovering physicians is not as strong as they'd like to see it. The research hasn't been as good as they'd like to see it; but it's still about as good, second only, probably, to the data they have about recovering airline pilots, and so it is still pretty good data compared

to recovering elementary school teachers or recovering librarians. They don't even have as good data about recovering clergy as they do about recovering physicians. With physicians, you see high recovery rates. Depending on the state that you look at and the quality of the study you look at, you see 75% with five-year sobriety rates, some will say there's even as high as 90% with five-year recovery rates. They know that if a person is sober after five years, they have an overwhelming likelihood, between 90% and 95%, of not relapsing ever again in their life. Dr. Parran commented that that's great, because if not, the Board should just go ahead and revoke because why should it extend the waiting period.

Dr. Parran stated that the factors that predict whether a person will fall into that minority that don't do well are very difficult to identify from the literature, but the strongest one is a psychiatric dual diagnosis, especially a psychiatric dual diagnosis that's been missed. As a non-psychiatrist working in the addictions field, the addictions field, in general and historically, until relatively, recently has tended to say that everything was the addiction until a person has been sober six to twelve months, and then maybe we'll talk about whether you have another psychiatric disease along with this. He stated that, when you're playing with high stakes, like the Medical Board with apples and a limited number of bites, that's not appropriate. Fortunately, the addiction field has moved over the last 15 years, perhaps, certainly in the last ten years, to much more of a comprehensive assessment of people. Dr. Parran stated that he has been actually surprised that a fair number of licensees he has been monitoring with OPEP, and whom the Board has also monitored, have had a series of relapses and then someone stumbled to a bipolar diagnosis or a major depressive disease diagnosis that tends to exacerbate. As soon as that was being treated along with the addictive disorder, he's seen people do exceedingly well for a long period of time.

Dr. Egner asked whether, when Dr. Parran talks about this other diagnosis, he means either one of the Axis 1 and Axis 2 diagnoses.

Dr. Pratt stated that addiction is Axis 1 and a mood disorder is Axis 1. He informed Dr. Parran that he earlier noted that, unfortunately, psychiatry has kind of confused the issue, too, and they have always looked at addiction as an underlying something. Or addiction is a self-medication problem.

Mr. Schmidt stated that a lot of psychiatrists with whom the Board deals still look at it that way. They don't understand that it's a primary disease.

Dr. Pratt stated that it's a co-occurring process on Axis 1.

Dr. Egner asked whether the majority are co-occurring.

Dr. Parran stated that he would say that it's not in physicians.

Dr. Jones stated that it is higher in women physicians.

Dr. Steinbergh stated that the Board sees so much of it. When the Board sits and hears some probationers, they think that this is not just a chemical dependency. This guy has a problem, and maybe somewhere down the line another diagnosis will come up. Why can't that diagnosis be reached sooner?

Dr. Pratt stated that back in the days when there were some really solid treatment programs, these folks

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would come in, there would be a thorough chemical history and thorough family evaluation, and for a long time there was some very good neuropsych testing. They had a pretty solid awareness that, unfortunately, they didn't know what to do with. Dr. Pratt stated that when he did his fellowship at DePaul, they did psych testing on everyone, and the beauty of all that was that they had a very clear characterization of people who had addiction, addiction co-occurring with some other mood disturbance, and personality disorder pathology. They could also get a fairly good understanding, because they followed these people longitudinally and would repeat testing on those folks, as to who had personality regression. In other words, because of their addiction, because their personality regressed to a more adolescent stage of behavioral acting out, what have you, what people had that based on just the addiction versus what people had a solid personality disorder co-occurring with their addiction. The ones that were retested got better, and some didn't get better at all. If you follow them over time and do appropriate testing, you can see the ones who are changing from the ones who aren't changing.

Dr. Pratt stated that when he had his first psychological testing profile in 1983, you couldn't be sure whether he was just an angry little boy who needed to be spanked from a narcissistic personality disorder. He was retested two years later by the same individual, who wondered what happened with him. There were elements now of vulnerability, uncertainty, basic human developmental conflict that was beginning to show up in the testing. He was retested at five years and it didn't even look like the same test he took in 1983.

Dr. Pratt stated that if we're monitoring people, we need to objectify the data. Psychological testing data is pretty objective, we just don't do it anymore. Dr. Pratt added that he doesn't know why they don't do it anymore, but he thinks it's cost more than anything else.

Dr. Whitney stated that he thinks it has been cost. At Shepherd Hill the threshold for psychological testing is dropping on a daily basis. What they have seen in people who have relapsed and returned to treatment is the presence of an Axis 2 diagnosis, but, periodically he will see an Axis 1, major depressive disorder, bipolar disorder, is so frequently involved in the relapse that 100% of relapsers, and now an increasing number of individuals coming in for their first treatment, his threshold for getting psychological testing is dropping in order to address this group that the Board struggles with as chronic relapsers. Dr. Whitney stated that they actually have a separate software package now that has dramatically dropped the cost, so that they can now get psychological testing virtually in a day.

Dr. Steinbergh asked whether it was a cost reimbursement issue.

Dr. Whitney stated that it was previously. Now, because the cost has dropped, essentially what they're doing is that they can take the psychologist out of the loop and go directly to the software package that spits out the diagnostic package selected at an extremely low cost. It's no more than a couple of drug screens.

Dr. Steinbergh asked Dr. Parran to continue with his statement.

Dr. Parran stated that it must seem to Board members that everybody who relapses has a dual diagnosis, and that's because there are a couple of levels that people have to fail before they often wind up before the Board. A typical physician with addiction who gets identified might well get reported to OPEP and get

popped in for an evaluation, and then be given a consent agreement and go to 30 days of residential treatment, and then when the residential treatment's over, do an intensive outpatient program in their area, and stay sober, and be monitored for three to five years by OPEP, and the Board doesn't hear about it. Then there's a person with a little more rocky course than that, but the facts of their case don't quite reach the threshold of being a person that has to be reported to the Board. Then there's the person who has a little more rocky course than that, and it just does reach the threshold, they get reported to the Board, it generally gets taken care of within the Board's monitoring committee, it's a consent agreement with an initial meeting and then quarterly meetings, and the Board still doesn't hear about it. By the time it gets to the full Board, he would suspect, as often as not, that it's pretty ugly, and it's a very selected population. Using a full-Board hearing as a screening test for chemical dependency is kind of like using a brain CT scan for carcinoma of the breast.

Dr. Steinbergh stated that the full Board does see everyone in a consent agreement and the Secretary and Supervising Member sees them after the initial report, but the Board does see the monitoring reports every month. She stated that she still wants to know whether anyone thinks that a person can take control of his or her disease and make a choice as to whether he or she will relapse or not.

Dr. Parran stated that a person can clearly take control of their disease or diseases each day.

Dr. Steinbergh asked whether they can make a choice not to relapse.

Dr. Davidson asked whether you can choose not to have diabetes.

Dr. Parran stated that a person can take control of their disease each day; they can make that choice for today.

Dr. Jones stated that it's a daily commitment.

Dr. Pratt stated that, in a real simplistic way, it's kind of like a design. If you can imagine "this" as the progression of addiction, and "this" as the deterioration of choice, there's a point there where there is a line where compulsion and damage exceeds one's ability to have choice. The goal of treatment is to get back behind the line to where the damage is such and the compulsion is such where the choice returns. Dr. Pratt advised that people say, "isn't it a choice, don't they choose to be an addict?" Dr. Pratt stated that the initial exposure to any chemical, gambling or sex is a choice, but there's a point where the compulsion, the cognitive impairment, the psychosocial damages, the emotional hits that one takes in the process of this dysfunction pushes people beyond this arbitrary line out here where the choice no longer exists, because that which outweighs choice is stronger than what the individual would have to summon to say no. What has been lost by not being able to differentiate different people in treatment and by not having a differential approach to how long somebody should be in treatment through the proper evaluation of their neurocognitive status, their family scenario, their Axis 1 conditions – whether there's just one or they have comorbid problems – is a thorough evaluation so that we can individualize these situations and see where they are relative to that line of choice.

Dr. Steinbergh stated that, somewhat like dementia, they can't do it.

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Dr. Pratt stated that they can't do it, but he's had people who sat in Shepherd Hill back in the '80s, when he was there, who would show up purple as a pumpkin and are now actively practicing, are sober and are doing well. There is a point where neurocognitive capability for many of these people will return, but there are some people who won't return.

Dr. Steinbergh asked what makes it return.

Dr. Pratt stated that abstinence is the key..

Dr. Whitney stated that time also makes it return.

Dr. Jones added that healthy exposure to other healthy people also makes it return.

Dr. Pratt stated that neurophysiology is one of the slowest responders to change compared to any other organ in the body.

Dr. Whitney stated that that is a very important point. Referring to Dr. Steinbergh's questions, Dr. Whitney stated that there definitely is a point beyond which the disease progresses and the power of choice is lost. However, following adequate treatment and adequate preparation and diagnosis of other comorbid conditions, then the individual regains the power of choice to continue to take the actions to keep their disease in remission. If they are not taking the action to keep their disease in remission, then eventually, and it might be days, weeks, months or years, they will then lose the power of choice. Their compulsion to use chemicals will become so great that they have lost the ability to choose. The choice must come before this line in order to continue the activities, taking their medications, going to recovery meetings, going to individual therapy, working with the sponsor, spiritual recovery program, physical health and exercise and so forth. If these actions are not taken on this side of the line, then they cross that line and the choice is lost. Monitoring individuals' recovery activities is a very valid point, certainly for OPEP and this Board to be convinced that the individual is taking the actions necessary to stay on this side of the line.

Dr. Whitney stated that another point that is very well taken, and what they see at Shepherd Hill on a continuing basis, is that one of the advantages of he has at Shepherd Hill is time. He has an individual who is going to be at Shepherd Hill for almost always a minimum of ten weeks under close supervision. That's a luxury. He has those individuals being monitored by counselors, peers and himself, and if, necessary, a psychiatrist or individual counselor. They have the luxury of having them in time for their abnormalities of brain and body chemistry to begin to normalize, which clearly does not happen over night or in the first two or three weeks in the great majority of circumstances. Brains that have been awash in Fentanyl, alcohol, marijuana, cocaine, benzodiazepines and combinations thereof are not going to clear in the first three or four weeks after treatment. Again, the luxury they have is having people under their close supervision for ten weeks or so.

Dr. Pratt stated that it's also safe to say that you ought to know their chemical use history to know who's going to clear quicker.

Dr. Whitney said that there's no question that a complete chemical use history, of which you get the tip of

the iceberg on the first day and the rest of the iceberg becomes clear in time.

Dr. Pratt stated that people who have been using benzodiazepines for five and ten years will take a lot more time than somebody who has confined his or her use to Fentanyl.

Dr. Whitney agreed, and stated that, obviously, someone who has been drinking a fifth a day of Jack Daniels for twenty years is not going to clear anywhere as close to somebody who has been drinking a six-pack a day for the last ten years and gets a DUI. Time and abstinence are key factors, which is why they make the strong recommendation that the great majority of physicians that come through Shepherd Hill, after they complete treatment, not return to full practice, usually for an additional three months. They recommend that these physicians go home, work their recovery plan, attend aftercare and Caduceus, and they will be seeing their monitoring physician so that they have additional time for their brain and body chemistry to begin to normalize. There's not a magic number, but time builds on additional insurance that people have at least had time to get their thinking straight, and can also clarify whether this is bipolar or cocaine, alcohol and marijuana simulating bipolar, or is it both. Trying to understand and make an accurate diagnosis within the first three weeks or so when someone enters treatment, you're going to get all sorts of wild psychological and psychiatric findings that can clear within the first three to six month of time. Dr. Whitney stated that he wishes that there was a magic number or magic answer, but there is none because they have to individually assess patients with this disease as in any other field of medicine, but time and abstinence is so critical.

Dr. Davidson asked whether Dr. Whitney ever feels that there's a length of time that is too long. She noted that the Board has been taking anesthesiologists out for four years.

Dr. Whitney stated that he struggles with that. He stated that one of the few papers that has been published specifically on anesthesiologists was done by a Dr. Gallegos, Dr. Talbot and others at Talbot Recovery Center, and he tends to use these criteria and have had anesthesiologists, specifically in every category: Category 1 – can return immediately to practice, accepts and understands their disease, bonding and regular attendance at 12-step recovery meetings, healthy and strong family support, committed to a contract of recovery, balanced lifestyle (they have a spiritual recovery program, they have hobbies, and they have physical exercise), no presence of comorbid psychiatric disease or severe personality disorders, and good treatment experience in their program. These individuals, despite the fact that they're anesthesiologists, who are over-represented in the physician chemical dependency community, can return fairly promptly to the practice of anesthesia. A high proportion, or all of them, should be on Naltrexone, and obviously all of them should be monitored.

Dr. Whitney stated that Category 2, who he recommends stay out of the operating room and not handle operative anesthetic drugs until a reassessment at the end of two years, include those who have relapsed, family dysfunction is still present, not really truly bonded in a twelve-step recovery community, are attracted to anesthesiology because it is an enjoyable practice and not because of drug access, their skills in recovery are improving, they still have some impediments to recovery, but not severe, and there's still no severe comorbid psychiatric illness. Those individuals should be taken out for two years and then reassessed prior to reintroduction to the operating room.

Dr. Whitney advised that those who should completely be taken out of anesthesia and retrained in another

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field, have prolonged intravenous use (using more than six months before treatment), multiple relapses after treatment, initially or currently attracted to the field of anesthesiology because of drug access, severe psychiatric or personality disorders, shown inability to follow their OPEP monitoring contract, poor involvement with twelve-step recovery meetings and severe family dysfunction. He advised that those individuals probably should be permanently taken out of anesthesia and retrained in another field.

Dr. Whitney referred the Board to Dr. Talbot's book, *Healing the Healer*. There's a separate published 1987 study from Dr. Gallegos and Dr. Talbot. Hopefully they have some guidelines that the Board can use. He stated that he has personally used these guidelines, and has had anesthesiologists in all three categories. He found that those that really demonstrate strong bonding in twelve-step accept their disease, especially those anesthesiologists who have not used Fentanyl, but had alcohol as the primary drug of choice, can do really well.

Mr. Albert stated that the Board spends a lot of time considering how much punitive time out it should impose.

Dr. Whitney stated that he personally feels that punitive should probably be for severe patient harm and for criminal activity. Punitive action just for being chemically dependent can be counterproductive. We recognize that you have a disease, we recognize that you were raised in an alcoholic home and have a strong genetic influence, but we're going to punish you by restricting you from practicing and allow skills degradation and have to struggle to make a living and feed your family – purely punitive actions for being chemically dependent can be counterproductive.

Mr. Schmidt at this time stated that he would at this time like to allow Dr. Jones to speak on an issue she's wanted to discuss, and then take a brief break.

Dr. Jones stated that what she wants to talk briefly about is her own experience, having went through Shepherd Hill 18 years ago, a totally different direct, totally different program, when addiction was looked at as the only disease you could have. She was the first woman physician there, and the only woman physician there. She was put into a male program of confrontation and abuse. The treatment center was actually led by people who were not in good recovery. The direction coming down was not the healthiest.

Dr. Jones stated that she had some serious psychiatric problems before that. She had been hospitalized and was doing well. When she entered Shepherd Hill, she was taken off of her antidepressant and told her that her problems were only addiction, and any problem she had then was drug seeking. Therefore you don't tell people. After being there for four months, she took a bottle of 250 aspirin, went to a motel to die, wanted to die, and ended up calling friends from a halfway house to come get her because she didn't want to die alone. Her funeral was planned. She woke up after three days in a coma with some serious complications, still wanting to die. At that point she got psychiatric care and then had to lose everything she had, her practice and everything, which was very painful. It took a while to get a proper diagnosis of a severe mood disorder that currently requires four medications, and she does fine. Dr. Jones stated that she didn't have those four medications when she needed them 17-18 years ago.

Dr. Jones stated that it took several years of seeing some different people, and lots of psychotherapy, lots of support, lots of A.A., good sponsors, good support, and the Board advocated for her. Dr. Cramblett was on

the Board, and he knew her from medical school and advocated for her to get on the staff at Riverside Hospital to do addiction medicine. Dr. Jones stated that she had very pleasant experiences, once she got over the fear of coming before the Board. The Board actually was a positive experience for her. She didn't need an attorney, she just said, "tell me what you want me to do and I'll do it." Dr. Jones stated that she didn't want to die, probably about two years later. Proper diagnosis is the key to treating any illness, and when you have blinders, like you did 18-20 years ago in the addiction field, where addiction is here and psych is here, and they don't talk to each other, people died. Doctors died. Dr. Jones remarked that she believes that in the addiction field they have learned that their patients have a higher incidence of comorbidity, and they have to look for it very carefully. She watches her patients like a hawk, meets with them on a regular basis, watches them in Caduceus, she talks with them, but they need to be able to be open with her if they're having psychiatric problems that she can treat aggressively as soon as they come up. Dr. Jones added that she doesn't want another physician to go through what she did. That's her commitment to what she is doing.

Dr. Jones indicated that she is very happy to say that what happened to her is no longer the case with what happens at Shepherd Hill, and hasn't been for a long time, with Dr. Karaffa having been there and Dr. Pratt's short term there. The thing is that they were very hard on women's physicians back then. They made her do daily witnessed drug screens for six months when she went back to work. She stated that one can imagine the stress that that put on her life. That was because the Medical Director interpreted her contract from the Medical Board and told her in no uncertain terms that she was not to call the Board and ask what they really meant. Now she is allowed to call and ask.

Mr. Schmidt indicated that the screens were to be done once a week, but if you called and asked, that would be considered not following good orderly direction.

Dr. Jones stated that you weren't even allowed to have rights as a patient or human being to question what was happening. Dr. Jones stated that they've come a long, long way in treating people. Physicians have special needs; they have a hard time accepting help. Physicians have a very hard time admitting that they have problems, because they're supposed to be the healers. The Book, *Healing the Healer*, is an excellent book. Dr. Jones stated that her personal experience has taught her the severe consequences that can come to someone who is not properly diagnosed psychiatrically. Dr. Jones stated that she does dual diagnosis herself, and has for a long time, and she insists on doctors getting close follow-up for psychiatric problems. She had a physician recently who came in, and they thought that he was a hyper guy and that this was the way he had always been. He used to use cocaine, but most recently it was something else. Dr. Jones stated that she thought he was really bipolar. He went home from their outpatient program, came back, and there was no question that this gentleman is bipolar. He had burned some bridges by his hypomanic behavior. She's now treated him with Depakote and the man is doing great. It took some time to sort through what was going on with him, but he's now a totally different person, after a six-week period of time. There was a lot of resistance; he did not want to believe that he had a problem. He still doesn't like the diagnosis – it takes time to accept those things. It takes time to accept your chemically dependent, it takes time to accept your bipolar or whatever it is, but you have to be persistent with requiring the person to follow treatment, and eventually, hopefully, the patient will accept his or her problem and be totally responsible for caring for it.

Dr. Jones stated that she commends the Board on close follow-up of physicians and for assisting physicians

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with direction and the right tools. Attending meetings and other requirements the Board imposes are the things that work. Those are the things that give a high success rate. The requirements are in the aftercare contracts, OPEP has them, and the Board has them. They all reinforce the same things that work for doctors, and there are people who don't make the choices when they have a choice that will keep them healthy. It's not just their practice – they will usually lose everything, which is very sad, but she doesn't want them to be her doctor. The reality is that if she says someone is going to be a physician, she has to ask herself whether she would let that individual be her anesthesiologist when she has surgery.

Mr. Schmidt commented that he believes most of the Board members have asked themselves that question.

Dr. Jones stated that, if she can't say yes, the Board shouldn't say yes.

Mr. Schmidt stated that, before the Board takes a short break, he'd like to note that the Board's rule for evaluations actually does require a neuropsych assessment. That's been in place since 1990, and was written by Dr. Pratt in 1987.

Mr. Dilling at this time said that the Board would like to take advantage of the panel's wisdom while it has them here, so he'd like to keep the break to about five minutes. He stated that he did want to clarify one issue. The Board does not intend to be punitive towards somebody for their chemical dependency. He said he hasn't seen that historically and he doesn't see it now. Dr. Davidson's question could be rephrased to say, "if we discipline somebody for longer than a two-year period of time, or longer than the time needed to protect the public or get them back into proper treatment, are there any studies or anything showing that that could be detrimental to their recovery.?" The Board is faced with cases where there is a mixed bag. There is the chemically dependent doctor who has done some egregious things, and the Board feels and the public feels that they need to be punished for that. There is constant wrestling with this problem. In the four-year case, the person wasn't being taken out for four years because he or she is chemically dependent. He or she was taking drugs from other patients, doing things so egregious that the Board struggled whether they should be taken out of practice permanently. The Board wants to salvage that physician, if possible. Mr. Dilling stated that, rather than look to the panel towards what that ultimate punishment should be, the Board is looking to the panel towards setting up some better understanding of aggravating and mitigating circumstances in each case, with varying fact patterns. Mr. Dilling remarked that he thinks that the Board does a really good job, but he thinks the Board is looking to take that next step and perhaps try to get, not only the Board, but the people who report to the Board – its approved providers, answering the same types of questions, heading to the same direction, and how does the Board best do that. He asked that the discussion be tailored toward that end after the break.

The Board at this time took a brief break.

Dr. Bhati left the meeting during the break.

Mr. Dilling stated that the Board had originally budgeted time from 8:00 a.m. until 11:00 a.m. today to discuss matters, answer some questions, and maybe sum up some thing and move on and get some answers. He noted that this meeting is a follow-up to the October 2003 retreat, which was attended by some of the panel members. Mr. Dilling stated that he appreciates the panel coming today, and suggested that, if they're able to stay, the Board may continue this discussion past the 11:00 time.

Mr. Dilling advised that one thing with which the Board is struggling is that it will send letters to Board-approved providers, saying that it has somebody, these are the very basic facts, and the Board needs the provider's opinion back. Some opinions are more detailed than others, and the Board doesn't get some answers. Staff might question why they aren't getting answers, or why they aren't getting answers in a certain way. Mr. Dilling stated that he would like to get some idea from the panel about the questions the staff should be asking, other than the statutory question of whether or not the physician is impaired in their ability to practice. Mr. Dilling stated that that's a big question. How far should the Board delve into why the physician committed a certain act, or where they were on Dr. Pratt's chart in terms of whether it was their decision or whether they had no other choice because of all these other factors. Mr. Dilling stated that the Board needs to try to get all these providers on the same page. He noted that Dr. Parran has visited the Board before and has said that "what we ought to be getting to into the future is maybe only having three or four places that do the evaluation and everybody else treats from that evaluation, just because the evaluation part is so important." He asked to start the discussion with how important that initial evaluation is. When the Board rule requires neuropsych testing, he'd like to know what that means legally. What is the Board getting back? Is it getting back the computerized MMTI, or is the Board getting something consistent back? He asked Ms. Gilbert if that is what the Board is seeing down the line in terms of being able to rely on from a consent agreement or even the Board orders.

Ms. Gilbert stated that she would say that it's a pretty inconsistent part of the evaluations. In fact, there are times when that's something that the staff has to go back and say that this wasn't done at all in any psychiatric component. Ms. Gilbert stated that frequently what the staff sees is that they answer the question, "is this person impaired," usually toss in a diagnosis, and sometimes that's where people stop. As far as crafting a consent agreement or order to go forward with this person, it's not a great deal of help. Ms. Gilbert stated that she talked with Dr. Jones recently about an impaired anesthesiologist situation that the Board had, and what a tremendous help her report of evaluation, a return to practice evaluation, was. Dr. Jones acknowledged that she understood that the person was an anesthesiologist, and she found that the person can return to practice, even as an anesthesiologist, and then gave a laundry list of well-thought-out criteria for monitoring this individual. It wasn't a cookie-cutter recommendation. Dr. Jones thought about this person's history, treatment, status in recovery, what the individual is returning to, and what the individual will be able to be effectively monitored under. Those kinds of things, from the Board's perspective are extremely helpful. But the report on the specific psych evaluation was weak.

Mr. Dilling stated that part of that may be the Board's burden, as well. He acknowledged that the staff may not be going back and being forceful enough to say, we haven't met this. Mr. Dilling suggested that the staff may not know what the providers' capabilities are and how far the Board should be pushing this.

Dr. Parran stated that, when dealing with physician assessments, initial physician evaluations, it's very high stakes. It's a little less high stakes in Ohio since Ohio adopted a mandatory 30-day residential stay, because at least that's not on the table. A physician who shows up knows that they have to go to a Board approved program, and they have to do at least a month of residential treatment. Dr. Parran stated that he believes that the initial assessment is really important, and he knows that some treatment programs outside of Ohio that specialize in treating physicians have gotten themselves in some deep water by being the assessment facility and the treatment facility, and having, at least what looked to a court of law over time like there was a cookie cutter assessment; i.e., if you were a physician, you got the long treatment, and if

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you weren't, you didn't, and if you didn't accept the long treatment, you weren't compliant with your treatment plan and therefore you were reported back to your Board and got yanked. Dr. Parran stated that he thinks that it is an ethically problematic issue. He's not saying that a treatment program that provides treatment for recovering physicians in Ohio or from outside of Ohio and also does assessment can't do it and can't do it ethically, but he thinks that it is something that, as a Board, if Ohio mixes assessment providers with treatment providers in the same pot, he would think that the Board would want to be looking at the assessments that come out and looking for variation, and fairly broad variation, depending upon the level of pathology that goes in.

Dr. Pratt stated that he thinks that the Board should be fundamentally concerned with the various layers in the individual that comes to the Board. The first layer is whether the organism functions properly. In a neuropsych battery, you should get a sense of one's cognitive capability, one's dexterity, and the ability of the brain and the body to work in synergy together. You will have a lot of procedural specialties presenting here. If you have neurocognitive impairment, which can affect how one thinks and how one makes judgments, how flexible one is under stressful circumstances and whether they have impacted dexterity, what you're really trying to determine is whether this organism works. At the next layer, let's say you have somebody that has a clean neuropsych battery. He's an anesthesiologist and his neuropsych testing is such that, technically, they would be able to intubate; technically, they would be able to put in a J line; technically, they'd be able to start IVs; technically, they'd be able to dial in the right gases. That's one layer.

Dr. Pratt stated that at the next layer is their MMPI, their personality function. Does that person's neurocognitive brain integrity then work effectively with their emotions to function as a human being? A human being is more than just a technical organism, and so you want to know, relative to the personality disorder piece, if this person has an intact body, and then does he have an intact emotional world that has him functioning appropriately as a human being. Then, once you determine that, you go to the next step, which is knowing their neurocognitive integrity and their emotional environment. Are they then capable of acting on the recovery guidelines that are set down for them. That's where Dr. Parran is coming from when he says that the Board should be getting differential data back. Not everybody is using the same drugs in the same way and the same pattern.

Dr. Pratt stated that when you put it all together, the questions that will come to the Board will come in four basic boxes: what is their addiction remission status; what is their Axis 1 position, other than addiction; what is their Axis 2 position; and then what is their family and legal circumstances? Those are the big four boxes as he sees it. Dr. Pratt stated that it would be nice if the Board could look at somebody and say, "you know, I see that you have a histrionic personality disorder. What are you doing about that?"

Mr. Schmidt stated that when the Board does have that history on probationers, it does ask that question.

Dr. Pratt stated that when he puts "family" and "legal" in the same box, he thinks frequently when somebody comes to you and you start asking the family questions, there are going to be issues of the affected family member and the legal manifestations of that in divorce, financial problems that the home has, the wife is now under the stress of a \$50,000 treatment bill. Dr. Pratt commented that Mr. Graff was asking about issues of orthopods who are paying \$15,000 a month in malpractice fees who are then pulled out for four months. If this person has intact neurocognitive capability and intact emotional stuff and they're doing the right recovery things, does the Board need to pull their license for an arbitrary or

consistent similar amount of time? Dr. Pratt stated that what he's hearing Mr. Dilling say is can this Board go to another level of doing differential assessments and differential recommendations for different kinds of doctor problems that come to the table, but then do it in an orderly manner. Do it in a manner that shows consistency and a consistent application of the law.

Dr. Whitney stated that there is a difference between psychological testing and neuropsychological testing. There's been a lower and lower threshold for obtaining psychological testing that will yield good data for Axis 1 and Axis 2, but the neuropsychological testing is much more involved and detailed and requires a neuropsychologist to administer and are much more hand/eye coordination, memory specific parts of the brain oriented, which he personally uses selectively because not all individuals who arrive really need the expense and time involved in neuropsychological assessment. Dr. Whitney stated that, in a perfect world, all patients, but certainly all physicians, would get neuropsychological testing, but the time and expense involved with time, and he was asked the question about cost of treatment, in an attempt to struggle between time, duration, cost and accurate assessment, the Board has not or only selectively required neuropsychological testing, but, he thinks, reasonably expects psychiatric evaluation, oftentimes including psychological evaluation yielding that Axis 1/Axis 2 information.

Dr. Whitney continued that, with regard to the reports to the Board, he would be, and has been, contacted previously, saying, "okay this is great, but we would also like some additional information," because sometimes he includes their recovery plan, which includes specified numbers of recovery meetings, ongoing psychiatric care and so forth. Anything that is required, requested or would like to have in a specific letter from himself as medical director, he'd be more than happy to expand into a four-page letter. He tries to attempt to summarize as to not overwhelm, but he's hearing that more information is better than less information, and he could certainly comply with that. Dr. Whitney stated that he has not in the past included copies of reports from the psychiatrist and the psychologist, but, again, those can and will be included if they will be specifically helpful to the Board. What he likes to do is take that information and summarize. If there's essentially little that needs to be done with it, then fine, but if that's additional information that the Board would find useful to make the determination, any or all of that can certainly be included. If he is very comfortable with recommending an individual return to work, he feels that a shorter letter is fine. With someone he has real concerns over, more information will be more useful.

Dr. Whitney stated that briefly touching on the 72-hour evaluations, at least at Shepherd Hill, when an individual is found to be diagnosable as abuse or dependence, then they're informed and given a copy of the Board regulations, saying that they need to be in a Board-approved treatment program within 48 hours. They are not told that they must stay at Shepherd Hill and complete its program. They're given the list of approved providers and are told that they can pick any of these that the Board will approve, but once the individual starts treatment at a facility, it will have to follow that treatment provider's recommendation.

Mr. Schmidt asked whether you can use their selection of a treatment program as a tool to determine whether they have made a self-diagnosis. If they decide to go elsewhere, does that give an indication that there's a greater likelihood that they're not yet with the program?

Dr. Jones stated that she's there to assess the appropriateness of the diagnosis and what this person needs, but she's also there as a physician to try to help them. She tries to build a good, solid rapport. There are times when people come in in such horrible denial, obviously they have a problem, it's just that they're the

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only one that isn't seeing it. They get angry, and it would not be unusual for them to maintain that anger and you couldn't work through that in the 72 hours that you have them to establish a rapport. They're angry, and they don't trust you, but trust is a key when you're treating people. They might want to go elsewhere. Dr. Jones stated that she always tells them that they don't need to stay at her facility. She gives them a list of other places they can go, and indicates which of the other approved providers have strong programs, such as Shepherd Hill.

Dr. Steinbergh commented that sometimes they just need a second opinion.

Dr. Jones agreed, and added that that is often offered. If the patient doesn't agree with her, that's fine, let's get another opinion. What she has found is that doctors who have come to her for assessment have stayed. Some may have gone home for a few days – and in the case of a recent physician, had surgery – but will come back, and that's because you build rapport with a patient and they trust you. Some people have so much denial and so much anger that they have to put it somewhere, and it comes out on you. You're the person who delivered the bad news; "you're the person who's disrupted my entire life." Dr. Jones stated that she had a patient who recently told her that. They're angry, and they're really angry at themselves and their disease, but you're the person in front of them, telling them that "you've got to change your life, you've got to do this, you're going to have to come out of work, you're going to have to make arrangements for people to cover your practice, you're going to have to do all these things;" and you get to be the deliverer of bad news, which actually, in her respect, it's great news. We can treat them and help them to get better, but they're angry, and that's a natural, normal response to being told that they have a serious, chronic, lifetime illness that can kill you and you don't want it. No one wants it. No one wants to be an addict or diabetic for that matter, and so they're angry, and they might choose to blame the assessor and choose to do treatment at another facility. Dr. Jones stated that it depends upon the skills of the people in the treatment team as to how well they can get beyond that anger, educate, try to break through the denial, so that maybe even in 72 hours they have done some self-diagnosis and are beginning to open a little bit to see that they are sick and maybe they should get help. Dr. Jones stated that it's an individual thing. She's had some doctors come back to treatment, and she knows that they hate her, but as they work through their process of self-identifying that they're an addict and that they need to make changes, and they see other doctors at Caduceus who felt the same way but who are doing well now, they decide that maybe they should give it a chance. Eventually, the rapport is reestablished. Dr. Jones stated that she wouldn't think that it was unusual to go someplace else, and certainly they always have the choice.

Mr. Schmidt stated that he asked the question because when the Board first promulgated these rules in 1990, it added to the material that had been put together by treatment providers and O.S.M.A. the requirement that physicians diagnosed as impaired be given the option to get their treatment from any Board approved provider, based on the reputation that a couple of providers had of holding a gun to people's head, to require the patient to get his or her treatment from that provider or else. The Board thought the requirement made sense, but what they were told at the time was that it did create a possibility of people running from treatment, essentially, running from the problem. He added that the Board hasn't found that to be a big problem, and it's good to hear that the providers are complying with the rule and don't find it to be counter-therapeutic.

Mr. Schmidt at this time noted that Dr. Fred Karaffa has also joined the meeting. Dr. Karaffa is a family practitioner/addictionist in Newark-Granville. He has been the medical director of Shepherd Hill, and has

had long involvement with OPEP, and he's on faculty at Ohio State University, where he was teaching this morning. Dr. Karaffa has actually spoken at investigator seminars and helped the investigative staff and the Board attorneys understand, when you're investigating impairment issues, what you should be looking for and ways of intervening and dealing with these situations. Dr. Karaffa has been a long-time help to the Board. Mr. Schmidt asked Dr. Karaffa to join the discussion if he feels that he has input for the Board.

Mr. Schmidt recognized Dr. Sateren at this time.

Dr. Sateren stated that he believes this meeting this morning is extremely valuable, and he's grateful to be invited to be a part of it. With respect to talking about anesthesiologists, Dr. Sateren stated that he believes that the comments made are basically about opiate-addicted anesthesiologists, and he'd like to hear some comments on the pure alcoholic anesthesiologist, and how they would be dealt with, either differently or the same.

Dr. Jones stated that she believes that they're very different scenarios. She stated that she has had several anesthesiologists who are alcoholic go back to work without difficulty. Alcohol is a drug where, if that's the only drug you do, you're less likely to relapse. If you're into opiates and have easy access, your likelihood to relapse is much, much higher and can be fatal. She doesn't worry so much about alcoholic anesthesiologists, but she also knows that they can switch drugs. They could start taking something else, so they have to be watched very closely. The alcoholic anesthesiologist doesn't provoke to her as much worry or concern as an opiate or a sedative-addicted anesthesiologist. They're going to be triggered when they walk into the OR. That's where they got their stuff. They're going to be triggered when they walk in. For an alcoholic anesthesiologist, that's not where they got their stuff. They aren't going to be triggered immediately to start thinking about using when they walk into an OR.

Mr. Schmidt asked Dr. Jones what she means by "triggered."

Dr. Jones said cravings. The disease has biological, physiological things. People have reflexes, and the disease, addiction, is in the lower part of the brain where all the other instincts and drives are. There are things that trigger people. They see it and they immediately think of a positive response to using that chemical.

Dr. Pratt stated that if someone is using cocaine in New Albany in their \$5 million mansion, he might tell them to sell the house, and they'll say, I can't do that. He'll tell them that they will either sell the house now or lose it later, and they all lose it, because cocaine incorporates the carpet, the wallpaper, the smells, the flowers, the furniture, everything. When they go into a treatment center, they've never used in that treatment center, so they say to themselves that they're never going to use again. But they've never done it there, and as soon as they go home it's like walking into a big blow. Consequently, a lot of people with specific drugs have to move. Certain anesthesiologists have to move out of the OR.

Dr. Parran stated that his concern with an alcoholic is that alcohol has some big league brain effects in terms of functioning. Wet brain syndrome from alcoholism is very real, and anybody who's been to medical school and has done third year rotations in hospitals knows that. With the alcoholic anesthesiologist, he's really worried about cognitive impairment and abilities to function as a doctor. With the opiate addicted anesthesiologist, he's not worried about cognitive impairment in terms of motor skills

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and such. There's a full professor at Cleveland State University, a department chairman, who has been on methadone maintenance for 28 years. Dr. Parran stated that he's not worried about opiates causing that kind of impairment. He's worried about that physician being in the OR with the keys to the candy jar without Naltrexone in his belly every day he goes to work for the next five years.

Dr. Pratt stated that that comes back to the neuropsych testing component.

Dr. Whitney stated that, in general he believes the panel all agrees that the triggering for the Fentanyl or opiate addicted anesthesiologist is the key worry, whereas less so for an alcoholic, as far as specifically the triggering effect of walking into the operating room.

Dr. Pratt stated that there are a lot of things that can be done. He noted that at the Mayo Clinic they monitor both Naltrexone and Antabuse. The anesthesiologist walks in and before he even puts on his scrubs he drinks his Antabuse or swallows his Naltrexone and then he goes and passes whatever he passes.

Dr. Talmage noted that the Board is starting to use saliva screens now. He asked whether there would be a point where the saliva is tested before the physician goes into the operating room.

Dr. Jones stated that that's what she's been doing with some of the doctors.

Dr. Talmage stated that he understands that that is good for alcohol but not yet good for the opioids.

Dr. Pratt stated that Fentanyl has such a narrow window and others are even worse.

Dr. Parran stated that he's not real worried about the Fentanyl when the anesthesiologist is going into the OR. He's worried about the period while the anesthesiologist is in the OR.

Dr. Whitney stated that the saliva test in the morning for the alcoholic surgeon and anesthesiologist could be an excellent tool for reassurance of the operating room crew and the hospital staff.

Dr. Talmage stated that the Board has used that once so far and it seems logical.

Dr. Parran stated that recovering people will like it. People who aren't really in that mentality won't.

Dr. Jones commented that she's the one who brought up the saliva testing to the Board because of the QED and some of the other tests that have come out that are very, very accurate. Being a point of service, you have an answer before they even work. She stated that she tells the doctors that it is in their advantage to keep a log because a malpractice carrier or a patient hears that he has trouble with his license, he's a perfect sitting duck to be sued and to lose almost every case, just because you're recovering. They're going to question how the physician can prove that he didn't drink or use drugs and screw up. She tells the physicians that if they have that record, they at least have something evidential that someone can look at and say that the physician wasn't drinking that day.

Dr. Kumar asked what the turn-around time for the saliva test is.

Dr. Jones stated that it's immediate. It's a point of service test, meaning that it's done right now and you get results right now.

Dr. Whitney stated that it's like a breathalyzer.

Dr. Jones stated that it's just as accurate.

Mr. Schmidt asked whether this will become available for other drugs.

Dr. Jones stated that saliva is good for alcohol.

Dr. Steinbergh asked how the test is performed.

Dr. Jones stated that there's a swab used to take the sample, and it will turn. She stated that one of the DOT regulations is that they like people to be trained in giving the test. There's a computer course that takes a couple of hours to be "certified" in administering this test. But it's not much different from a pregnancy test. It doesn't take a lot of brains to do the saliva test, any more than a urine dipstick. You could do those at point of service, too, but you miss drugs like fentanyl and methadone. You're going to miss a lot of drugs. Some of the hydrocodone, such as Vicodin, don't show up on certain screens.

Dr. Steinbergh asked whether the testing is highly sensitive and reliable.

Dr. Jones stated that saliva is for alcohol.

Mr. Schmidt stated that one of the topics the Board wanted to talk about today is Trexan. He stated that there might be a couple Board members who aren't familiar with opioid antagonist therapy. He asked Dr. Parran to address that topic.

Dr. Parran stated that about 20 years ago they developed naloxone, or narcan, to reverse opiates in a person who has an unintentional or intentional overdose. In about 1985 they rolled out an oral form of narcan called naltrexone. It's been marketed as Trexan and ReVia. It has a pretty long half-life. Once a person has been taking it for five days at 50 mg a day, it provides very good blocking of any opiate, even for anesthesia purposes, for at least 24 hours and probably 48 hours. It's got a low side-effect profile. There are some reports of elevated liver function tests associated with it, but most of the actual literature around the elevated liver function test was from the early 1980s when they were trying 200 to 400 mg doses a day in heroin addicts to see if you could give them a huge dose once a week and it would be good for a week. Most of the elevated liver function tests at that time were elevated alkaline phosphatase and bilirubin, looking at more of a sludge kind of picture rather than really a hepatocellular injury kind of picture. It's actually very well tolerated and has very low side effects, and the data on it, in terms of using it with recovering opiate addicts, is that it doesn't work except in two populations: recovering professionals, where someone has them by the license; or criminal justice populations where someone has them by the probation officer. It doesn't work because people don't take it. It works rather well when people do take it to minimize slips or initial use, to block initial use turning into a full-blown relapse.

Dr. Parran commented that the A.A. Big Book talks about "urges" to use and then it talks about "cravings."

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The “cravings” they talk about in A.A. is the overpowering urge to use again, after you’ve used the first time. “The man takes the drink and then the drink takes the man,” if you have addiction. It’s that first use of the mood altering drug that triggers the changes in the brain that brings on this overpowering urge to continue to use and results in a binge and a full-blown relapse. If a person’s on Naltrexone, and they use some opiates, they fire a blank. Nothing happens. To some extent there’s mixed literature about Naltrexone with alcoholism, but at least it’s mixed, meaning that there are several studies indicating that it works pretty well, and there’s one large VA study, multi-center study, with as many participants in it as all the rest of the studies combined that said it didn’t work any better than a placebo.

Mr. Schmidt asked whether it blocks the effects of alcohol or the euphoria.

Dr. Parran stated that it’s unclear. Things are up in the air about Naltrexone and alcoholism right now, although many physicians are still prescribing it to people who are repetitive alcohol relapsers, thinking that it may have some helpful effects.

Dr. Jones stated that she has seen it have helpful effects with some patients.

Dr. Parran stated that he also seen it with some patients, but if you do a literature search and you sit down with the person who does the critical analysis of the medical literature at your medical school, the person will say it’s not clear whether it’s worth giving it to people. More studies are coming out all of the time, and most of them are positive. But in terms of opiates, it’s clear that, for the first three months, six months, maybe a year, when a person with opiates as a drug of choice, having them on observed administration of Naltrexone has no downside and has a significant upside.

Dr. Whitney stated that it may actually reset the receptors and make them less likely to having craving over the long haul.

Dr. Parran stated that it may, and added that, when it comes to alcohol, he would say that having people on observed administration of Antabuse for a relatively short period of time, three to six months, has very little downside, and a fair amount of upside as long as they’re appropriately monitored.

Dr. Whitney added that the Board and the patient need to understand that this is not in place of recovery efforts, it’s in addition to recovery efforts. This needs to be reinforced. The pill isn’t going to make you well, it’s extra, added insurance. Seeing the individual take his or her Neltrexone can also give OR personnel, the Medical Board and others an extra degree of reassurance that the individual is okay today, and probably for the next couple of days because of its prolonged half-life. Dr. Whitney added that the two subgroups, at least at the meetings he attended on Naltrexone and alcoholism, that seem to benefit the most are those with a very strongly positive family history and those with recurrent intense cravings. However, overall, as a subgroup, he’s still very selective on those to whom he prescribes it.

Dr. Whitney continued that the side effects he has found to be periodically problematic and possibly in line with the literature are dysphoria, i.e., mild depression, as well as sleep disturbance and nightmares, sometimes to the point where he actually has to discontinue it, so it’s not a completely benign medication. There is also the theoretical possibility that an individual will be in a motor vehicle accident or fall down and have a fracture, require opiates for legitimate pain relief and have a blocker on board. Those are all

things to factor into the equation, but he would agree that there is much more of an upside than a downside.

Dr. Parran stated that it tends not to be used.

Dr. Davidson stated that a minority of the Board agreements include that requirement. She asked whether that was because the evaluator didn't recommend it. Can the Board require it if the evaluator doesn't recommend it?

Dr. Whitney stated that, should the Board require an extra level of reassurance on a given individual and requires it, so long as there's a physician willing to prescribe it and all the indications and contraindications are discussed, he would see little downside to it.

Mr. Schmidt asked whether the Board has used it in a non-anesthesiologist case.

Several Board members indicated that it has.

Dr. Davidson added that it's not been used consistently. The Board has had some pretty major hydrocodone orthopods.

Dr. Parran stated that he would strongly recommend it. He added that he believes pharmacotherapy is something the Board should seriously consider in anybody with opiates as a drug of choice.

Dr. Jones stated that if you have a person who is alcoholic with serious liver damage, she would not put the patient on Naltrexone. It's a clinical decision.

Dr. Egner stated that she doesn't think that it's the Board's job to make that decision. It's the medical management of the patient, and that's not what the Board's role is.

Dr. Parran stated that it may not be the Board's job, but he would suggest it. He stated that the treatment community in Ohio has, in some ways, led the world in recovery. It's called twelve-step. The treatment community in Ohio, in some ways, is way behind treatment communities in other parts of the world in pharmacotherapy, using other medications as an adjunct to the management of addiction treatment. It would be appropriate for the Board to ask the treating program to specifically address whether pharmacotherapy is recommended. Dr. Parran stated that he would guarantee the Board that there are many Board-approved programs that never think about pharmacotherapy, just because they never think about it because their granddaddy didn't think about it. It's not the way it is everywhere anymore; it is the way it was everywhere 20 years ago, but it's still the way it is at a fair number of programs that are on the Board's list. Dr. Parran suggested that if the other programs just thought about it, they'd probably think that it's a pretty good idea.

Mr. Albert asked how long you can keep someone on Antabuse.

Dr. Parran stated that you can keep them on it as long as you monitor them appropriately. If you have selection criteria so that you don't put a person on it that shouldn't be on it in the first place, and as long as you monitor them appropriately, they can be on Antabuse forever.

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Dr. Pratt stated that the question with Antabuse is another one of liver function monitoring, but the other issue with that is whether or not the patient can tolerate an Antabuse reaction.

Mr. Albert stated that the Board has a probationer on Antabuse who has passed the time he could be taken off it according to his Agreement, but he doesn't want to stop taking it.

Dr. Parran stated that as long as the liver function tests are okay, and the person can tolerate a bad reaction if he got one, it's okay to stay on it for a long period of time. Antabuse is generally a fear-based intervention. You don't drink because you're afraid you'll get sick, at least initially. Fear is a pretty good motivator of human behavior change for about two weeks or two months. It's a good motivator for the short term. If fear was a good long-term motivator of human behavior change, syphilis would have died out centuries ago; and it did pretty well until penicillin came along. Dr. Parran stated that he thinks Antabuse can be very helpful, especially in a relapser, who's doing lots of the other stuff, but early on.

Mr. Schmidt stated that, concerning Dr. Egner's comments about it not being the Board's place to treat, at the same time the Board is deciding whether to return an anesthesiologist to anesthesiology, and what the Board is hearing is that they should only be returned with Trexan if opiates were the drug of choice. If you have a situation where you have someone the Board got because they were passed out under the operating table with Fentanyl or Sufentanyl in them, and the Board has returned them to the OR with an agreement that requires Trexan, and then they have a reaction or liver problems and they can't take the Trexan, where does that leave the Board? Does the Board let them stay in the OR, or does it take them out? The Board mandating Trexan, although it's a treatment decision, it's also a decision about the circumstances under which the Board will allow the physician to go back into the OR.

Dr. Egner suggested that they shouldn't go back into the OR. Then the Board doesn't have to worry about the physician taking the drug.

Dr. Jones asked whether the Board is going to make a hard and fast rule that no anesthesiologist can go back to the OR. She stated that she doesn't think that it can.

Dr. Karaffa expressed concern about the emphasis on anesthesiologists since, statistically, primary care doctors in the form of family doctors and internists have caught up to them as far as impairment is concerned, and there are certainly a lot more of them than there are anesthesiologists. Dr. Karaffa stated that the issue shouldn't be narrowed down to anesthesiologists, although they are certainly the people with their fingers on the triggers, medically speaking.

Dr. Karaffa stated that there are Boards in this country that demand that all physicians be on Trexan when they leave treatment, and that's just a common practice. To avoid the Board feeling like it's practicing medicine, he would see no difficulty in writing a rule for physicians that they be on Trexan when they leave treatment, no matter what their specialty is, if medically indicated. That takes the Board off the hook right there because if someone is not medically able to take the drug, they shouldn't take it. Dr. Karaffa stated that he thinks that there is merit on having people on Trexan. The Board wants to be careful about putting a time limit on it, and let that simply be between the treating people and the patient, rather than having the Board involved in it.

Dr. Robbins asked whether there are providers who would disagree with that.

Dr. Karaffa stated that he's sure there aren't.

Dr. Robbins asked why it is not routinely ordered, if providers agree that it is appropriate.

Dr. Karaffa stated that the drug was around for quite a while and basically ignored. It was used simply to give to people for detoxification. It wasn't used properly initially and it developed a bit of a reputation. It was basically ignored. Now that they're finding that, even though it's a questionable concern about using Trexan and alcohol, whether it's really beneficial or not, he's had patients who ran out of Trexan that were alcoholic and came back and said that they had to have more Trexan because their cravings have just jumped something fierce. Dr. Karaffa stated that it may be a placebo effect, and placebo effect doesn't last long term, but he does think that it's a drug that has been neglected, and now it's really coming into its own.

DR. STEINBERGH MOVED TO REFER THE MATTER OF REQUIRING THE USE OF TREXAN TO THE BOARD'S CONSENT AGREEMENT COMMITTEE FOR RECOMMENDATION TO THE FULL BOARD. DR. ROBBINS SECONDED THE MOTION. All members voted aye. The motion carried.

Mr. Poczekaj stated that the diversion program of the California Board did a five-year study with anesthesiologists, and it was published in the *Journal of Psychoactive Drugs* in 1991. The summary states that California's experience demonstrates that they have an equal chance of recovery and contradicts the pessimism about recovery in anesthesiologists. The New Jersey program also did a retrospective study, and, again, they stated that their analysis showed most statistical significance between the two groups, namely anesthesiologists and a control group. He added that there's a lot of interesting information on the American Society of Addictionologists website that the Board might find pertinent and helpful. One of the things that was introduced to him on that website is that they discuss the differences in reported relapse rates and they asked questions concerning differences in definitions of relapse, duration of follow-up, and the intensity and effectiveness of treatment given. Mr. Poczekaj stated that that might be something that needs to be considered, also.

Mr. Schmidt stated that one question he wants to make sure is covered before the meeting adjourns is whether or not there are other tools the Board is missing. Mr. Schmidt stated that he has read a lot about acupuncture, for example, being used, and he has no idea whether it has any efficacy whatsoever. Are there other pharmacologic tools, other aversion therapies, blocking therapies or other therapies about which the Board should be aware that the Board isn't using.

Dr. Jones stated that there is a newer therapy out, suboxone (buprenorphine with Naltrexone), which she has been prescribing, and she understands that Dr. Parran is prescribing, and she has been quite amazed with the difference in recovery rate with her opiate addicts. Before she started using it, she rarely had an opiate addict who truly finished her whole program and didn't relapse. Now she has people with ten years of recurrent relapses, multiple treatments, losing everything, that have nine months clean, who are happy, going to meetings, have their life together, working. Suboxone doesn't tend to make people euphoric.

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There's a ceiling effect on the ability to make people high. It's an agonist/antagonist, and she is very much in favor of that medication and she uses it a lot. She uses it for detox, short term, long term and maintenance. She has people on nine months maintenance doing extremely well. They have their lives together. Function is what you want to see come back in people's lives. You want to see them be able to be a part of a family, go back to work, those types of things, and they're doing it. It's been a miraculous medication with which she has just been amazed. Dr. Jones stated that, as far as she knows, the Boards have not dealt with whether a physician with opiate addiction can take Suboxone and return to work. That's something to look at.

Mr. Schmidt stated that the question has certainly been discussed, although not have been dealt with, and this was pre-suboxone days, whether a physician on methadone maintenance can be returned to practice.

Dr. Jones stated that they're not the same drug.

Mr. Schmidt stated that he understands that one is a pure agonist, and the other is mixed, but it's a variation of that and it has not come forward. He added that there's a lot of uneasiness about returning a methadone patient to practice. Should that uneasiness exist if they're on suboxone or subutex?

Dr. Jones stated that she doesn't think so.

Mr. Schmidt asked what they do cognitively.

Dr. Jones stated that you're basically putting a buprenorphine as an opiate, so you're hitting the receptor sites that stop cravings and withdrawal symptoms. Then you have an antagonist. The patient doesn't get high. The drug itself has a ceiling on it. It's amazing, even depression lifts, dysphoria lifts. Dr. Jones stated that she sees nothing but good things coming from this medication. She sees a very quick return to function, a very quick return to work, family. They don't crave; they don't have drug hunger all of the time so that they can work their recovery program. Dr. Jones remarked that you have to have a special DEA to write this medicine. She added that she has been very impressed with this medicine with non-healthcare professionals, and she sees it totally different from methadone. She stated that she doesn't prescribe methadone, is not a big fan of methadone, but that's been the number one treatment of opiate addiction in this country for years. What she's hearing through ASAM and various other things is that suboxone is working well for patients, and why wouldn't you offer a medication like suboxone to, especially, an opiate addicted anesthesiologists who can walk into the OR and not crave and not be drug hungry and just do their job? She stated that she doesn't have any literature or research on this.

Dr. Whitney stated that that is the only drawback. There really isn't enough data and research specifically in health professionals for this Board.

Dr. Jones stated that, from her experience and from what she has seen, it's a tremendous medication.

Mr. Schmidt stated that some Board members are aware that Dr. Parran and his partner, Dr. Chris Adelman, have made an offer to the Board, if the Board has an interest at some point, to come do a presentation, because they have put together a course. You have to have a federal waiver, and part of getting that federal waiver is a minimum eight-hour course. Dr. Parran has such a course in which he's

involved in teaching. He and Dr. Adelman has volunteered to do a presentation for the Board if there's an interest. Mr. Schmidt asked that Board members who are interested should contact either Mr. Dilling or him.

Dr. Karaffa asked whether Dr. Jones has had any experience with withdrawal from this drug.

Dr. Jones stated that she has, but it's minimal compared to heroin or something like that. She stated that some people want to be totally drug free. She commented that, to her, that's the old mentality that this is not a real disease and there's no medicine that can help. She stated that this is a real disease and medicine can help. What she does is taper them slowly, and tell them that if you start having these symptoms, and she has a scale for them, call me or let me know and we'll slow the taper. Most of my patients have thought about tapering, and have tried initially and then come back and said, "my wife will kill me if I go off this medicine because I am doing so well." She stated that she has had threats from wives that they will come find her if she takes their husbands off the drug.

Dr. Jones stated that she had a lady who may be going to jail, she has a hearing coming up, and she was worried because they don't give medications in jail. She's very stable; she's bipolar and is very stable on her medications. She was afraid when she showed up for court last Friday that they would put her in jail, which would mean that she would be cold turkey off suboxone. Fortunately, they didn't put her in jail and she's still on suboxone, and now she's worried about her next court appearance. All her issues have to do with addiction, possession, and things of that nature. She's doing great in recovery, but that fear of being cold turkeyed in jail is there.

Dr. Jones stated that she doesn't have any doctors currently taking the drug, because she doesn't know what the Medical Board will do.

Mr. Schmidt stated that this is a fairly new issue for the Board. One thing of which the Board needs to be aware is that its rules are abstinence-based. They are A.A. model rules, which is not to say that they shouldn't be changed, but the rules as they stand now require total abstinence.

Dr. Parran commented that this is a Schedule 3 drug.

Mr. Schmidt stated that that may be something that the Board really needs to take another look at. He added that at the time the rules were written by the O.S.M.A. Committee under Dr. Pratt's leadership in the 1980's, you had a few people doing rational recovery and ending up in prison, and you didn't have anything other than the A.A. model and the total abstinence model that seemed to work, at least in this country. He understands that in Europe and Britain there is a different model, but he's also been told by a number of people that their model, the idea of returning users to social use of alcohol for example, doesn't work. The idea of abstinence, as a basis, made sense when you didn't have this partial agonist that wasn't going to cause euphoria, other than maybe the first time you try it – and a small amount even then, if at all – and it's use, but it's not use. Mr. Schmidt stated that we're in a different world than we were when the rules were written.

Dr. Jones stated that medical science has come a long way since A.A. in the 1930s, and she recommends A.A. for all patients, across the Board. It works, it's always worked, it's the best thing they have.

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Dr. Jones added that they do run into trouble when people who are on methadone or suboxone go to meetings and let people know, "oh, I'm not sober," and she tells them that, yes, they are sober. The person is under the treatment of an addictionist who is educated in medicine and has a medication that may help you stay alive. Opiate addicts don't do well. Why wouldn't you use a medication that doesn't make them high, doesn't alter their judgment, but takes away their drug hunger so that they can function and have a life.

Dr. Jones commented that it's obvious that she's a big proponent of this medication. She has seen such wonderful results from the majority of her patients. But they can't use it instead of their recovery program. It allows them to do their recovery program. If they think that that's going to be the magic bullet, they're going to relapse.

Dr. Steinbergh asked how long she keeps them on the drug.

Dr. Jones stated that you can do maintenance, and how long can you do maintenance?

Dr. Steinbergh asked whether this isn't just transferring dependency to another.

Dr. Jones stated that she doesn't think so because of the antagonist property of the drug. The patient isn't getting high. Methadone people go up and up and up and up because they can get a higher and higher effect. With this, there's a ceiling of just feeling well.

Mr. Schmidt stated that Dr. Pratt mentioned earlier the concept of resetting the opioid receptors. He asked how suboxone maintenance impact on that.

Dr. Parran stated that it's unclear. Suboxone is basically buprenorphine, and buprenorphine has been around for a long time. It was originally marketed as a "super morphine;" .3 mg of buprenorphine given IM after an operation would be equal to 7 mg of morphine given IM. Buprenorphine mg for mg is 20 times more potent than morphine. But the old injectible drug of it was Schedule 5. So you've got this drug, which is 20 times more potent from a pain relieving standpoint, that's schedule 5, so it's a weird drug. It's also got a really long half-life. Dr. Parran stated that they don't really know how long the half-life is, because they haven't given radio-labeled drug to people and seen how long it took them to clear it, but it has a very long half-life. So here you've got a very potent opiate that delivers very little euphoria, has a very long half-life, and has a higher receptive affinity than morphine.

Dr. Parran stated that he had a couple of patients with addiction who loved Demerol. They were in the hospital, beating doctors out of Demerol shots, and they asked for an addiction consult. Dr. Parran said that he advised that the patient be switched to buprenorphine. Unfortunately, they switched them to buprenorphine 45 minutes after a Demerol shot. When the patient was at the peak euphoria of Demerol, they popped him with buprenorphine, and what the patient experienced was a sudden lessening of the euphoria, and they said, "oh, man, I'm allergic to that." On the other hand, if you wait for six hours after the last Demerol shot and give them the buprenorphine, they say, "it's not my Demerol," and they're told that that's all they'll be given, and they say, "okay." Because it does relieve pain very effectively. It's a funny drug.

Dr. Parran stated that NIDA (The National Institute on Drug Abuse) has been studying the drug for about eight years to see if it could be a substitute for methadone maintenance. Dr. Parran stated that he wants to be very clear about what the goal of the drug was. It's a substitute for methadone maintenance. It's an opiate maintenance program. The question is, is it safer than methadone? The answer is yes.

Buprenorphine has a ceiling effect in terms of its respiratory depressant effects. So if you give "x" amount of buprenorphine to a patient, you get a certain amount of respiratory depression. Just like morphine, if you double the dose, you get doubling of the respiratory depression; and not like morphine, if you increase the dose by four times you get a flattening of the respiratory depressant effect. If you increase the dose by eight times you start breathing faster. At low doses it looks like a full mu agonist, at middle doses it has a plateauing effect, and at high doses it has the opposite effect of opiates. The FDA's not worried about people overdosing on it, like with methadone, and dying.

Dr. Parran continued that the next question was whether it takes away drug hunger. Is it good enough to keep people who have opiates as their drug of choice from using opiates. The answer is yes. It takes away drug hunger just as well as methadone. The last question is whether there's unlimited tolerance to this drug, like there sort of is to methadone to some extent. Everybody who is on suboxone and buprenorphine, all the several thousand patients across the country right now, every single one of them are on between 8 and 24 mg a day. A few of them are at 28 and 32, nobody is on higher than 32 mg a day. So it seems like a certain dose just kind of takes care of everybody; whereas with methadone, the doses are all over the place.

Dr. Pratt stated that, again, there is a strong tendency with addiction to tunnel down on addiction as the only problem. Not only do you get into these abstinence models and so forth, but you begin focusing all of your attention on addiction, and you forget that this person carries other things along with them. Another way to look at buprenex, if it were to become more acceptable to a group wondering whether they want a doctor out their practicing on this stuff, that's the big question, one way to look at it is if you think about buprenorphine silencing one of the boxes to allow you a better look at the other boxes that he talked about – do they have other comorbid problems that come along with addiction? Do they have a personality disorder that comes along with addiction? – if you quiet down the addiction piece and some of these other boxes start looking fairly normalized, that's going to answer some questions for you. In other words, you can use it as a differential tool, as well. Now we don't question whether somebody's differential tool is Prozac, when we look at the box of mood disturbances, but the Board has sanctioned folks who have come to the Board for mood disorders, and Dr. Pratt knows a few of them. They get similar consent agreements, but the stigmatization is not in the box of mood disorders and personality disorders as it is with the addiction box.

Dr. Steinbergh stated that's only if they're dysfunctional. if they're impaired in their work. Certainly there are a lot of physicians who are on drugs for depression and so forth that there's no reason for anyone to know about. The Board goes into consent agreements because someone makes a complaint to the Medical Board, the Board has investigated, and it feels that it needs to do this for public protection.

Dr. Pratt stated that part of the reason he brings this up is that he thinks that among opioid users are two rather distinct groups; and within the physician population, opioid utilization is seen, to a strong degree, in the generalized anxiety disorders, including panic disorder and the obsessive compulsive personality disordered physician. These are people that, when they take an opioid, they wake up. In other words, an

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anxious obsessive compulsively driven bald little anesthesiologist looks much better on opioids than he does off of them because a lot of the anxiety goes away. Then, though, what you need to also look at is that there's a high utilization of opioids within the antisocial population. That's where a lot of the data that is coming from methadone and buprenorphine programs, they're looking at what this is doing to the antisocial personality disorder. It would be criminal to lump those groups together and say that the antisocial street addict is the same creature as the physician creature who's been using opioids as well. Dr. Pratt stated that there may be some fundamental differences in subsets of the neurophysiology. Addiction is a neurosystems abnormality, but different people are endowed with different receptor populations. The dysphoria that you see with naltrexone probably has a lot to do with different people get different clumps and clusters of signal receptors. Dr. Pratt stated that his mother is a good example – you give her morphine and she's psychotic, and she has a huge population of signal receptors that just can't take the stuff. Her son is different.

Dr. Pratt stated that 1986 was a big year; Dr. Karaffa was a young fellow under a new doctor who had just arrived at Shepherd Hill and was really involved in smoking cessation; Dr. Sateren was a critical care doctor who just discovered computers at Mt. Carmel; Doug Graff was a very quiet member of O.S.M.A.'s Impaired Physicians' Committee; Dr. Jones was still trying to figure out if she was crazy; Dr. Parran was born sober and never had a problem in his life; and he and Dr. Adelman had gotten together. That was when the Ohio Society of Addiction Medicine was born. They wrote the constitution and got that thing all put together. Dr. Pratt stated that he then disappeared. Dr. Pratt stated that they sent some suggestions to a young Medical; Board attorney, who was vigorous and evangelical about how to get some consistency brought to the Board in terms of these recovery issues, which then sort of got incorporated as Board rules. Part of what was happening at that time – and this is probably what got him in trouble at Shepherd Hill – he was at O.S.M.A. saying that there should not be one provider in town. People who are impaired in Cleveland should probably recover in Cleveland. People who are impaired in Cincinnati should probably recover in Cincinnati. In Columbus, it should probably be a local treatment center like Shepherd Hill. That didn't go over well with his board, which, at the time consisted of a fellow named John Walton Wolf, a Supreme Court Justice named Craig Wright, and most of Vorys, Sater, Seymour and Pease. Dr. Pratt advised that he was trying to get away from this idea of arm-wrenching people into treatment. Dr. Pratt stated that many have gone through the Talbot three-day evaluation and six months later the three days are up. It was a real interesting time. There were all kinds of activities going on. It's been a dramatic time, and the beauty of this is that, besides Dr. Parran who has been sober forever, there are about sixty years of evolution on the panel. He's amazed at the consistency of what they are all saying, because he doesn't think it would have been that way 15 years ago. He doesn't think they would be having open, rational discussions about buprenorphine. It would be emotion, and this is more collegial. Dr. Pratt commended the Board on its evolution over time. The Board interviewed him when he first came to Ohio in 1987. It's been a long walk.

Mr. Schmidt noted that it is 11:12 a.m., and indicated that at least one of the panelists will need to leave relatively soon. He invited those who are interested to stay around if they had more comments and were able to stay to answer more questions. He did thank all the panelists for taking the time today to come and help the Board. He added that he truly believes that this has been one of the better discussions the Board has had of impairment issues. Mr. Schmidt stated that he believes everyone present has found the discussion to be enlightening, and the panel is to be congratulated for taking the time out, and for coming in so early.

The Board recognized the panel with applause.

Mr. Albert stated that he believes everyone on the panel has greatly contributed to the success the Board has had. Both the Board and the staff are grateful.

Dr. Jones thanked the Board. She commented that this wouldn't have happened 15 years ago, or 5 years ago. Having everyone speak openly and people listening and processing is great. She thanked the Board for asking her to participate.

DR. STEINBERGH MOVED TO ADJOURN. DR. EGNER SECONDED THE MOTION. All members voted aye. The motion carried.

Thereupon at 11:14 a.m. on March 11, 2004, the March 11-12, 2004 meeting of the State Medical Board of Ohio was duly adjourned.

We hereby attest that these are the true and accurate approved minutes of the State Medical Board of Ohio, meeting on March 11-12, 2004, as approved on April 14, 2004.

Anquetette Sloan, President

Anand G. Garg, M.D., Secretary

(SEAL)

