BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF	*	
	*	CASE NO. 15-CRF-045
BERNARD DESILVA, M.D.	*	

ENTRY OF ORDER

On May 6, 2016, Bernard DeSilva, M.D., executed a Surrender/Retirement of his license to practice medicine and surgery in Ohio with consent to permanent revocation, which document is attached hereto and fully incorporated herein.

Wherefore, upon ratification by the Board of the surrender/retirement, it is hereby ORDERED that Certificate No. 35.034102 authorizing Bernard DeSilva, M.D., to practice medicine and surgery in the State of Ohio be permanently REVOKED.

This Order is hereby entered upon the Journal of the State Medical Board of Ohio for the 11th day of May 2016, and the original thereof shall be kept with said Journal.

Kim G. Rothermel MD

Kim G. Rothermel, M.D.
Secretary

(SEAL)

May 11, 2016
Date

STATE OF OHIO
THE STATE MEDICAL BOARD
PERMANENT SURRENDER/RETIREMENT OF CERTIFICATE
TO PRACTICE MEDICINE AND SURGERY
CASE NO. 15-CRF-045

Do not sign this agreement without reading it. An individual who permanently surrenders a certificate issued by the Board is forever thereafter ineligible to hold a certificate to practice or to apply to the Board for reinstatement of the certificate or issuance of any new certificate. You are permitted to be accompanied, represented and advised by an attorney, at your own expense, before deciding to sign this voluntary agreement.

I, Bernard DeSilva, M.D., am aware of my rights to representation by counsel, the right of being formally charged and having a formal adjudicative hearing, and do hereby freely execute this document and choose to take the actions described herein.

I, Bernard DeSilva, M.D., do hereby voluntarily, knowingly, and intelligently surrender/retire my certificate to practice medicine and surgery, License #35.034102, to the State Medical Board of Ohio [Board], thereby relinquishing all rights to practice medicine and surgery in Ohio.

I understand that as a result of the surrender/retirement herein I am no longer permitted to practice medicine and surgery in any form or manner in the State of Ohio.

I agree that I shall be ineligible for, and shall not apply for, reinstatement or restoration of certificate to practice medicine and surgery License #35.034102 or issuance of any other certificate pursuant to the authority of the State Medical Board of Ohio, on or after the date of signing this Permanent Surrender/Retirement of Certificate to Practice Medicine and Surgery. Any such attempted reapplication shall be considered null and void and shall not be processed by the Board.

I hereby authorize the State Medical Board of Ohio to enter upon its Journal an Order permanently revoking my certificate to practice medicine and surgery, License #35.034102, with said revocation taking effect sixty days from the effective date of this agreement, and in conjunction with which I expressly waive the provision of Section 4731.22(B), Ohio Revised Code, requiring that six (6) Board Members vote to revoke said certificate, and further expressly and forever waive all rights as set forth in Chapter 119., Ohio Revised Code, including but not limited to my right to counsel, right to a hearing, right to present evidence, right to cross-examine witnesses, and right to appeal the Order of the Board revoking my certificate to practice medicine and surgery. Upon ratification of this agreement and during the sixty day period before the permanent revocation is effective, I shall not commence treatment of new patients in my medical practice.

I, Bernard DeSilva, M.D., hereby release the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This document shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data banks and governmental bodies. I, Bernard DeSilva, M.D., acknowledge that my social security number will be used if this information is so reported and agree to provide my social security number to the Board for such purposes.

I stipulate and agree that I am taking the action described herein in lieu of further formal disciplinary proceedings in Case No. 15-CRF-045, pursuant to Sections 4731.22(B)(2); (B)(6); and (B)(20) Ohio Revised Code, as set forth in the Notice of Opportunity for Hearing issued by the Board on May 13, 2015, a copy of which is attached hereto as Exhibit A and fully incorporated herein. I admit to failing to practice according to the minimal standard of care for documentation of medical records in violation of R.C. 4731.22(B)(6) in accordance with the allegations outlined in the May 13, 2015, Notice of Opportunity for Hearing.

EFFECTIVE DATE

It is expressly understood that this Permanent Surrender of Certificate is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

BERNARD DESILVA, M.D.

5/6/16
DATE

DOUGLAS E. GRAFF
Attorney for Dr. DeSilva

5/6/16
DATE

KIM G. ROTHERMEL, M.D.
Secretary

5/11/16
DATE

BRUCE R. SAFERIN, D.P.M.
Supervising Member

5-11-16
DATE

KYLE C. WILCOX
Assistant Attorney General

5-6-16

DATE

State Medical Board of Ohio

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

(614) 466-3934 med.ohio.gov

May 13, 2015

Case number: 15-CRF-045

Bernard DeSilva, M.D.
3475 Vista Avenue
Cincinnati, Ohio 45208

Dear Doctor DeSilva:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) From in or around July 2004 to in or around April 2014, in the routine course of your practice, you provided care and treatment for Patients 1 through 13 as identified on the attached Patient Key **(Key is confidential and to be withheld from public disclosure).**

You inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document your treatment of Patients 1 through 8 and 10 through 13.

(a) Examples of such conduct for Patients 1 through 8 and 10 through 13 include, but are not limited to, the following:

(i) You prescribed medications without conducting and/or documenting a reasonable psychiatric evaluation. You also failed to provide and/or document a psychiatric diagnosis.

(ii) You failed to employ reasonable methodology in your evaluation of these patients in that you failed to gather and/or document elements of a standard psychiatric evaluation, including the patient's history of present illness and past psychiatric history. You also failed to conduct and/or document conducting a Mental Status Examination. Additionally, you failed to provide and/or

document a psychiatric diagnosis based on accepted DSM-IVTR criteria.

(iii) You failed to employ reasonable methodology in your treatment of these patients, in that you failed to prescribe or document a course of treatment without conducting and/or documenting a proper psychiatric evaluation. You also prescribed a course of treatment that was not based on or related to a documented psychiatric diagnosis. Additionally, you failed to periodically document the patient's response to treatment, and you failed to perform and/or document performing subsequent Mental Status Examinations. You also failed to document that you had received the patient's informed consent for treatment.

(b) Further examples of additional conduct specific to each patient include, but are not limited to, the following:

(i) You treated Patient 1 from on or about August 10, 2006, to on or about March 29, 2007. You failed to document Patient 1's chief complaint and his medical history. Although you prescribed medications for Patient 1, you failed to document the rationale for Patient 1's treatment plan. The medical record you provided to the Board is missing documentation of patient encounters, and the progress notes are partially illegible and incomplete.

(ii) You treated Patient 2 from on or about January 10, 2007, to on or about November 25, 2008. Although you failed to document a psychiatric diagnosis based on accepted DSM-IVTR criteria, you prescribed medications as treatment. Additionally, while you did keep some records, the progress notes are partially illegible and incomplete.

(iii) You treated Patient 3 from on or about July 7, 2004, to on or about October 15, 2008. Throughout your treatment of Patient 3, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 3 without documenting a medical justification for this practice. You also prescribed Depakote for Patient 3, but failed to arrange for her to have blood level monitoring of this medication. Additionally, you failed to document Patient 3's chief complaint and her medical history. Patient 3's medical chart is missing progress note entries for several patient encounters, and many progress notes are partially illegible and incomplete.

(iv) You treated Patient 4 from on or about December 14, 2006, to on or about August 4, 2009. Throughout your treatment of Patient 4, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 4 without documenting a medical justification for this practice. In or around 2008, you prescribed three antidepressant medications concurrently for Patient 4, although you failed to document a reason or justification. Additionally, you failed to document Patient 4's chief complaint and her medical history. Further, Patient 4's medical chart is missing progress note entries for several patient encounters, and many progress notes are partially illegible and incomplete.

(v) You treated Patient 5 from on or about July 22, 2010, to on or about August 23, 2012. Throughout your treatment of Patient 5, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 5 without documenting a medical justification for this practice. You also failed to document Patient 5's chief complaint and his medical history. Further, you failed to document the rationale for Patient 5's treatment plan, and many progress notes are partially illegible and incomplete.

(vi) You treated Patient 6 from on or about June 6, 2008, to on or September 6, 2012. Throughout your treatment of Patient 6, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 6 without documenting a medical justification for this practice. You also failed to document Patient 6's chief complaint and his medical history. Further, you failed to document the rationale for Patient 6's treatment plan, and many progress notes are partially illegible and incomplete.

(vii) You treated Patient 7 from on or about March 20, 2012, to on or about April 17, 2014. Throughout your treatment of Patient 7, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 7 without documenting a medical justification for this practice. You also failed to document Patient 7's chief complaint and her medical history. Further, you failed to document the rationale for Patient 7's treatment plan, and many progress notes are partially illegible and incomplete.

(viii) You treated Patient 8 from on or about October 19, 2010, to on or about September 28, 2012. Throughout your treatment of Patient

8, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 8 without documenting a medical justification for this practice. You also failed to document Patient 8's chief complaint and her medical history. Further, you failed to document the rationale for Patient 8's treatment plan, and many progress notes are partially illegible and incomplete.

(ix) You treated Patient 10 from on or about June 15, 2011, to on or about May 30, 2013. You failed to document Patient 10's chief complaint and his medical history. Further, you failed to document the rationale for Patient 10's treatment plan, and many progress notes are partially illegible and incomplete.

(x) You treated Patient 11 from on or about May 30, 2007, to on or about May 16, 2013. You failed to document Patient 11's chief complaint and his medical history. You also failed to document the rationale for Patient 11's treatment plan, and many progress notes are partially illegible and incomplete.

(xi) You treated Patient 12 from on or about November 4, 2009, to on or about May 18, 2013. You failed to document Patient 12's chief complaint and his medical history. You also failed to document the rationale for Patient 12's treatment plan, and many progress notes are partially illegible and incomplete.

(xii) You treated Patient 13 from on or about August 3, 2011, to on or about September 4, 2012. You prescribed Depakote for Patient 13, but failed to arrange for her to have blood level monitoring of this medication. Additionally, you failed to document Patient 13's chief complaint and her medical history, and many progress notes are partially illegible and incomplete.

(2) Although you prescribed medications, including controlled substances, for many of your patients, you failed to record in a patient record all of the controlled substances you prescribed. Examples of such conduct for Patients 5, 6, 9, 10, 11, 12 and 13 include, but are not limited to, the following:

(a) On or about January 8, 2011; March 3, 2011; January 27, 2012; March 8, 2012, and March 28, 2012, you prescribed Valium for Patient 5. Valium is a controlled substance. You failed to document these prescriptions in Patient 5's medical record.

(b) On or about February 16, 2011, and October 4, 2011, you prescribed Lyrica for Patient 6. Lyrica is a controlled substance. You failed to document these prescriptions in Patient 6's medical record.

(c) On or about February 5, 2010; June 10, 2011; June 30, 2011; September 2, 2011; October 14, 2011; November 4, 2011; December 9, 2011; February 22, 2012; May 4, 2012; July 18, 2012, and August 9, 2012, you prescribed Lyrica for Patient 9. Lyrica is a controlled substance. You failed to produce a patient record for Patient 9 showing that you documented these prescriptions in Patient 9's medical record.

(d) On or about August 17, 2011; February 2, 2012, and February 16, 2012, you prescribed Xanax for Patient 10. Xanax is a controlled substance. You failed to document these prescriptions in Patient 10's medical record.

(e) On or about May 24, 2012 and August 12, 2010, you prescribed Ambien for Patient 11. Ambien is a controlled substance. You failed to document these prescriptions in Patient 11's medical record.

(f) On or about October 7, 2010, and March 16, 2011, you prescribed Lyrica for Patient 12. Lyrica is a controlled substance. You failed to document these prescriptions in Patient 12's medical record.

(g) On or about January 12, 2012, and January 24, 2012, you prescribed Ativan for Patient 13. Ativan is a controlled substance. You failed to document these prescriptions in Patient 13's medical record.

(3) You have written prescriptions for medications for Patients 5, 6, 8, 9, 10, 11, 12, and 13, and have failed to record all of the required information on the written prescription, including the patient's address. At times, you have written prescriptions with controlled substances and non-controlled substances on the same prescription, despite having been notified by representatives of the Board of Pharmacy that this was inappropriate.

(4) During the period of in or around 2010 to in or around 2012, you wrote prescriptions for dangerous drugs for Patients 5, 6, 9, 10, 11 and 12 with more than three dangerous drugs on the prescription, despite having been notified by representatives of the Board of Pharmacy that this was inappropriate.

(5) You have failed to timely and fully respond to all subpoenas issued to you by the Board.

(a) On or about June 4, 2012, the Board issued to you a subpoena, requesting that you produce 13 patient records on or before June 25,

2012. When you failed to produce the records by that date, on or about September 28, 2012, the Board sent you a letter, requesting production of the records on or before October 15, 2012. Subsequently, you produced some of the records, although you failed to produce all of the records, including the records for Patient 9. In response to a letter sent to you by a Board representative, you claimed you did not have any records for Patient 9. To date, you have failed to produce Patient 9's records.

(b) On or about October 9, 2014, the Board delivered to you a subpoena, requesting the production of a patient's records. The records were to be produced on or before October 30, 2014. When the records were not produced, on or about March 2, 2015, the Board sent a letter to your counsel, requesting production of the patient's records on or before March 16, 2015. To date, you have failed to produce the patient's records.

Your acts, conduct, and/or omissions as alleged in paragraph (1) through (1)(b)(xii) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (1)(b)(xii) and (4) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Additionally, your acts, conduct, and/or omissions as alleged in paragraph (2) through (2)(g) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code. Further, pursuant to Rule 4731-11-02(F), Ohio Administrative Code, a violation of any provision of Rule 4731-11-02 shall constitute a violation of Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (3) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(E), Ohio Administrative Code, as it incorporates Section 3719.06, Ohio Revised Code, and Rules 4729-5-13 and 4729-5-30, Ohio Administrative Code.

Additionally, your acts, conduct, and/or omissions as alleged in paragraph (5) above, individually and/or collectively, constitute "[f]ailure to cooperate in an investigation conducted by the board under division (F) of this section, including failure to comply with a subpoena or order issued by the board or failure to answer truthfully a question presented by the board in an investigative interview, an investigative office conference, at a deposition, or in written interrogatories," as that clause is used in Section 4731.22(B)(34), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Kim G. Rothermel M.D.

Kim G. Rothermel, M.D.
Secretary

KGR/CDP/pev
Enclosures

CERTIFIED MAIL #91 7199 9991 7034 8383 0132
RETURN RECEIPT REQUESTED

CC: Douglas E. Graff
Graff and McGovern, LLP
604 East Rich Street
Columbus, Ohio 43215

CERTIFIED MAIL #91 7199 9991 7034 8383 0149
RETURN RECEIPT REQUESTED

IN THE MATTER OF BERNARD DESILVA, M.D.

15-CRF-045

MAY 13, 2015, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.

State Medical Board of Ohio

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

(614) 466-3934 med.ohio.gov

May 13, 2015

Case number: 15-CRF- 045

Bernard DeSilva, M.D.
3475 Vista Avenue
Cincinnati, Ohio 45208

Dear Doctor DeSilva:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) From in or around July 2004 to in or around April 2014, in the routine course of your practice, you provided care and treatment for Patients 1 through 13 as identified on the attached Patient Key **(Key is confidential and to be withheld from public disclosure).**

You inappropriately treated and/or failed to appropriately treat and/or failed to appropriately document your treatment of Patients 1 through 8 and 10 through 13.

(a) Examples of such conduct for Patients 1 through 8 and 10 through 13 include, but are not limited to, the following:

(i) You prescribed medications without conducting and/or documenting a reasonable psychiatric evaluation. You also failed to provide and/or document a psychiatric diagnosis.

(ii) You failed to employ reasonable methodology in your evaluation of these patients in that you failed to gather and/or document elements of a standard psychiatric evaluation, including the patient's history of present illness and past psychiatric history. You also failed to conduct and/or document conducting a Mental Status Examination. Additionally, you failed to provide and/or

Mailed 5-14-15

document a psychiatric diagnosis based on accepted DSM-IVTR criteria.

(iii) You failed to employ reasonable methodology in your treatment of these patients, in that you failed to prescribe or document a course of treatment without conducting and/or documenting a proper psychiatric evaluation. You also prescribed a course of treatment that was not based on or related to a documented psychiatric diagnosis. Additionally, you failed to periodically document the patient's response to treatment, and you failed to perform and/or document performing subsequent Mental Status Examinations. You also failed to document that you had received the patient's informed consent for treatment.

(b) Further examples of additional conduct specific to each patient include, but are not limited to, the following:

(i) You treated Patient 1 from on or about August 10, 2006, to on or about March 29, 2007. You failed to document Patient 1's chief complaint and his medical history. Although you prescribed medications for Patient 1, you failed to document the rationale for Patient 1's treatment plan. The medical record you provided to the Board is missing documentation of patient encounters, and the progress notes are partially illegible and incomplete.

(ii) You treated Patient 2 from on or about January 10, 2007, to on or about November 25, 2008. Although you failed to document a psychiatric diagnosis based on accepted DSM-IVTR criteria, you prescribed medications as treatment. Additionally, while you did keep some records, the progress notes are partially illegible and incomplete.

(iii) You treated Patient 3 from on or about July 7, 2004, to on or about October 15, 2008. Throughout your treatment of Patient 3, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 3 without documenting a medical justification for this practice. You also prescribed Depakote for Patient 3, but failed to arrange for her to have blood level monitoring of this medication. Additionally, you failed to document Patient 3's chief complaint and her medical history. Patient 3's medical chart is missing progress note entries for several patient encounters, and many progress notes are partially illegible and incomplete.

(iv) You treated Patient 4 from on or about December 14, 2006, to on or about August 4, 2009. Throughout your treatment of Patient 4, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 4 without documenting a medical justification for this practice. In or around 2008, you prescribed three antidepressant medications concurrently for Patient 4, although you failed to document a reason or justification. Additionally, you failed to document Patient 4's chief complaint and her medical history. Further, Patient 4's medical chart is missing progress note entries for several patient encounters, and many progress notes are partially illegible and incomplete.

(v) You treated Patient 5 from on or about July 22, 2010, to on or about August 23, 2012. Throughout your treatment of Patient 5, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 5 without documenting a medical justification for this practice. You also failed to document Patient 5's chief complaint and his medical history. Further, you failed to document the rationale for Patient 5's treatment plan, and many progress notes are partially illegible and incomplete.

(vi) You treated Patient 6 from on or about June 6, 2008, to on or September 6, 2012. Throughout your treatment of Patient 6, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 6 without documenting a medical justification for this practice. You also failed to document Patient 6's chief complaint and his medical history. Further, you failed to document the rationale for Patient 6's treatment plan, and many progress notes are partially illegible and incomplete.

(vii) You treated Patient 7 from on or about March 20, 2012, to on or about April 17, 2014. Throughout your treatment of Patient 7, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 7 without documenting a medical justification for this practice. You also failed to document Patient 7's chief complaint and her medical history. Further, you failed to document the rationale for Patient 7's treatment plan, and many progress notes are partially illegible and incomplete.

(viii) You treated Patient 8 from on or about October 19, 2010, to on or about September 28, 2012. Throughout your treatment of Patient

8, you engaged in polypharmacy, prescribing excessive types of psychotropic medications for Patient 8 without documenting a medical justification for this practice. You also failed to document Patient 8's chief complaint and her medical history. Further, you failed to document the rationale for Patient 8's treatment plan, and many progress notes are partially illegible and incomplete.

(ix) You treated Patient 10 from on or about June 15, 2011, to on or about May 30, 2013. You failed to document Patient 10's chief complaint and his medical history. Further, you failed to document the rationale for Patient 10's treatment plan, and many progress notes are partially illegible and incomplete.

(x) You treated Patient 11 from on or about May 30, 2007, to on or about May 16, 2013. You failed to document Patient 11's chief complaint and his medical history. You also failed to document the rationale for Patient 11's treatment plan, and many progress notes are partially illegible and incomplete.

(xi) You treated Patient 12 from on or about November 4, 2009, to on or about May 18, 2013. You failed to document Patient 12's chief complaint and his medical history. You also failed to document the rationale for Patient 12's treatment plan, and many progress notes are partially illegible and incomplete.

(xii) You treated Patient 13 from on or about August 3, 2011, to on or about September 4, 2012. You prescribed Depakote for Patient 13, but failed to arrange for her to have blood level monitoring of this medication. Additionally, you failed to document Patient 13's chief complaint and her medical history, and many progress notes are partially illegible and incomplete.

(2) Although you prescribed medications, including controlled substances, for many of your patients, you failed to record in a patient record all of the controlled substances you prescribed. Examples of such conduct for Patients 5, 6, 9, 10, 11, 12 and 13 include, but are not limited to, the following:

(a) On or about January 8, 2011; March 3, 2011; January 27, 2012; March 8, 2012, and March 28, 2012, you prescribed Valium for Patient 5. Valium is a controlled substance. You failed to document these prescriptions in Patient 5's medical record.

(b) On or about February 16, 2011, and October 4, 2011, you prescribed Lyrica for Patient 6. Lyrica is a controlled substance. You failed to document these prescriptions in Patient 6's medical record.

(c) On or about February 5, 2010; June 10, 2011; June 30, 2011; September 2, 2011; October 14, 2011; November 4, 2011; December 9, 2011; February 22, 2012; May 4, 2012; July 18, 2012, and August 9, 2012, you prescribed Lyrica for Patient 9. Lyrica is a controlled substance. You failed to produce a patient record for Patient 9 showing that you documented these prescriptions in Patient 9's medical record.

(d) On or about August 17, 2011; February 2, 2012, and February 16, 2012, you prescribed Xanax for Patient 10. Xanax is a controlled substance. You failed to document these prescriptions in Patient 10's medical record.

(e) On or about May 24, 2012 and August 12, 2010, you prescribed Ambien for Patient 11. Ambien is a controlled substance. You failed to document these prescriptions in Patient 11's medical record.

(f) On or about October 7, 2010, and March 16, 2011, you prescribed Lyrica for Patient 12. Lyrica is a controlled substance. You failed to document these prescriptions in Patient 12's medical record.

(g) On or about January 12, 2012, and January 24, 2012, you prescribed Ativan for Patient 13. Ativan is a controlled substance. You failed to document these prescriptions in Patient 13's medical record.

(3) You have written prescriptions for medications for Patients 5, 6, 8, 9, 10, 11, 12, and 13, and have failed to record all of the required information on the written prescription, including the patient's address. At times, you have written prescriptions with controlled substances and non-controlled substances on the same prescription, despite having been notified by representatives of the Board of Pharmacy that this was inappropriate.

(4) During the period of in or around 2010 to in or around 2012, you wrote prescriptions for dangerous drugs for Patients 5, 6, 9, 10, 11 and 12 with more than three dangerous drugs on the prescription, despite having been notified by representatives of the Board of Pharmacy that this was inappropriate.

(5) You have failed to timely and fully respond to all subpoenas issued to you by the Board.

(a) On or about June 4, 2012, the Board issued to you a subpoena, requesting that you produce 13 patient records on or before June 25,

2012. When you failed to produce the records by that date, on or about September 28, 2012, the Board sent you a letter, requesting production of the records on or before October 15, 2012. Subsequently, you produced some of the records, although you failed to produce all of the records, including the records for Patient 9. In response to a letter sent to you by a Board representative, you claimed you did not have any records for Patient 9. To date, you have failed to produce Patient 9's records.

(b) On or about October 9, 2014, the Board delivered to you a subpoena, requesting the production of a patient's records. The records were to be produced on or before October 30, 2014. When the records were not produced, on or about March 2, 2015, the Board sent a letter to your counsel, requesting production of the patient's records on or before March 16, 2015. To date, you have failed to produce the patient's records.

Your acts, conduct, and/or omissions as alleged in paragraph (1) through (1)(b)(xii) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as those clauses are used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (1)(b)(xii) and (4) above, individually and/or collectively, constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Additionally, your acts, conduct, and/or omissions as alleged in paragraph (2) through (2)(g) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code. Further, pursuant to Rule 4731-11-02(F), Ohio Administrative Code, a violation of any provision of Rule 4731-11-02 shall constitute a violation of Sections 4731.22(B)(2) and 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (3) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(E), Ohio Administrative Code, as it incorporates Section 3719.06, Ohio Revised Code, and Rules 4729-5-13 and 4729-5-30, Ohio Administrative Code.

Additionally, your acts, conduct, and/or omissions as alleged in paragraph (5) above, individually and/or collectively, constitute "[f]ailure to cooperate in an investigation conducted by the board under division (F) of this section, including failure to comply with a subpoena or order issued by the board or failure to answer truthfully a question presented by the board in an investigative interview, an investigative office conference, at a deposition, or in written interrogatories," as that clause is used in Section 4731.22(B)(34), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,

Kim G. Rothermel M.D.

Kim G. Rothermel, M.D.
Secretary

KGR/CDP/pev
Enclosures

CERTIFIED MAIL #91 7199 9991 7034 8383 0132
RETURN RECEIPT REQUESTED

CC: Douglas E. Graff
Graff and McGovern, LLP
604 East Rich Street
Columbus, Ohio 43215

CERTIFIED MAIL #91 7199 9991 7034 8383 0149
RETURN RECEIPT REQUESTED

IN THE MATTER OF BERNARD DESILVA, M.D.

15-CRF-045

MAY 13, 2015, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.