BEFORE THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

STATE OF GEORGIA

IN THE MATTER OF:	*	
	*	
JOHN SAVINO, M.D.	*	
	*	
	*	**DOCKET NUMBER: 20070069**
License No. 17424,	*	OSAH NO.: OSAH-CSBME-PHY-0723505-24-HOWELLS
	*	
Respondent.	*	

FINAL DECISION

An Initial Decision in the above-matter was entered on November 16, 2007, and docketed by the Board on November 26, 2007. Neither the Board nor the Respondent has requested a further review of the Initial Decision. In the absence of an application to the agency for review of said Initial Decision, or an order by the Board to review said Initial Decision on its own motion, said Initial Decision becomes the Final Decision of the Board by operation of law, pursuant to O.C.G.A. § 50-13-17(a).

FINDINGS OF FACT

The Findings of Fact entered by the Administrative Law Judge in the Initial Decision are hereby adopted and incorporated by reference herein.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the Administrative Law Judge in the Initial Decision are hereby adopted and incorporated by reference herein.

ORDER

The Order entered by the Administrative Law Judge in the Initial Decision are hereby adopted and incorporated as follows:

1.

Respondent's license to practice medicine in the State of Georgia shall be placed on probation for a period of five (5) years commencing on the docket date of this Final Decision, until discharged by the Board, with the following terms and conditions:

(a) Respondent shall submit to the Board a fine of one thousand five hundred dollars ($1,500.00) to be paid in full by cashier's check or money order made payable to the Board within sixty (60) days of the docketing of this Final Decision. Failure to pay the entire amount by the sixtieth (60^{th}) day shall be considered a violation of this Final Decision, and shall result in further sanctioning of Respondent's license, including revocation, upon substantiation therof.

(b) Respondent shall complete twenty (20) hours of continuing medical education ("CME") in Bariatric Medicine and three (3) hours in Medical Record Keeping. These hours shall be in addition to the normal hours of CME required for license renewal for all Georgia physicians. Prior to obtaining CME, Respondent shall submit the title of the course(s) he plans to attend and information concerning the course(s) to the Board's Medical Director for approval. Respondent shall submit proof upon completion of each course to the Board within eighteen (18) months of the docketing of this Final Decision.

(c) Respondent shall use a triplicate prescription system for all controlled substances prescribed by him. Each prescription for such a controlled substance written by Respondent shall be sequentially numbered and the copies distributed as follows: original to patient, one copy to the Board, and one copy to the patient's chart. Respondent shall not begin renumbering when he reaches 1000, but shall continue to

number sequentially. The copies for the Board shall be mailed or delivered to the Board by Respondent once per quarter.

(d) Respondent shall personally maintain for inspection a contemporaneous log (separate from his clinical records) of all controlled substances prescribed, administered, dispensed, or ordered by him. The log shall include the date, patient name, drug, strength, quantity, and refill status, on a form approved by the Board. The log shall include the diagnosis and the reasons for prescribing, administering, dispensing, or ordering each drug. A copy of the log shall be mailed or delivered to the Board by Respondent once per quarter. Additionally, the Board shall be authorized to inspect Respondent's log at any time. If Respondent's log fails to comply with the requirements of this consent order, the Board is authorized to summarily suspend Respondent's license, pending a hearing.

(e) Prior to prescribing, administering, ordering, or dispensing any controlled substance, Respondent shall detail fully the examination performed and the diagnosis reached in the particular patient's file. Respondent shall specifically record all physical data of the patient and detail the exact nature of Respondent's evaluation of the patient. In addition to this requirement, Respondent agrees to comply with all current record keeping requirements of the Board.

(f) Respondent shall not be eligible to petition for termination of probation until three (3) years from the effective date of this Final Decision. At such time, Respondent may petition for termination by certifying under oath before a notary public that Respondent has complied with all terms and conditions of probation and by providing documentation supporting discharge from probation. The Board shall review and evaluate the practice of the Respondent prior to lifting the probation. At such time, the Board shall be authorized to restore all rights and privileges incident to the Respondent's license, unless the Board finds that Respondent has not complied with the terms of this Final Decision or has otherwise failed to comply with the laws and rules

regulating the practice of medicine. Should the Board determine that reasonable cause exists for maintaining Respondent's license on probationary status, the Board shall notify Respondent of its intent to extend the probationary status, and Respondent may respond to such notification in writing or request an appearance before the board or its representative as in a non-contested case. In any event, this Order shall remain in effect, pending a final determination by the Board and notification that the probationary period has terminated.

2.

This Final Decision shall be considered a PUBLIC REPRIMAND of Respondent by the Board and may be disseminated as such.

Said Initial Decision having become final by operation of law, this Order is hereby made the Final Decision of the Board.

This 24th day of January, 2008.

COMPOSITE STATE BOARD OF
MEDICAL EXAMINERS

EDDIE R. CHEEKS, M.D.
President

(Board Seal)

ATTEST:

LASHARN HUGHES
Executive Director

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	Docket No.: OSAH-CSBME-PHY-0723505-24-Howells
v.	:	Agency Reference No.: 17424
JOHN SAVINO M D, Respondent.	:	

NOTICE OF INITIAL DECISION

This is the Initial Decision of the Administrative Law Judge (Judge) in the case. This decision is reviewable by the Referring Agency. If a party disagrees with this decision, the party may file a motion for reconsideration, a motion for rehearing, or a motion to vacate or modify a default order with the OSAH Judge. A party may also seek agency review of this decision.

FILING A MOTION WITH THE JUDGE AT OSAH

The Motion must be filed in writing within ten (10) days of the entry, i.e., the issuance date, of this decision. **The filing of such motion may or may not toll the time for filing an application for agency review.** ***See*** O. C.G.A. §§ 50-13-19 and 50-13-20.1. Motions must include the case docket number, be served simultaneously upon all parties of record, either by personal delivery or first class mail, with proper postage affixed, and be filed with the OSAH clerk at:

Clerk
Office of State Administrative Hearings
Attn.: Jennifer Risko, jrisko@osah.ga.gov
230 Peachtree Street, NW, Suite 850
Atlanta, Georgia 30303-1534

APPLICATION FOR AGENCY REVIEW

An application for Agency Review must be filed within thirty (30) days after service of this Initial Decision. O.C.G.A. §§ 50-13-17 and 50-13-41.A copy of the application for agency review must be simultaneously served upon all parties of record and filed with the OSAH clerk. The application for Agency Review should be filed with:

Composite State Board of Medical Examiners
Attn: Legal Services, Appeal Reviewer
2 Peachtree Street, S.W., 10th Floor
Atlanta, Georgia 30303.

This Initial Decision will become the Final Decision of the agency if neither party makes a timely application for agency review. O.C.G.A. §§ 50- 13-17 and 50-13-41. In certain cases, an Initial Decision may become Final and therefore not subject to review either by agency provision or the provisions of O.C.G.A. § 50-13-17(c). When a decision becomes Final, an application for judicial review must be filed within thirty (30) days in the Superior Court of Fulton County or the county of residence of the appealing party. If the appealing party is a corporation, the action may be brought in the Superior Court of Fulton County or the superior court of the county where the party maintains its principal place of doing business in this state. O.C.G. A. § 50-13-19(b).

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner, v. JOHN SAVINO M D, Respondent.	:	Docket No.: OSAH-CSBME-PHY-0723505-24-Howells Agency Reference No.: 17424

INITIAL DECISION

The Composite State Board of Medical Examiners ("Petitioner" or "Board") initiated this matter for the purpose of sanctioning Respondent's medical license. Specifically, Petitioner seeks the revocation of Petitioner's medical license. The hearing was held on August 20-21, 2007. The record was held open until November 8, 2007, to allow counsel for Respondent to submit additional guidance on the issue of an appropriate sanction. For the reasons stated below, this Tribunal finds that Respondent's medical license should be placed on **PROBATION** with certain terms and conditions.

Findings of Fact

1.

Respondent John Savino is licensed to practice medicine in the State of Georgia. He has been licensed in this state since December 3, 1975. (State's Exhibit 1).

2.

Respondent graduated from medical school in 1971. He completed an internship in general psychiatry in 1973 and a fellowship in child psychiatry in 1975. (Tr. 419-420). Respondent primarily practiced psychiatry through 1997. (Tr. 431-433, 443).

3.

In or around 1995, Respondent began assisting Dr. Cooper with some of his weight control patients. Around 1998, Respondent began treating weight-control patients on a full-time basis. (Tr. 432-433, 443, 449).

4.

Respondent's practice is called the Folkston Diet Medical Center P.C. It is a weight-control or weight-management practice. It is not a psychiatric practice. Respondent sees himself as practicing in the area of weight-control. (Tr. 456, 504, 509).

5.

Respondent currently sees weight-control patients two weeks a month at his practice in Folkston, Georgia. During the other two weeks out of the month, Respondent sees child and adolescent psychiatric patients at the Samaritan Medical Center in Watertown, New York. In that capacity, his role is limited to medication follow-up or psychopharmacology. Respondent started the psychiatric practice in New York approximately two years ago. (State's Exhibit 4; Tr. 476-478, 505-506).

6.

There are no universally accepted criteria for diagnosing a patient as overweight or obese. Some criteria include Body Mass Index, percent over ideal body weight, percent body fat, and waist-hip ratio. Nevertheless, both the Centers for Disease Control ("CDC") and the National Institutes of Health ("NIH") recognize Body Mass Index ("BMI") as a means of determining whether an individual is considered overweight or obese. BMI is a calculation based on height and weight. According to the NIH, a person is considered overweight if his or her BMI is between 25 and 29.9. A person is considered obese if his or her BMI is 30 or greater. (Tr. 118, 119, 177, 336, 337, 354, 379, 382, 383; *See* Ex. R-2).

7.

Respondent primarily prescribes phentermine for his weight loss patients. Phentermine is a Schedule IV sympathomimetic amine used for appetite suppression. It is related to the amphetamine class of drugs. However, phentermine is non-habituating and has a low potential for abuse. Adipex and Fastin are brand name versions of phentermine. (Tr. 44, 47, 73, 125, 126, 238, 239, 243, 340, 457; State's Exhibits 7, 8, 10). Elevated blood pressure and heart rate are potential risks associated with phentermine. (Tr. 126, 384, 462, 510).

8.

Dr. Lonny Horowitz (Petitioner's expert witness) and Dr. David Bryman (Respondent's expert witness) agree that in some instances it is appropriate to prescribe anorectic medications for patients who are not technically obese, but who are in the overweight category. (Tr. 289-292, 336). Both experts also agree that long-term use of anorectic medications, including phentermine, can be appropriate if it is professionally indicated. Both experts agree that phentermine is non-habituating and has a low potential for abuse. (Tr. 126-127, 243, 337-330).

9.

The minimum standard of care for any physician prescribing anorectic medication requires that the physician keep adequate medical records, including the documentation of vital signs, weight, Body Mass Index ("BMI") or some other criteria initially establishing the diagnosis of overweight or obesity, a complete medical history, and a physical examination. (Tr. 286-288, 354, 368, 369, 370, 384).

10.

Respondent treated patient M.R. between March 13, 1998 and October 12, 2005. The medical record contains a one page "Patient Information" sheet which includes M.R.'s address and a brief

medical history completed by M.R. A total of 57 office visits are recorded over the course of seven years. On each visit M.R.'s diagnosis is preprinted as "Overweight." The patient's weight is recorded for 48 of the 57 visits. A copy of a prescription for Adipex-P or Fastin is included in the medical records for each of the 57 visits. Each prescription is dated, and states the name of the medication, the dose, and the quantity. For the first 6 visits between March 13, 1998 and July 29, 1998, M.R.'s blood pressure was recorded as 124/82. On each of the 26 visits between August 27, 1998 and May 2, 2003 M.R.'s blood pressure was recorded as 124/76. No blood pressure was recorded for the 15 visits between June 12, 2004 and October 12, 2005. No pulse or heart rate was ever recorded. Respondent's medical records contain no documentation that a physical examination was ever performed on M.R. For each of the visits between March 13, 1998 and April 11, 2001, the medical records state that M.R.'s last physical exam was performed in 1997. Between May 17, 2001 and November 15, 2003, the medical records state that M.R.'s last physical examination occurred in 1999. For each of the visits between December 9, 2003 and October 12, 2005, there is no documentation of when M.R.'s last physical examination occurred. (State's Exhibit 7; Tr. 368).

11.

Respondent treated patient T.K. between January 27, 2001 and September 9, 2005. The medical record contains a one page "Patient Information" sheet which includes T.K.'s address and a brief medical history completed by T.K. A total of 40 office visits are recorded over the course of four years and nine months. On each visit T.K.'s diagnosis is preprinted as "Overweight" and her weight is recorded. However, T.K.'s BMI is not recorded in the medical records. Her initial height and weight are recorded as 5'2" and 115 lbs. According to NIH criteria, T.K. would not be considered overweight. Rather, she would be considered in the normal weight range. T.K.'s percent of body fat or percent over ideal body weight is not recorded. A copy of a prescription for Fastin is included in

the medical records for each of the 40 visits. Each prescription is dated, and states the name of the medication, the dose, and the quantity. For the first 24 visits, between January 27, 2001 and October 23, 2003, T.K.'s blood pressure was recorded as 112/68. No blood pressure was recorded for the 16 visits between December 12, 2003 and September 9, 2005. No pulse or heart rate was ever recorded. Respondent's medical records contain no documentation that a physical examination was ever performed. For each of the visits between January 27, 2001 and March 1, 2003, the medical records state that T.K.'s last physical examination occurred in January of 2000. For each visit between May 5, 2003 and January 8, 2004, the medical records state that T.K.'s last physical examination was in January of 2002. For each of the visits between February 11, 2004 and September 9, 2005, there is no documentation of when T.K.'s last physical examination occurred. (State's Exhibit 8; Tr. 163, 357, 358, 368).

12.

Respondent treated patient T.H. between July 23, 1998 and October 11, 2005. The medical record contains a one page "Patient Information" sheet which includes T.H.'s address and a brief medical history completed by T.H. A total of 51 office visits are recorded over the course of seven years and 3 months. On each of the visits T.H.'s diagnosis is preprinted as "Overweight." T.H.'s initial BMI is recorded as 31.3. According to NIH standards, a BMI of 31.3 is considered obese. T.H.'s weight is recorded for each of the 51 visits. A copy of a prescription for Adipex-P, Fastin, or Profast is included in the medical records for each of the 51 visits. Each prescription is dated, and states the name of the medication, the dose, and the quantity. For the 40 visits between November 19, 1998 and December 11, 2003, T.H.'s blood pressure is recorded as 122/74. No blood pressure is recorded for the 11 visits between February 20, 2004 and October 11, 2005. No pulse or heart rate was ever recorded. Respondent's medical records contain no documentation that a physical examination was

ever performed. For each of the visits between July 23, 1998 and February 22, 2003, the medical records state that T.H.'s last physical examination was in 1996. For the visits between May 1, 2003 and February 20, 2004, the medical records state that T.H.'s last physical examination occurred in 2002. There is no documentation of when T.H.'s last physical examination occurred for the visits between May 6, 2004 and October 11, 2005. (State's Exhibit 10; Tr. 167)

13.

Ginger Johns is an L.P.N. employed by Respondent. She started working for Respondent in 1998 as a certified nursing assistant. Ms. Johns became an L.P.N. approximately four years ago. She is responsible for weighing the patients, calculating their BMI, and taking their blood pressures. She is also responsible for documenting these things in the patient's chart. Ms. Johns admits that she has not been the best record-keeper. (Tr. 396, 403, 406, 407).

14.

It is highly unlikely for a patient's blood pressure to be exactly the same month after month over a period of years. The medical records for M.R., T.K., and T.H. often contain the same exact blood pressure reading month after month for a period of one or more years. The most likely explanation for such an occurrence is that Ms. Johns simply copied the blood pressure from a preceding visit, and continued to write the same blood pressure month after month.[1] (Tr. 147, 369, 408).

15.

Respondent acknowledges that his medical records are poor. He accepts full responsibility for the medical records of his patients.[2] He is not proud of the state of his medical records. (Tr. 452-453,

[1] It was Ms. Johns who offered the explanation that "somebody" could have copied the blood pressure from the previous visit. Although Ms. Johns stopped short of admitting that she was the person who copied the blood pressure from the preceding visits, she did admit that it was her responsibility to document the patient's blood pressure in the chart. (*See* Tr. 407-408).

[2] Based on Respondent's demeanor and the manner in which he testified, the undersigned found him to be frank and

482, 484). He instructed Ms. Jones to take the patients' blood pressure, weigh the patients, calculate a BMI, and record these parameters on the patients' charts. (Tr. 465). He "kind of looks[s]" at the charts when he sees patients. (Tr. 452). Respondent either (1) was not looking a the patient charts closely enough to notice that in many instances no blood pressure was recorded or the same blood pressure was copied month after month, or (2) he noticed the problems with the charting, but did not take sufficient measures to correct or reprimand his staff. (*See* Tr. at 452, 483, 484).

16.

Respondent acknowledges that phentermine can cause an increase in blood pressure and heart rate. (Tr. 456, 462, 510). Respondent relies on his patients to tell him about their blood pressure. However, he agrees that many people can walk around with elevated blood pressure without knowing it. He also agrees that without having accurate blood pressure readings in the chart, he cannot know if the phentermine is causing an increase in that patient's blood pressure. (Tr. 462,463, 482, 511).

17.

The majority of Respondent's patients have a primary care physician. Respondent relies on his patients' primary care physicians to order lab work and perform physical examinations. (Tr. 455, 461; *see also* State's Exhibits 7, 8, 10). He talks to his patients about their medical histories and any lab work performed by their primary care physicians. (Tr. 454-455, 461-462). He counsels his patients about their diets. (Tr. 462).

18.

Respondent has developed a habit of not writing medical information in his patient charts. This is a habit he developed during his years of practicing as a psychiatrist. He has found that including

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sincere.

certain information in patient charts can unfairly hinder a patient's ability to obtain life or health insurance. (Tr. 449, 496).

19.

Respondent has taken steps to improve his record-keeping. He has hired a bariatric practice consultant to help him improve the quality of his record-keeping. Within the last year and a half, Respondent has taken approximately 30 hours of continuing medical education in the field of Bariatrics. (Tr. 518-519).

20.

Three of Respondent's patients testified on his behalf. T.K is one of Respondent's patients. She began treatment with Respondent for her weight in 2001. T.K.'s mother and both grandmothers were obese. Her sister is obese. T.K.'s weight frequently fluctuates. (Tr. 386-387). T.K. discussed her family history and her weight fluctuation with Respondent. (Tr. 486). She felt like Respondent understood her and that he cared about her. (Tr. 386-387, 393-394). T.H. has been one of Respondent's patients since 1996. Initially, he began seeing Respondent for psychiatric treatment of his post-traumatic stress disorder. In 1998, T.H. began seeing Respondent for weight-control. (Tr. 307-308, 320). T.H's impression is that Respondent is very concerned about his well-being. (Tr. 313). Amanda H. started seeing Respondent for weight control approximately eight years ago. When she first started seeing Respondent, she weighed 389 lbs. She could not get around very well. She could not fit into a seat at the movie theater. While Amanda H. did not divulge her current weight, it was apparent that she has lost considerable weight and that she has no difficulty getting around. Amanda H. attributes much of her success in losing the weight to Respondent. (Tr. 527).

21.

The opinions of Petitioner's expert are based solely on a review of Respondent's medical records.

(Tr. 190). Petitioner's investigator did not speak to or interview any of Respondent's patients. (Tr. 85). Petitioner presented no evidence of complaints against Respondent from patients or other health care providers. Petitioner presented no evidence that any of Respondent's patients have been harmed or injured while in his care. Petitioner presented no evidence of any prior disciplinary actions against Respondent.

Conclusions of Law

1.

Petitioner seeks the revocation of Respondent's medical license. Accordingly, Petitioner bears the burden of proof. Ga. Comp. R. & Regs. r. 616-1-2-.07. The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. r. 616-1-2-.21.

2.

Petitioner alleges that Respondent has violated Georgia Code Sections 43-1-19(6) and 43-34-37(7) by engaging in unprofessional conduct. Specifically, Petitioner alleges that Respondent engaged in the following unprofessional conduct as defined by Board Rule 360-3-.02:

* * *

> (7) Failing to maintain appropriate patient records whenever Schedule II, III, IV or V controlled substances are prescribed. Appropriate records, at a minimum, shall contain the following:
> (a) The patient's name and address;
> (b) The date, drug name, drug quantity, and patient's diagnosis necessitating the Schedule II, III, IV, or V controlled substances prescription; and
> (c) Records concerning the patient's history.
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> * * *
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> (14) Failing to use such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem.
>
> * * *
>
> (16) Failing to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response.

* * *

(18) Any other practice determined to be below the minimal standards of acceptable and prevailing practice.

Ga. Comp. R. & Regs. r. 360-3-.02 (2007).

Rule 360-3-.02(7) – Failure to Maintain Appropriate Patient Records When Prescribing Controlled Substances

3.

Petitioner has not established that Respondent failed to maintain appropriate patient records whenever Schedule II, III, IV, or V controlled substances are prescribed in violation of Rule 360-3-.02(7). This rule describes the minimal amount of information a physician must document when prescribing controlled substances. This rule does not describe what record keeping is necessary to comply with the prevailing standard of care. Rather, this rule describes ministerial or administrative requirements. Pursuant to this rule, the record must contain the patient's name and address, the date, the drug name and quantity, the patient's diagnosis necessitating the scheduled medication, and records concerning the patient's history. Ga. Comp. R. & Regs. r. 360-3-.02(7).

4.

Each set of medical records tendered by Petitioner contains the required pieces of information. *See* Findings of Fact ¶¶ 10, 11, 12. While there may be some disagreement as to whether the patient diagnoses are in fact accurate, the rule does not seem to require that the patient's diagnosis is absolutely accurate. This Tribunal can envision a situation in which an initial diagnosis is recorded and a controlled substance is prescribed, and then the patient's diagnosis is subsequently revised. If this rule required patient diagnoses to be 100% accurate, then any physician who later revised or changed the diagnosis of a patient's for whom that physician prescribed a controlled substance would be in violation of the rule. Such an outcome cannot be the aim of this rule.

Rule 360-3-.02(14) –Failure to Use History, Physical Examination, Laboratory Studies . . . to Diagnose a Medical Problem

5.

Petitioner has not established that Respondent failed to use history, physical examination, laboratory, or radiographic studies, where applicable, to diagnose a medical problem. Ga. Comp. R. & Regs. r. 360-3-.02(14). The "medical problem" at issue in this case is overweight or obesity. Respondent's medical records for M.R. and T.H. contain a BMI establishing that they were overweight or obese. T.K.'s medical record does not contain a BMI or any other parameter establishing a diagnosis of overweight. However, T.K. testified that her weight fluctuates and that she has a significant family history of obesity. She discussed these issues with Respondent. Thus, while Respondent's medical records do not reflect this history, there was some evidence that Respondent used history to diagnose T.K.'s "medical problem." Furthermore, Respondent testified that he talks to his patients about their medical histories and laboratory studies performed by their primary care physicians. While this testimony can be seen as self-serving, Petitioner failed to present any evidence to contradict this testimony. Accordingly, Petitioner did not establish by a preponderance of the evidence that Respondent failed to use history, physical examination, laboratory, or radiographic studies, where applicable to diagnose a medical problem.[3]

[3] There is no question that Respondent failed to *document* a complete medical history, physical examination and other pertinent information concerning his patients. However, this is a documentation issue, rather than a diagnosis issue.

Rule 360-3-.02(16) – Failure to Maintain Patient Records Documenting Course of Patient's Medical Evaluation, Treatment and Response

6.

Petitioner has not established that Respondent failed to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response in violation of Rule 360-3-.02(16). The thrust of Rule 360-3-.02(16) is the *amount of time* a physician must maintain (or keep) a patient's medical records. This can be gleaned from the subparts of the rule. Subpart (a) states, in pertinent part: "A physician shall be required to maintain a patient's complete treatment records for a period of no less than 10 years from the patient's last office visit." Ga. Comp. R. & Regs. r. 360-3-.02(16)(a). Subpart (b) explains that the requirements of the rule do not apply to retired physicians or physicians who have sold their practice if they meet certain requirements. *See* Ga. Comp. R. & Regs. r. 360-3-.02(16)(b). Thus, Rule 360-3-.02(16) does not address the quality of a physician's record keeping. Rather, it states a requirement that physicians must maintain or keep patient records for a minimum of 10 years after the patient's last office visit. Petitioner presented no evidence that Respondent has failed to keep patient records for the requisite amount of time. Accordingly, Petitioner has failed to establish that Respondent violated Rule 360-3-.02(16).

Rule 360-3-.02(18) – Engaging in a Practice Determined to be Below the Minimal Standards of Acceptable and Prevailing Practice

7.

Petitioner has established that Respondent engaged in a practice which fell below the minimal standards of acceptable and prevailing practice. Ga. Comp. R. & Regs. r. 360-3-.02(18). Petitioner argued that Respondent's medical records, diagnosis and treatment of patient's M.R., T.H. and T.K. fell below the standard of care. Petitioner's evidence was based solely on a review of Respondent's medical records. The evidence concerning the quality of Respondent's "diagnosis" and "treatment"

of M.R., T.H. and T.K. was insufficient to meet Petitioner's burden of proof. Petitioner's only evidence that Respondent's diagnosis and treatment of these patients fell below the standard of care consisted of the conclusory opinions of Petitioner's expert witness. (*See* Tr. 160-61, 165-66, 172).[4] On the other hand, the evidence of Respondent's poor record-keeping was compelling.

8.

The minimum standard of care for any physician prescribing anorectic medication requires that the physician keep adequate medical records, including the documentation of vital signs, weight, Body Mass Index ("BMI") or some other criteria initially establishing the diagnosis of overweight or obesity, a complete medical history, and a physical examination. *See* Findings of Fact ¶ 9.

9.

Respondent failed to keep proper medical records for patients M.R., T.H., and T.K. Respondent acknowledges that phentermine can be associated with an increase in blood pressure and heart rate. However, in many instances the same exact blood pressure is recorded month after month for a period of one or more years. It is clear that these are not accurate blood pressure readings. *See* Findings of Fact ¶ 14. On other occasions, no blood pressure is recorded. No heart rate is recorded for any of the office visits for these three patients. For patient T.K., there is no information upon which the diagnosis of overweight could be based. The medical record contains no BMI, percent body fat, percent over ideal body weight, or waist-hip ratio. The medical records do not reflect that a physical examination was ever performed on any of the three patients. In many instances, the medical records state that the patient's last physical examination occurred 2 to 5 years prior to the office visit. For each patient, the medical history is contained on a one page "Patient Information"

[4] Although Petitioner's expert opined that "overweight" was not a proper diagnosis, his testimony on this point was contradictory. (*Compare* Tr. 141 with Tr. 180-181). Ultimately, Petitioner's expert conceded that in some circumstances it may be appropriate to prescribe an anorectic medication to a patient who is "overweight," as opposed to obese. (Tr.

sheet completed by the patient. There is no indication in the medical records that this was ever reviewed with the patient. This type of record keeping falls below the standard of care for any physician prescribing anorectic medications. Given the potential adverse risks of elevated blood pressure and increased heart rate, the failure to record or accurately record these vital signs, a complete medical history and a physical examination constitutes unprofessional conduct harmful to the public. O.C.G.A. § 43-34-37(7); O.C.G.A. § 43-1-19(6); Ga. Comp. R. & Regs. r. 360-3-.02(18).

Sanction

10.

Georgia Code Sections 43-1-19(6) and 43-34-37(7) authorize the Board to discipline a licensee upon a finding that the licensee has engaged in unprofessional conduct. When the Board finds that a physician should be disciplined, it may suspend, revoke, limit, or restrict a license; administer a public or private reprimand; make an adverse finding but withhold imposition of judgment; or impose the judgment but suspend the enforcement of such judgment and place the physician on probation. Further, the Board may vacate any probation if the physician fails to comply with reasonable terms imposed by the Board. O.C.G.A. § 43-34-37(b); O.C.G.A. § 43-1-19(d), (e). Finally, the Board may impose a fine of up to $500.00 for each violation of law, rule or regulation. O.C.G.A. § 43-1-19(d)(7).

11.

Respondent violated Georgia Code Sections 43-1-19(6) and 43-34-37(7). Respondent's medical records for patients M.R., T.H., and T.K. fell below the standard of care. This conduct constitutes sufficient grounds to sanction Respondent's medical license. However, based on the evidence presented, Respondent's willingness to accept responsibility for the state of his medical records, and

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the fact that he has already taken some steps to improve his practice, this Tribunal finds that Revocation is too harsh a sanction.[5]

12.

Notwithstanding, Respondent chose to make the change from a psychiatric practice to a weight-control practice. He must make the corresponding change in how he conducts his practice. He cannot continue to rely solely on what his patients *tell* him about their blood pressure, heart rate, and physical examinations. If he wishes to continue in the weight-control practice he must reacquaint himself with physical diagnosis and appropriate record keeping.

ORDER

13.

This Tribunal finds that Respondent's license to practice medicine in the State of Georgia should be placed on probation for a period of five (5) years commencing on December 19, 2007, until discharged by the Board, with the following terms and conditions:

(a) Respondent shall submit to the Board a fine of $1,500.00 to be paid in full by cashier's check or money order made payable to the Board within 60 days of the date of this Order. Failure to pay the entire amount by the 60th day shall be considered a violation of this Order, and shall result in further sanctioning of Respondent's license, including revocation, upon substantiation thereof.

(b) Respondent shall complete 20 hours of continuing medical education ("CME") in Bariatric Medicine and 3 hours in Medical Record Keeping. These hours shall be in addition to the normal hours of CME required for license renewal for all Georgia physicians. Prior to obtaining the

[5] *See In the Matter of Jeffrey Bull Grable*, 279 Ga. 1 (2005) (acknowledging that certain factors can mitigate a licensee's conduct such that a less severe sanction may be appropriate). *See also In the Matter of Terrill Mark Wright, M.D.*, Docket No. 20040012; *In the Matter of Ashok Kumar Sinha*, M.D., Docket No. 20020048; *In the Matter of Stephen D. Spain, M.D.*, Docket No. 98-134 (public consent orders in factually similar cases wherein the Board issued the sanction of probation).

CME, Respondent shall submit the title of the course(s) he plans to attend and information concerning the course(s) to the Board's Medical Coordinator for approval. Respondent shall submit proof upon completion of each course to the Board within 18 months of December 19, 2007.

(c) Respondent shall use a triplicate prescription system for all controlled substances prescribed by him. Each prescription for such a controlled substance written by Respondent shall be sequentially numbered and the copies distributed as follows: original to patient, one copy to the Board, and one copy to the patient's chart. Respondent shall not begin renumbering when he reaches 1000, but shall continue to number sequentially. The copies for the Board shall be mailed or delivered to the Board by Respondent once per quarter.

(d) Respondent shall personally maintain for inspection a contemporaneous log (separate from his clinical records) of all controlled substances prescribed, administered, dispensed, or ordered by him. The log shall include the date, patient name, drug, strength, quantity, and refill status, on a form approved by the Board. The log shall include the diagnosis and the reasons for prescribing, administering, dispensing, or ordering each drug. A copy of the log shall be mailed or delivered to the Board by Respondent once per quarter. Additionally, the Board shall be authorized to inspect Respondent's log at any time. If Respondent's log fails to comply with the requirements of this consent order, the Board is authorized to summarily suspend Respondent's license, pending a hearing.

(e) Prior to prescribing, administering, ordering, or dispensing any controlled substance, Respondent shall detail fully the examination performed and the diagnosis reached in the particular patient's file. Respondent shall specifically record all physical data of the patient and detail the exact nature of Respondent's evaluation of the patient. In addition to this requirement, Respondent agrees to comply with all current record keeping requirements of the Board.

(f) Respondent shall not be eligible to petition for termination of probation until three years from the effective date of this Order. At such time, Respondent may petition for termination by certifying under oath before a notary public that Respondent has complied with all terms and conditions of probation and by providing documentation supporting discharge from probation. The Board shall review and evaluate the practice of the Respondent prior to lifting the probation. At such time, the Board shall be authorized to restore all rights and privileges incident to the Respondent's license, unless the Board finds that Respondent has not complied with the terms of this Order or has otherwise failed to comply with the laws and rules regulating the practice of medicine. Should the Board determine that reasonable cause exists for maintaining Respondent's license on probationary status, the Board shall notify Respondent of its intent to extend the probationary status, and Respondent may respond to such notification in writing or request an appearance before the Board or its representative as in a non-contested case. In any event, this Order shall remain in effect, pending a final determination by the Board and notification that the probationary period has terminated.

14.

This Order shall be considered a PUBLIC REPRIMAND of Respondent by the Board and may be disseminated as such.

SO ORDERED, this 19th day of November, 2007.

STEPHANIE M. HOWELLS
Administrative Law Judge

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS,
Petitioner,

v.

JOHN SAVINO M.D.,
Respondent.

Docket No.: OSAH-CSBME-PHY-0723506-24-Howells

OMNIBUS ORDER

On October 22, 2007, Respondent filed a Motion for Default. Petitioner filed a Response in Opposition on October 26, 2007.

Respondent asserts that Petitioner has failed to comply with the Open Records Act and this Court's Order approving Respondent's Open Records Act request. The Court does not agree. Petitioner has made paper copies of the requested "open" records available to Respondent. Nothing in Sections 50-18-70 or 50-18-71 requires Petitioner to maintain paper copies of its records. Furthermore, there is no requirement that Petitioner make paper copies available at no cost. Georgia Code Section 50-18-71 clearly provides that the agency may charge and collect a copying fee of 25 cents per page and a reasonable charge for the search, retrieval, and other direct administrative costs for complying with a request. O.C.G.A. § 50-18-71.

Petitioner's copying of the requested records and making those records available has satisfied the requirements of the Open Records Act. Accordingly, Respondent's Motion for Default is **DENIED**.

IT IS FURTHER ORDERED that the record in this matter shall close at 5:00 p.m. on November 8, 2007. Respondent shall have until that time to provide any additional authority or support on the issue of an appropriate sanction. The Court's Initial Decision shall be issued within 10 days of the closing of the record.

IT IS FURTHER ORDERED that Respondent's request for this Court to make an in-camera inspection of Private Consent Orders entered into by the Petitioner and other physicians is **DENIED**.

SO ORDERED November 2, **2007.**

Stephanie M. Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	
v.	:	Docket No.: OSAH-GSBME-PEV-0702505-24-Howells
JOHN SAVINO M.D., Respondent.	:	

ORDER ON RESPONDENT'S MOTION FOR EXPERT REPORTS

On July 9, 2007, Respondent filed a motion requesting an order requiring Petitioner to provide Respondent with any and all expert witness reports. For the reasons stated below, Respondent's motion is **GRANTED in part and DENIED in part**.

To expedite the adjudication of a matter, the ALJ may consider requiring the parties to submit expert witness disclosures identifying any expert or experts the party expects to call, the substance of the facts and opinions to which the expert witness is expected to testify, and a summary of the grounds for each opinion. OSAH Rule 616-1-2-.14. In this case, the exchange of such information is likely to expedite the adjudication of this matter.

Accordingly, Respondent's motion is **GRANTED** to the extent it is consistent with the following. The parties are hereby **ORDERED** to disclose the identities of any experts they expect to call as a witness, the substance of the facts and opinions to which their experts are expected to testify, and a summary of the grounds for each opinion.

The parties are further **ORDERED** to exchange and file these disclosures with the Court, no later than August 6, 2007.

Petitioner may exchange and file any existing report from its expert(s), to the extent it satisfies the requirements stated above. Alternatively, Petitioner may prepare and submit a new disclosure that satisfies those requirements.

SO ORDERED July 12, **2007.**

Stephanie M. Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	Docket No.: OSAH-CSBME-0716-Board 24-Howells
v.	:	
JOHN SAVINO M.D., Respondent.	:	

ORDER DENYING MOTION TO DISMISS

On July 9, 2007, Respondent filed a Motion to Dismiss. Respondent argues that he has been denied due process and the right to confrontation because Petitioner has announced its intent to seek revocation of Respondent's medical license. Upon review of Respondent's Motion to Dismiss, the undersigned finds that the motion is without merit. No decision has been rendered with respect to Respondent's medical license. Therefore, there has been no denial of due process or right to confrontation. The hearing in this matter is set for August 20-21, 2007. An initial decision will be rendered after a full hearing on the merits.

Moreover, there is nothing improper about Petitioner requesting specific relief. In fact, the undersigned routinely requires Petitioner to specify the sanction it is seeking. Accordingly, Respondent's motion is **DENIED**.

SO ORDERED July 12, **2007.**

STEPHANIE M. HOWELLS
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

DOCKET NUMBER
20070069

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	Docket No.: OSAH-CSBME-PHY-0723505-24-Howells
v.	:	
JOHN SAVINO M.D., Respondent.	:	

ORDER ON REQUEST FOR INVESTIGATIVE FILE

On May 17, 2007, Respondent filed a Request for Investigative File. Petitioner has not filed a response. Respondent's request for the investigative file is **GRANTED in part**, and **DENIED in part**. Respondent's request is granted to the extent that the investigative file contains any exculpatory, favorable, or arguably favorable information which is relative to the Matters Asserted. O.C.G.A. § 50-13-18; *see also*, *Wills v. Composite State Board of Medical Examiners*, 259 Ga. 549, 551-53 (1989). Respondent's request is denied as to any information contained in the investigative file, which is not exculpatory, favorable, or arguably favorable.

SO ORDERED June 13, **2007.**

Stephanie M. Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	Docket No.: OSAH-CSBME-PHY-0723505-24-Howells
v.	:	
JOHN SAVINO M.D., Respondent.	:	

ORDER APPROVING OPEN RECORDS REQUEST

On May 17, 2007, Respondent submitted an open records request for approval pursuant to O.C.G.A. § 50-18-70 (e). Respondent's open record request, dated May 17, 2007, is hereby **APPROVED**.

SO ORDERED June 13, **2007.**

Stephanie M. Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	Docket No.: OSAH-CSBME-PHY-0723505-24-Howells
v.	:	
JOHN SAVINO M.D., Respondent.	:	

ORDER DENYING MOTION TO STRIKE

On May 17, 2007, Respondent filed a Motion to Strike. Petitioner has not filed a response. Respondent seeks to strike portions of the Matters Asserted and Statutes and Rules Involved which relate to Georgia Code Section 43-1-19.

Respondent asserts that pursuant to Georgia Code Section 43-34-24.1 the Petitioner Composite State Board of Medical Examiners ("Petitioner") is an independent State agency and is not a professional licensing board. Respondent presumably argues that Section 43-1-19 is inapplicable because Petitioner is not a professional licensing board. However, this argument ignores the portion of Section 43-34-24.1 (a) which states: "The board . . . shall have . . . the powers, duties, and functions of such licensing boards as provided in Chapter 1 of this title." O.C.G.A. § 43-34-24.1 (a). This portion of Section 43-34-24.1 (a) appears to confer upon the Petitioner the authority to rely on the provisions of Section 43-1-19. Accordingly, Respondent's Motion to Strike is hereby **DENIED**.

SO ORDERED June 13, **2007.**

Stephanie M. Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	
v.	:	Docket No.: OSAH-CSBMB-PHY-0723505-24-Howells
JOHN SAVINO M.D., Respondent.	:	

ORDER DENYING MOTION FOR A MORE DEFINITE STATEMENT

On May 17, 2007, Respondent filed a Motion for a More Definite Statement. Petitioner has not filed a response. Georgia Code Section 50-13-13 and Rule 360-18-.01 of the Composite State Board of Medical Examiners require Petitioner to provide reference to the particular sections of the statutes and rules involved and a short and plain statement of the matters asserted. Petitioner's Matters Asserted contains detailed descriptions of the factual allegations and reference to the particular sections of the statutes and rules involved. Petitioner has satisfied the requirements of Section 50-13-13 and Rule 360-18-.01. Accordingly, Respondent's motion is **DENIED**.

SO ORDERED June 13, **2007.**

Stephanie M Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	
v.	:	Docket No.: OSAH-CSBME-PHY-0723505-24-Howells
JOHN SAVINO M.D., Respondent.	:	

CONTINUANCE ORDER AND
NOTICE OF RESET HEARING DATE

Petitioner has filed a Motion for Continuance. The motion states that Respondent has requested to address the Petitioner Board at its next meeting, scheduled for June 7-8, 2007. The motion further states that the parties are engaged in settlement discussions, which may obviate the need for a hearing. Accordingly, Petitioner's motion for a continuance is **GRANTED**.

Petitioner is hereby **ORDERED** to provide a status report on **June 11, 2007**. In the event a settlement is reached and a Consent Order is approved by the Petitioner Board during its July 12-13, 2007 meeting, Petitioner is **ORDERED** to notify the Court that a settlement has been reached and withdraw its request for a hearing, no later than **July 16, 2007**.

If the parties are unable to reach a settlement, the hearing in this matter will go forward on **August 20 and August 21, 2007, at 09:30 AM, at the Charlton County Courthouse, 100 S. Third Street, Folkston, Georgia 31537.** Other than the change in date, time, and location **all other information contained in the original notice of hearing shall remain the same.**

SO ORDERED this 4th day of June, 2007.

Stephanie Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

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BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS,
Petitioner,

v.

JOHN SAVINO, M.D.,
Respondent.

Docket No.: OSAH-CSBME-PHY-0723505-24-Howells

ORDER GRANTING CONTINUANCE

Respondent filed a Motion for Continuance on April 11, 2007. Respondent's motion is **GRANTED in part**, and **DENIED in part**.

A continuance shall be granted only upon a showing of good cause and shall not be granted simply because the parties and/or their counsel agree thereto. Among the factors the Judge may consider in connection with a motion for continuance are the impact of the continuance upon any parties who do not consent to the motion, the Judge's calendar, the difficulty in rescheduling the hearing site, the need for an expeditious resolution of the matter(s) at issue, and the public health, safety and welfare. A notice of conflict filed shall not be considered as a motion for continuance unless the notice expressly requests a continuance. OSAH Rule 616-1-2-.41(1).

Accordingly, the hearing in **this matter is continued to June 6-7, 2007, at 9:30 AM, at the Office of State Administrative Hearings, 230 Peachtree Street, NW, Suite 850, Atlanta, GA.** Other than the change in date, time, and location all other information contained in the original notice of hearing shall remain the same.

SO ORDERED April 16, 2007.

Stephanie M. Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS, Petitioner,	:	Docket No.: OSAH-CSBME-PHY-0723505-24-Howells
v.	:	
JOHN SAVINO, M.D., Respondent.	:	

SCHEDULING ORDER

The parties are directed to exchange and file witness and exhibit lists by **May 23, 2007**. Witness lists shall include the name, title, address, and telephone number (if known) of the witness, and a brief description of the substance of the witness' anticipated testimony.

The hearing in **this matter is scheduled for JUNE 6-7, 2007, at 09:30 AM, at OSAH - OFFICE OF STATE ADMINISTRATIVE HEARINGS, 230 PEACHTREE STREET, NW, SUITE 850, ATLANTA, GA.**

SO ORDERED April 16, 2007.

Stephanie M. Howells

STEPHANIE M. HOWELLS
Administrative Law Judge

BEFORE THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

STATE OF GEORGIA

IN THE MATTER OF:	*	
	*	
JOHN SAVINO, M.D.,	*	**DOCKET NO.** 20070069
License No. 17424,	*	
	*	
Respondent.	*	

MATTERS ASSERTED AND
STATUTES AND RULES INVOLVED

Pursuant to O.G.G.A. § 50-13-13, the Composite State Board of Medical Examiners ("the Board") hereby provides JOHN SAVINO, M.D. (hereinafter "Respondent"), with the matters asserted and the statutes and rules involved for purposes of sanctioning the Respondent's license. The matters asserted below, if correct, constitute sufficient grounds for the revocation of Respondent's license to practice as a physician and to seek reimbursement for the costs of bringing this action.

MATTERS ASSERTED

1.

Respondent is licensed by the Board to practice medicine in the State of Georgia, and was issued license number 17424 on December 3, 1975, which license is set to expire on January 1, 2009.

2.

On or about September 5, 1998, Respondent began seeing patient O.W. At the time of her initial visit, O.W. was a 67-year-old 5' 2" tall female who weighed 185 pounds. O.W.'s medical records identified her illness simply as "overweight." There is no indication in said records that O.W.'s patient history was ever reviewed by Respondent. Respondent repeatedly prescribed Phentermine (Adipex) 37.5 mg for O.W., approximately 52 times over the course of her treatment. Phentermine is classified as a Schedule IV controlled substance under O.C.G.A.

§ 16-13-28. O.W. was also given a non-specific weight loss plan consisting of pre-printed instructions regarding "vitamins, exercise, an apple ½ hour before meals, 3-6 ounces of meat, and 6-8 glasses of water." Her records also indicate that she was given "Diet Literature."

O.W.'s medical records show that her blood pressure was only recorded at each monthly visit from September 1998 until June 2003, even though she continued to be Respondent's patient until approximately October 4, 2005. Further, on *every* occasion that her blood pressure was purportedly taken by Respondent, it was the same, i.e., 112/76. No temperature, pulse or respiration for O.W. was ever recorded. There are no clear progress notes contained in O.W.'s record. During O.W.'s seven years of treatment by Respondent, she lost only fifteen (15) pounds. There is no documentation supporting a maintenance plan or weight loss goals.

3.

Patient T.H., a 56-year-old male, began seeing Respondent on or about July 23, 1998. T. H.'s recorded height was 5' 10" and his weight at initial visit was 218 pounds. Respondent noted T.H.'s diagnosis as simply "overweight." T.H. saw Respondent monthly from July 23, 1998 until October 5, 2005. T.H.'s medical records contain no evidence that any physical examination or laboratory testing was performed during this time. T.H.'s treatment consisted of the same "program" that Respondent prescribed for O.W. (i.e., vitamins, exercise, apple before meals, 6-8 glasses of water). T.H. was also prescribed Phentermine (Profast or Fastin or Adipex P) in dosages ranging from 18.75 mg to 37.5 mg, in 30-day supply, approximately 54 times over his course of treatment with Respondent. In addition, Respondent prescribed Hydrocodone 10mg #120 a total of seven times for T.H., although there is no evidence in the

medical record as to why this medication was prescribed. Hydrocodone is a Schedule II controlled substance, pursuant to O.C.G.A. § 16-13-26.

T.H.'s medical records indicate that his temperature, pulse and respiration were never recorded. His blood pressure was checked monthly from July 1998 until February 2004, with the exact same reading (122/74) recorded for a period of three years. From February 2004 until October 2005, there is no blood pressure reading recorded. Respondent maintained no progress notes for T.H. throughout T.H.'s treatment. At the end of T.H.'s treatment, his weight was recorded at 222 pounds – reflecting a net *gain* of four pounds.

4.

Patient T.K., a 32-year-old female, began treatment with Respondent on January 27, 2001 and continued until October 4, 2005. At the time of her initial visit, T.K. weighed 115 pounds and was 5' 2" tall. Respondent diagnosed T.K. as being "overweight" even though T.K.'s Body Mass Index ("BMI") was, at 21, clearly out of the Obesity range as specified by National Institute of Health ("NIH") guidelines and low or below normal weight for her height. Respondent prescribed for T.K. the non-specific weight loss program, and she was given "Diet Literature." Respondent also prescribed Phentermine (Fastin) 30 mg in a 30-day supply for T.K. approximately 44 times. At one time the Respondent changed T.K.'s medication to Adipex 37.5 mg, but failed to note in T.K.'s chart why her medication was being changed. Respondent failed to maintain any progress notes during T.K.'s treatment.

There are no records of any laboratory tests being performed on T.K. during her entire 60-month course of treatment with Respondent. T.K.'s monthly blood pressure readings were recorded as 112/68 from January 2001 until December 2003; after this date, there are no recorded blood pressure readings. T.K.'s BMI reading was recorded only at her initial visit and

was not monitored thereafter for signs of progress. At T.K.'s last visit to Respondent on or about October 4, 2005, after approximately five years of treatment, her weight was 128 pounds, reflecting a net *gain* of 13 pounds.

5.

Patient S.R., a 28-year-old female, weighed 124 pounds and was 5' 2" tall at the time of her initial visit to Respondent on October 22, 1999. Her BMI at that time was 22.7, which is out of the Obesity range as established by the NIH and is low or below normal weight for S.R.'s height. Respondent diagnosed S.R. as being "overweight." S.R. received the non-specific weight reduction program and "Diet Literature" in addition to Phentermine (Adipex) 37.5 mg in 30-day supply. Respondent prescribed Adipex for S.R. approximately 57 times during her course of treatment, which ended on or about October 4, 2005. S.R.'s medical records contain no progress notes, nor do they contain any indication that any laboratory tests were performed on S.R. during her almost six-year course of treatment. There is no indication that a physical examination was ever performed on S.R. by the Respondent. S.R.'s BMI was never calculated again after her initial visit.

S.R.'s blood pressure was recorded at each monthly visit from October 1999 only until July 2003, despite the fact that S.R. was still being treated by Respondent until October 2005. Every blood pressure reading for S.R. is listed as 116/68. No pulse, temperature or respiration was ever recorded by Respondent. At the time of S.R.'s last visit to Respondent on or about October 4, 2005, she weighed 126 pounds, reflecting a net *gain* of 2 pounds.

6.

J.R., a 47-year-old female, began seeing Respondent on or about April 12, 2002, at which time she was diagnosed as being "overweight." No other specific illness is identified in

J.R.'s medical record. At the time of her first visit, J.R.'s height was 5' 6" and her weight was 235.5 pounds, giving her a BMI of 38, which is in the Obesity range according to NIH standards. J.R.'s records contain no indication that her history was ever reviewed by the Respondent, nor is there any indication that Respondent performed a physical examination of J.R. No laboratory tests were conducted at any time during J.R.'s course of treatment, which extended from April 12, 2002 until October 4, 2005. There are no progress notes in J.R.'s medical record.

J.R. was given the non-specific weight loss program, "Diet Literature," and a prescription for Phentermine (Adipex) 37.5 mg in 30-day supply. Respondent repeatedly prescribed Adipex for J.R., approximately 39 times over the course of treatment. No blood pressure readings were recorded in J.R.'s medical records after approximately September 2003, even though J.R. continued to see Respondent for another two years. All of the blood pressures which were recorded for J.R. were exactly the same, i.e., 126/72. No temperature, pulse or respirations were ever recorded. At her last visit to Respondent on October 4, 2005, J.R. weighed 188 pounds, reflecting a net weight loss of 47.5 pounds. However, there is no documentation supporting a maintenance plan for continued weight control.

7.

Patient L.D., a 41-year-old male, began treatment with the Respondent on or about October 19, 2000. He was diagnosed by the Respondent as being "overweight." No other specific illness is listed. At the time of his initial visit with the Respondent, L.D. was 5' 5" tall and weighed 158 pounds, resulting in a BMI of 26.3 which falls into the "Slightly Overweight" category as established by NIH. L.D. was a patient of Respondent's for approximately five (5) years. During this time L.D. was treated with the non-specific weight loss program, was given

"Diet Literature" and was prescribed Phentermine (Profast or Fastin) approximately 59 times, with dosages ranging from 18.75 mg to 30 mg. There is nothing in L.D.'s records to indicate why the dosage was changed.

L.D.'s blood pressure was only recorded by Respondent from October 19, 2000 until September 27, 2002, even though L.D. remained a patient of Respondent until on or about October 5, 2005. Every blood pressure recorded by the Respondent during this approximately two-year period was exactly the same, i.e., 120/68. No temperature, pulse or respiration was ever recorded in J.D.'s record. There were no laboratory tests performed and no indication that L.D. was ever given a physical examination by the Respondent. There are no progress notes contained in L.D.'s medical record. At the time of L.D.'s last visit with Respondent, L.D.'s weight was 172 pounds, representing a net *gain* of 14 pounds.

8.

Patient R.R. began seeing Respondent on or about March 5, 1998. At that time R.R., a 33-year-old female, was 4' 10" tall and weighed 139 pounds. She was diagnosed as "overweight" by Respondent. R.R. was treated by the Respondent for a total of 92 months, during which time she received prescriptions for Phentermine (Adipex P or Fastin) a total of 78 times, at dosages ranging from 30 mg to 37.5 mg, in 30-day supply. There is no indication in the records as to why R.R.'s medication dosage was adjusted. R.R. also received the non-specific weight loss regimen and "Diet Literature."

R.R.'s medical records contain no evidence that she ever received a physical examination from Respondent, no evidence that Respondent ever ordered any laboratory tests to be performed on R.R., and no evidence that Respondent properly monitored R.R.'s vital signs with each visit. There are no clear progress notes contained in R.R.'s record.

At the end of R.R.'s 92-month treatment regimen with Respondent, R.R. showed a net weight loss of only eight pounds.

9.

Patient R.C., a 47-year-old male, first saw Respondent on or about October 20, 2001 and was diagnosed as "overweight." No other specific illness is listed in R.C.'s records. At that time, R.C. weighed 213 pounds and was 5' 10" tall. There is no indication that Respondent ever performed a physical examination on R.C. or ordered any laboratory tests to be performed on R.C. R.C.'s vital signs were inconsistently monitored by Respondent, with blood pressure readings being recorded only through the September 12, 2003 visit (even though R.C. continued to see Respondent until September 6, 2005), and no temperature, pulse or respirations ever recorded. R.C.'s records show the same blood pressure reading at every visit for two years. There are no progress notes contained in R.C.'s medical records.

R.C.'s treatment with Respondent consisted of the non-specific weight loss plan, "Diet Literature," and prescriptions for Phentermine (Adipex) 37.5 mg in 30-day supply. This medication was prescribed by the Respondent for R.C. approximately 49 times. After 48 months of treatment with Respondent, R.C. weighed 211 pounds at his final visit on September 6, 2005, showing a net weight loss of only two pounds.

10.

Patient J.K. began treatment with Respondent on or about March 21, 1998, when he was 47 years old and weighed 166.5 pounds, with a height of 5' 7". J.K.'s diagnosis is listed as "overweight"; however, there is no indication in J.K.'s records that the Respondent ever performed a physical examination on him or ever ordered any laboratory tests. J.K. saw the Respondent for a total of 92 months. His treatment consisted of the non-specific weight loss

plan, "Diet Literature," and Phentermine (Adipex), 37.5 mg or Ionamin, 30 mg, in a 30-day supply. Respondent prescribed medication for J.K. approximately 75 times, yet there is no indication as to why Respondent periodically changed J.K.'s medication and/or dosage. No clear progress notes were found in J.K.'s records. J.K.'s blood pressure was recorded inconsistently, and his temperature, pulse and respirations were never recorded. At the time of J.K.'s last visit with Respondent on October 5, 2005, J.K. weighed 180 pounds, constituting a net *gain* of 14 pounds.

11.

Patient G.K., a 47-year-old female, saw Respondent for the first time on March 6, 1998. At that time she was 5' 8" tall and weighed 181 pounds. Her recorded BMI at that time was 27.4 ("slightly overweight" according to NIH standards) and she was diagnosed by Respondent as being "overweight." There is no indication in G.K.'s medical records that Respondent ever performed a physical examination on G.K. or ever ordered any laboratory tests. There are no clear progress notes contained in G.K.'s records. Respondent prescribed Phentermine (Adipex) for G.K. at a dosage of 37.5 mg, in 30-day supply, approximately 87 times over the course of G.K.'s treatment, which lasted until on or about October 8, 2005. G.K.'s records also indicate she was given the non-specific weight loss program and "Diet Literature."

G.K.'s blood pressure was recorded at 140/84 at her first visit, and 134/100 at her second visit, although there is no mention in the records of hypertension. At G.K.'s third visit, her blood pressure was recorded as 122/78 and that exact same reading is recorded at every visit until November 4, 2004, after which there are no further blood pressure readings recorded. G.K.'s temperature, pulse and respiration were never recorded in her medical records during

the entire course of her treatment with Respondent. At her last visit on October 8, 2005, G.K.'s weight was recorded as 182 pounds, reflecting a net *gain* of one pound.

12.

Patient S.K., a 24-year-old male, first visited the Respondent on August 22, 2001. At that time, he weighed 203 pounds and was 6' 1" tall. He was diagnosed as "overweight" by Respondent. S.K.'s medical records contain no indication that Respondent ever performed a physical examination on him or ever ordered any laboratory tests during S.K.'s entire course of treatment, which lasted until on or about October 8, 2005. There are no clear progress notes contained in S.K.'s record. During this time, Respondent prescribed Phentermine (Adipex), 37.5 mg in 30-day supply, approximately 20 times for S.K. S.K. also received the non-specific weight loss program and "Diet Literature."

Respondent recorded S.K.'s blood pressure as 130/78 from August 22, 2001 until September 24, 2003, after which time there are no blood pressure readings recorded for S.K. There are no readings for S.K.'s temperature, pulse or respirations ever recorded. S.K.'s weight was not recorded at his last visit, but his weight after 48 months of treatment is documented at 189 pounds. This reflects a net loss of 14 pounds; however, there is no weight loss maintenance plan contained in S.K.'s records.

13.

J.D., a 43-year-old female, first visited the Respondent on or about September 7, 1999. Her weight at that time was 145 pounds, which was actually normal or slightly below normal for her height of 5' 7" according to NIH standards. However, the Respondent listed J.D.'s diagnosis as "overweight" and prescribed Phentermine (Adipex or Fastin) at a dosage of either

30 mg or 37.5 mg in 30-day supply approximately 72 times over the 74 months of J.D.'s treatment. In addition, J.D. received the non-specific weight loss plan and "Diet Literature."

There is no indication that Respondent ever performed a physical examination of J.D., or ever ordered any laboratory tests on J.D. J.D.'s blood pressure was recorded as 124/72 at every single visit from September 7, 1999 until January 24, 2001, after which time there are no blood pressure readings recorded at all. There are no recordings for J.D.'s temperature, pulse and respiration anywhere in her medical records. There are no clear progress notes in J.D.'s records and thus no indication as to why the Respondent periodically changed J.D.'s medication and/or dosage. At her last visit, J.D.'s records indicate she lost a total of 14 pounds; however, there is no medical indication for weight loss treatment in an individual such as J.D. who is already at or below her normal weight.

14.

M.R., a 56-year-old female, weighed 156 pounds and was 5' 2" tall at the time of her first visit to the Respondent on March 13, 1998. Respondent calculated her BMI at 29.1, which placed M.R. in the "Obesity" range under NIH standards. There is no indication in M.R.'s records that Respondent ever conducted a physical examination of M.R. or ever ordered any laboratory tests be performed on M.R. Respondent gave M.R. the non-specific weight loss program and "Diet Literature." Respondent also prescribed Phentermine (Adipex P or Fastin), in 30 mg or 37.5 mg dosage, 30-day supply, approximately 92 times for M.R. over the course of her treatment, which lasted 92 months. There are no clear progress notes contained in M.R.'s records, thus there is no indication as to why Respondent changed M.R.'s medication and/or dosage.

M.R.'s temperature, pulse and respiration were never recorded by the Respondent throughout her entire 92 months of treatment. M.R.'s blood pressure was recorded as 124/82 from March 13, 1998 until August 27, 1998; it then changes to 124/76, and this exact same reading was recorded at every visit until November 15, 2003 after which there is no blood pressure reading recorded at all. At the time of M.R.'s last visit to the Respondent on October 12, 2005, she weighed 169 pounds, indicating a net *gain* of 11 pounds.

STATUES AND RULES INVOLVED

O.C.G.A. § 43-1-19 states, in part:

> (a) A professional licensing board shall have the authority to refuse to grant a license to an applicant therefor or to revoke the license of a person licensed by that board or to discipline a person licensed by that board, upon a finding by a majority of the entire board that the licensee or applicant has:
>
> . . .
>
> (6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice of harmful to the public, which conduct or practice materially affects the fitness of the licensee or applicant to practice as a business or profession licensed under this title, or of a nature likely to jeopardize the interest of the public, which conduct or practice need not have resulted in actual injury to any person or be directly related to the practice of the licensed business or profession but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness; unprofessional

conduct shall also include any departure from, or failure to conform to, the minimal reasonable standards of acceptable and prevailing practice of the business or profession licensed under this title;

(d) When a professional licensing board finds that any person is unqualified to be granted a license or finds that any person should be disciplined pursuant to subsection (a) of this Code section or the laws, rules, or regulations relating to the business or profession licensed by the board, the board may take any one or more of the following actions:

. . .

(5) Revoke any license[.]

. . .

(7) Impose a fine not to exceed $500.00 for each violation of a law, rule, or regulation relating to the licensed business or profession.

O.C.G.A. § 43-34-37 states, in part:

(a) The board shall have authority to refuse to grant a license to an applicant or to discipline a physician licensed under this chapter or any antecedent law upon a finding by the board that the licensee or applicant has:

. . .

(7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term 'unprofessional conduct' shall include any departure from, or

failure to conform to, the minimal standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to the patient as determined by the minimal standards of acceptable and prevailing medical practice or by rule of the board[.]

. . .

(b)(1) When the board finds that any person . . . should be disciplined pursuant to subsection (a) of this Code section, the board may take any one or more of the following actions:

(E) Revoke any license[.]

O.C.G.A. § 43-34-20 states, in part:

(2.1) 'Physician' means a person licensed to practice medicine under this article.

(3) 'To practice medicine' means to hold oneself out to the public as being engaged in the diagnosis or treatment of disease, defects, or injuries of human beings; or the suggestion, recommendation, or prescribing of any form of treatment for the intended palliation, relief, or cure of any physical, mental, or functional ailment or defect of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever; or the maintenance of an office for the reception, examination, and treatment of persons suffering from disease, defect, or injury of body or mind; or attaching the title 'M.D.,' 'Oph.,' 'D.,' 'Dop.,' 'Surgeon'' 'Doctor,' 'D.O.,' 'Doctor of Osteopathy,' either

alone or in connection with other words or any words or abbreviations to one's name, indicating that such person is engaged in the treatment or diagnosis of disease, defects, or injuries to human beings, provided that the terms 'doctors of medicine,' 'doctors of medicine licensed to practice in the state,' and similar terms wherever used or appearing in this article or elsewhere shall mean and include only those persons who are licensed to practice medicine under this article.

Board Rule 360-3-.01 provides:

The Composite State Board of Medical Examiners ('Board') is authorized to deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician or physician's assistant for all the ground set forth in O.C.G.A. § 43-1-19(a), and to deny, revoke, suspend, fine, reprimand or otherwise limit the license of a physician pursuant to O.C.G.A. § 43-34-37. In addition, the Board is authorized to terminate the approval of physician's assistant and to revoke the license of a physician's assistant pursuant to O.C.G.A. § 43-34-107.

Board Rule 360-3-.02 provides, in part:

O.C.G.A. §§ 43-1-19 and 43-34-37 authorize the Board to take disciplinary action against licensees for unprofessional conduct. 'Unprofessional conduct' shall include, but not be limited to, the following:

. . .

(7) Failing to maintain appropriate patient records whenever Schedule I, II, II, IV or V controlled substances are prescribed. Appropriate records, at a minimum, shall contain the following:

(a) The patient's name and address;

(b) The date, drug name, drug quantity, and patient's diagnosis necessitating the Schedule I, II, III, IV, or V controlled substances prescription; and

(c) Records concerning the patient's history.

. . .

(14) Failing to use such means as history, physical examination, laboratory, or radiographic studies, when applicable, to diagnose a medical problem.

. . .

(16) Failing to maintain patient records documenting the course of the patient's medical evaluation, treatment, and response.

(a) A physician shall be required to maintain a patient's complete medical record, which may include, but is not limited to, the following: history and physical, progress notes, X-ray reports, photographs, laboratory reports, and other reports as may be required by provision of the law. ...

. . .

(18) Any other practice determined to be below the minimal standards of acceptable and prevailing practice.

Board Rule 360-3-.03 provides, in part:

The Composite State Board of Medical Examiners is authorized to take disciplinary action for violations of laws and rules and regulations which relate to or in part regulate the practice of medicine. These laws, rules and regulations include, but are not limited to, the following:

(1) The Georgia Medical Practice Act (O.C.G.A. T. 43, Ch. 34);

(2) The Georgia Controlled Substances Act (O.C.G.A. T. 16, Ch. 13, Art 2);

(3) The Georgia Dangerous Drug Act (O.C.G.A. T. 16, Ch. 13, Art. 3);

(6) The Rules of the Composite State Board of Medical Examiners, Ch. 360, Rules and Regulations of the State of Georgia;

(8) The Code of Federal Regulations Relating to Controlled Substances (21 C.F.R. par. 1306); and

(9) O.C.G.A. Section 31-9-6.1 and Chapter 360-14 of the rules of the Composite State Board of Medical Examiners relating to informed consent.

COMPOSITE STATE BOARD
OF MEDICAL EXAMINERS

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