IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
GENERAL DIVISION

MYRON LYLE SHANK, M.D.,	**:**	
Appellant,	**:**	**CASE NO. 12-CV-643**
vs.	**:**	**JUDGE TIMOTHY S. HORTON**
THE STATE MEDICAL BOARD OF OHIO	**:**	
Appellee.	**:**	

DECISION AND ENTRY

HORTON, J.

This matter is before this Court pursuant to R.C. 119.12 from a December 30, 2011 Entry of Order of the State Medical Board of Ohio ("Board"). The Board found that Myron L. Shank, M.D., ("Appellant") violated R.C. 4731.22(B)(6) in that his acts, conduct and/or omissions, as set forth in the Hearing Examiner's November 17, 2011, Findings of Fact, 1 and 2(a)-(f), 2(g)(1), 2(j)(1), and 3(a)(1), individually and/or collectively, constituted a departure from, or the failure to conform to, minimal standards of care of similar physicians under the same or similar circumstances, whether or not actual injury to a patient is established. See R.C. 4731.22(B)(6).

FACTS AND PROCEDURAL HISTORY

In a January 12, 2011 letter, the Board notified Appellant that it proposed to take disciplinary action against his license to practice medicine and surgery in Ohio. The Board alleged that, between 2003 and 2008, the Appellant fell below the minimal standards in regard to his care and treatment of eleven patients. The patients are identified in this record by number so as to protect their privacy. The Board alleged that the Appellant inappropriately prescribed or

continued to prescribe narcotic analgesic medications to Patients 1-8, 10 and 11. Furthermore, the Board alleged that the Appellant failed to document objective data to support continued prescribing of narcotics to Patients 1-11, failed to recognize drug seeking behavior, and continued to prescribe controlled substances to Patients 1-3, 10 and 11, all in violation of R.C. 4731.22(B)(6). See State's Exhibit 1 and 1a. An administrative hearing was held before Hearing Examiner Gretchen Petrucci commencing on July 26 and ending on July 29, 2011.

Dr. Irene Chenowith, M.D., F.A.C.P. testified as an expert general practitioner on behalf of the Appellee regarding Dr. Shank's care and treatment of Patients 1 through 11. Dr. Myron L. Shank, M.D. testified as his own expert on his own behalf. The Appellant incorrectly asserts in his brief that the Board was required to present expert testimony from a pain management specialist. Neither Dr. Chenowith, *nor Dr. Shank*, for that matter, are board certified specialists in pain medicine management. Thus, the proper standard to apply in this case is based on the knowledge of a generalist physician; and the seminal issue in this case is focused upon Dr. Shank's failure to either terminate a patient's care and treatment, or refer them to someone with more expertise, such as pain management specialist. Tr. 127, 145-147, 158, 184, 194 209, 243, 265-266. Accordingly, the issue before the Board was whether the Appellant's conduct in his care and treatment of Patients 1 through 11 fell below the minimal standard for a general practitioner; and not, as Appellant argues, the minimal standard for a certified specialist in pain management.

The Hearing Examiner concluded that the Appellant fell below the minimal standards of care of similar physicians under the same or similar circumstances, whether or not actual injury to the patient was established, as set forth in her November 17, 2011, Report and Recommendation, Findings of Fact, 1 and 2(a)-(f), 2(g) (1), 2(j)(1), and 3(a)(1). See R.C.

4731.22(B)(6). Consequently, the Hearing Examiner recommended that Appellant's license be suspended for an indefinite period of time, but not less than 180 days. She also recommended imposing upon Appellant a term of probation following reinstatement, with conditions that included monitoring, reporting, and continuing education requirements. See November 17, 2011 Report and Recommendation. The Board modified the proposed discipline by imposing a ninety (90) day stayed suspension. See December 30, 2011 Entry of Order.

Both parties filed objections to the November 17, 2011 Report and Recommendation. The Appellant appeared before the Board on December 14, 2011. Thereafter, the Board adopted the findings of fact and conclusions of law of the hearing officer, but amended the proposed order. The Board mailed its Entry of Order on December 30, 201, and Appellant filed his appeal pursuant to R.C. 119.12.

STANDARD OF REVIEW

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

> The court may affirm the order of the agency complained of in the appeal if it finds, upon consideration of the entire record and such additional evidence as the court has admitted, that the order is supported by reliable, probative and substantial evidence and is in accordance with law.
>
> In *Our Place* the Ohio Supreme Court provided the following definition of reliable, probative and substantial evidence as:
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> (1) 'Reliable' evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) 'Probative' evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) 'Substantial' evidence is evidence with some weight; it must have importance and value.
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> *Our Place, Inc. v. Ohio Liquor Comm.*, 63 Ohio St.3d 570, 571, (1992).

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

APPELLANT'S ASSIGNMENTS OF ERROR

The Appellant has asserted the following two assignments of error:

> The State Medical Board of Ohio erred to the prejudice of Appellant in adopting the Hearing Examiner's Conclusion of Law 1, first paragraph, as that conclusion is not supported by reliable, probative and substantial evidence and is not in accordance with law.
>
> The State Medical Board of Ohio erred to the prejudice of Appellant, and violated his due process rights, in imposing discipline against Appellant's license on the basis of unarticulated standards of care and incompetent expert witness testimony, where Appellant himself testified as to the correct standards of care and his application of those standards to the treatment of his patients.

LAW AND ARGUMENT

The Appellant's assignments of error are interrelated and will be addressed simultaneously. The Appellant asserts in his assignments of error that the Board's order is not supported by reliable, probative and substantial evidence, and is not in accordance with law. The Appellant specifically asserts;

> Where the Board's expert witness did not render opinions in accordance with the correct legal standard and could not be qualified as an expert, and Appellant himself was qualified as an expert and testified as to the applicable standards of care and his application of those standards to the treatment of his patients, the Board's expert's report and testimony were inherently unreliable and not probative of the Board's allegations against Appellant; hence the Board's order is not supported by reliable, probative and substantial evidence and is not in accordance with law.

The Court will note from the onset, that the Appellant's two assignments of error do not address Dr. Shank's conduct in his (1) failure to follow up on a fine needle biopsy of a large thyroid mass on Patient 5's neck; (2) his failure to properly manage hypertension in Patient 6; and (3) inappropriately continuing to prescribe Schedule II stimulants to Patient 6 despite the possible contraindications, such as poorly controlled or uncontrolled hypertension. The Hearing Examiner concluded that the Board had proven these allegations and thus, since the Appellant has failed to address these issues, the Court concludes that the Appellant has conceded a violation of R.C. 4731.22(B)(6) on these issues. See November 17, 2011 Report and Recommendation.

The Appellant's two assignments of error only address Dr. Shank's falling below the minimal standards of care in regard to his conduct in inappropriately prescribing, or continuing to prescribe, narcotic analgesic medications to Patients 1-8, 10 and 11. The record demonstrates that Dr. Chenowith, the Board's expert witness, is board certified in internal medicine and in the subspecialty of geriatric medicine. See State's Exhibits 5, 8 and 11; Tr. 43, 280. The Appellant was board-certified in internal medicine, but he let that certification lapse. He is currently board certified in the subspecialty of endocrinology, diabetes and metabolism. He holds special certification in radioactive iodine diagnostics and therapy, diagnostic ultrasound of the thyroid, and ultrasonically guided fine needle biopsy and aspiration of the thyroid. See Respondent's Exhibit A; Tr. 503-504, 751. Neither the Appellant nor Dr. Chenowith is claiming board certification in pain medicine management.

The Appellant worked at the Holzer Clinic, located in southern Ohio, for four to five months in 2004-2005. As a result, his medical practice in Lima, Ohio, increased, since the majority of those clinic patients travelled from southern Ohio to be treated by him when he relocated his practice. Tr. 809-810, 819. The Appellant testified that during the relevant time period, 2003 through 2008,

approximately 20% of his practice at the Holzer Clinic involved treating patients' chronic pain, and approximately 5% of his Lima, Ohio, practice involved his treating patients for chronic pain. The Appellant also stated that approximately 20% of his prison practice involved managing pain issues. Tr. 505, 512, 550, 746-749, 789, 808.

The record shows that the Appellant did not use pain scales to measure his patients' pain because he did not find them helpful. The medical charts demonstrate that the Appellant developed his own pain questionnaires which were completed by the patients. Tr. 335, 404-406, 419, 431, 440, 467-468, 593-594, and 627. The Appellant also had his chronic pain patients execute pain management agreements which required the patients, among other things, to obtain the controlled or scheduled medication only from him, to use only the pharmacy designated in the contract, to agree not to misuse the medications, and to bring the medication in its bottle to each visit. Joint Exhibits 1-11.

Patient 1

In regard to Patient 1, the record substantiates that the Appellant received two calls from third parties who alleged that Patient1 was selling his medications. The Board's expert testified that before and after the first allegation accusing Patient 1 of selling his prescriptions, Patient 1 did not present with the correct number of pills, and that the Appellant did not respond appropriately. Patient 1 violated the pain form agreement that the Appellant required his patients to complete. However, the record is clear that the Appellant did not check with the Ohio Automated Rx Reporting System (OARRS) which would have given him additional objective information to help him determine if a problem existed. See Jt. Exhibit 1; Tr. 96-100, 102-103, 108-109, 297 582-583, 594-595, 627.

OARRS is an internet-accessible database depicting prescriptions of various controlled

substances. It contains the patient's name, address, the controlled substance prescribed, number of refills, estimated number of days of the prescription, and the name of the pharmacy and its location. Tr. 582-583. The Appellant acknowledged that OARRS was available, free of charge, during the relevant time period from 2003 through 2008. Tr. 812-813. Based on the foregoing, this Court concludes as a matter of law that there is reliable, probative and substantial evidence to conclude that the Appellant fell below the minimal standard of care in regard to Patient 1.

Patient 2

There is reliable, probative and substantial evidence to support the conclusion that the Appellant inappropriately prescribed narcotics to Patient 2, whom he diagnosed with fibromyalgia. The Appellant noted two concerns in Patient 2's medical chart; dementia and a change in Patient 2's mental status. Dr. Chenowith testified that the Appellant failed to address and/or document the contribution of possible polypharmacy[1] to Patient 2's purported dementia and/or cognitive impairment. Dr. Chenowith concluded that a failure to consider that the narcotics could have contributed to Patient 2's dementia and mental status change was below the minimal standard of care. See State's Exhibit 7; Tr. 123-124, 347-349, 481-482.

There is also reliable, probative and substantial evidence to support that the Appellant excessively prescribed narcotics to Patient 2. Patient 2 was trying to wean off of all pain medications three weeks before he began treating with the Appellant. However, the Appellant prescribed 320 mg of Oxycodone per day. Tr. 118-120, 266. Appellee's expert found that the Appellant's escalating doses of narcotics went beyond the recommended doses of the Physician's Desk Reference and other guidelines, and thus, was below the minimal standard of care. Furthermore, the Appellant did not review an OARRS report for Patient 2. State's Exhibit 7; Tr. 124-125, 378-380. Additionally, Patient 2 had respiratory issues and plaintiff's expert noted her

[1] Polypharmacy is the practice of administering or using multiple medications.

concern with the narcotics prescribed to Patient 2, when considering that the Appellant had knowledge that his patient was suffering with sleep apnea and chronic obstructive pulmonary disease (COPD). Tr. 123.

Dr. Chenowith also testified that it was inappropriate for the Appellant to continue to prescribe narcotics to Patient 2, despite the patient's violation of one or more of the clinical instructions given to him. Patient 2 repeatedly did not comply with his pain management agreement. He failed to bring in his pill bottles and he took his medication in excess of the prescribing directions. Additionally, he did not comply with the Appellant's instructions for physical therapy. Dr. Chenowith stated that the Appellant should have referred Patient 2 to a pain specialist because of his medical complexities. The Appellant acknowledged that Patient 2 violated his pain management agreement. Joint Exhibits 2, 7; Tr. 126-127, 151,164, 166, 281, 605, 610-611.

Patient 3

The record is replete with instances wherein Patient 3 failed to comply with his pain management agreement. Despite Patient 3's continual violations of this agreement, the Appellant continued to prescribe narcotics to him. Joint Exhibit 3; Tr. 132-134, 137-143, 159, 390-391, 718-721. Dr. Chenowith concluded that the Appellant's actions were below the minimal standard of care when he did not change Patient 3's prescription habits, even though there were problems with that patient's pill counts and urine screens. Additionally, she saw no notes regarding any discussion of the patient's irregular urine screens in February and October of 2007. The Appellant acknowledged that Patient 3's compliance with the pain management agreement was less than perfect. Tr. 615, 717. Clearly there is reliable, probative and substantial evidence to support that the Appellant fell below the standard of care in his treatment of Patient 3.

Patient 4

The record demonstrates that the Appellant repeatedly prescribed narcotics to Patient 4 in escalating strengths. Joint Exhibit 4; Tr. 65-71, 73, 75. There is reliable, probative and substantial evidence supporting that the Appellant inappropriately continued to prescribe narcotics to Patient 4, despite the patient's violation of one or more of the clinical instructions. The record demonstrates that in October, 2007, a urine screen of Patient 4 showed negative for opiates, even though the Appellant prescribed oxymorphone ER and oxymorphone IR, and the patient had reported that he had taken oxymorphone the day before. Joint Exhibit 4.

Dr. Chenowith did not find any notes in the patient's medical chart that the Appellant had discussed the noncompliance with the patient, warned him, checked OARRS, or ordered a urine drug screen. Dr. Chenowith testified that the Appellant's failure to take action after multiple instances of Patient 4 "being short" on medications was below the minimal standard of care. Moreover, even though Patient 4 admitted to drinking large amounts of alcohol, the Appellant acknowledged that he did not refer Patient 4 to an addictionologist. See State's Exhibit 7; Tr. 80-86, 725-728, 786. Clearly, there is reliable, probative and substantial evidence to support the Board's conclusions in regard to Patient 4.

Patient 5

Patient 5 reported a history of illegal drug use to the Appellant. Patient 5 was morbidly obese and was being treated for congestive heart failure, hypertension, diabetes, paroxysmal atrial fibrillation, thyroid mass, obstructive sleep apnea, and end-stage renal disease requiring dialysis. Joint Exhibit 5; Tr. 148, 619. The record is replete with reliable, probative and substantial evidence that the Appellant inappropriately continued to prescribe narcotics to Patient 5, despite the patient's violation of one or more clinical instructions. Joint Exhibit 5; Tr. 155-164. The Appellee's expert

stated that the Appellant should have checked OARRS and referred the patient to a pain management specialist. Tr. 166-167. As previously stated, the Appellant has not challenged the evidence against him, concluding that he failed to follow up on a fine needle biopsy of a large thyroid mass located in Patient 5's neck, which was concerning for possible malignancy and possible airway compression. Joint Exhibit 5; Tr. 174, 430-433, 456, 647, 650, 654, 821. Dr. Chenowith concluded that the Appellant's failure to follow up the fine needle biopsy was below the minimal standard of care. Thus, there is reliable, probative and substantial evidence in the record to support the Board's conclusion in regard to Patient 5. Tr. 169, 407-408.

Patient 6

The medical chart of Patient 6 demonstrates that he has a rod and screws inserted in his leg due to previous fractures to his tibia and ankle. Dr. Chenowith concluded, after a review of Patient 6's medical chart, that the Appellant did not address or otherwise manage this patient's high blood pressure. Joint Exhibit 6; Tr. 12, 21-26, 35-38, 438. Dr. Chenowith stated that a minimum expectation would be for the Appellant to check Patient 6's blood pressure and then recheck it. Tr. 483. Dr. Chenowith also stated that the Appellant did not make the appropriate modifications to the medications because of the patient's hypertension.

The plaintiff's expert also testified that the Appellant inappropriately continued to prescribe Schedule II stimulants, despite the presence of possible contraindications, such as poorly controlled or uncontrolled hypertension, and/or failed to acknowledge and/or document the potential connection between hypertension and Schedule II stimulant prescribing to Patient 6. Dr. Chenowith testified that prescribing methlphenidate can exacerbate high blood pressure because it is a stimulant. Therefore, close monitoring and adjustments are needed when prescribing that medication to a person with hypertension. State's Exhibit 7; Tr. 183-184. Likewise, as with several

of his other patients, the Appellant inappropriately continued to prescribe narcotics to Patient 6 despite the patient's conduct of being in violation of one or more clinical instructions. State's Exhibit 7; Tr. 184. Thus, the plaintiff's expert concluded that the Appellant's care and treatment of Patient 6 was below the minimal standard of care. Tr. 184.

Patient 7

On January 27, 2005, Patient 7 reported that he had taken the prescribed oycodone/acctaminophen and had taken twice the dosage. A urine screen that same day was negative for opiates. Although the Appellant documented the noncompliance and informed Patient 7 by a letter dated January 28, 2005 that he would no longer prescribe narcotics, he issued prescriptions for Patient 7 on January 27, February 14, and March 14, 2005. Joint Exhibit 7; Tr. 289, 292. Moreover, there were other incidents related to the pain agreement between the Appellant and Patient 7. Joint Exhibit 7.

Dr. Chenowith stated there is nothing in Patient 7's progress notes from June to August 2005 justifying the quadrupling of the per day amount of oxycodone the Appellant prescribed to Patient 7 during that time period. Accordingly, Dr. Chenowith concluded that the Appellant's care and treatment of Patient 7, and his excessive prescribing without justification, was below the minimal standard of care. She stated that "when you get to escalating doses that much, that quickly, and again, when there's red flags or concern about behavior, that this is a high-risk patient that should be cared for by a specialist." Tr. 194.

Dr. Chenowith also stated that the Appellant failed to address and/or document the contribution of polypharmacy to the purported dementia and/or cognitive impairment in Patient 7. Joint Exhibit 7. Dr. Chenowith stated that the Appellant's failure to consider a differential diagnosis or adverse drug effects from the medications prescribed to Patient 7 as contributing to his dementia

and/or cognitive impairment, was below the minimal standard of care. Tr. 481-482. Thus, there is reliable, probative and substantial evidence to support the Board's conclusions in regard to Patient 7.

Patient 8

Patient 8 had been recently hospitalized because of her taking too much of her pain medication (Methadone) prior to first seeing the Appellant. Joint Exhibit 8; Tr. 821. Patient 8 treated with the Appellant from December, 2004 through June, 2008. During that time period, he continually prescribed narcotic medications to her. Joint Exhibit 8. The record demonstrates that the PMR physician who examined Patient 8 in April, 2005 recommended that she be seen by a chronic pain psychologist. Joint Exhibit 8. However, the Appellant continued to inappropriately prescribe narcotics to Patient 8, despite the patient's violation of one or more clinical instructions. Dr. Chenowith stated that there were numerous incidents of Patient 8 not complying with her pain management agreement. She stated that these were "red flags" that should have prompted the Appellant to take further action. She stated that the Appellant should have consistently obtained OARRS reports and then terminated Patient 8 for repeated violations of the pain management agreement. She concluded that the Appellant's continued care was below the minimal standard of care, especially since he escalated the doses of narcotics to "very high" doses. Tr. 208-209.

Dr. Chenowith also testified that the Appellant's treatment of Patient 8 for fibromyalgia was less than the minimal standard of care. She stated that fibromyalgia is usually treated with non-opiod analgesics and that potentially habit forming medication is discouraged. State's Exhibit 7. Dr. Chenowith expressed her concern in that the three medications, which were prescribed by Appellant to Patient 8, have respiratory suppression and sedating side effects which could adversely affect a patient, such as Patient 8 who has COPD and possible sleep apnea. Tr. 202-203. Clearly,

there is reliable, probative and substantial evidence to support the Board's conclusion that the Appellant violated R.C. 4731.22(B)(6) in regard to Patient 8.

Patient 9

Dr. Shank acknowledged that he was not board certified in endocrinology at the time that he treated Patient 9. The record demonstrates that he failed to address and/or document an elevated alkaline phosphatase level for Patient 9. Additionally, he failed to perform and/or document that he performed a chromogranin A level on Patient 9, as well as failed to report and/or document a repeated urine serotonin testing after one abnormal test prior to beginning treatments. The initial evaluation of purported carcinoid syndrome in Patient 9 was inappropriately cursory, according to plaintiff's expert. Further, the Appellant failed to appropriately document the increase in the dosage of octreotide to Patient 9. Accordingly, Dr. Chenowith stated that the Appellant's care and treatment of Patient 9 fell below the minimal standard of care and there is reliable, probative and substantial evidence supporting the Board's conclusion as to Patient 9. See State's Exhibit 7.

Patient 10

The medical records of Patient 10, who was born in 1964, demonstrate that he sustained several injuries as a result of a motorcycle accident he had in his early 30s. Patient 10 explained that he treated with another physician until one year prior and had not taken any pain medication. He complained to the Appellant about pain in his shoulder, hip, knee and ankle. The Appellant diagnosed chronic pain in his shoulder, knee, hip and ankle and prescribed oxycodone CR 20 mg, one tablet, three times a day. Joint Exhibit 10.

In December, 2005, the Appellant referred Patient 10 to a PMR physician. He concluded that Patient 10 had significant arthritis in multiple joints. The PMR physician stated that the currently prescribed medications, Cymbalta, Lyrica, thyroid 100, Oxycontin 40mg, and Lidoderm

patches, seemed appropriate and recommended that Patient 10 try an NSAID (Nonsteroidal Antiinflammatory Drugs). Joint Exhibit 10. A review of the record demonstrates that from September, 2005, through October, 2007, the Appellant continually prescribed narcotic medications to Patient 10 for his pain as follows:

> Oxycodone CR, started at 60 mg per day and increased to 240 mg per day
> Lidoderm 5% patches, 1 to 2 patches per day
> Oxycodone/acctaminophen for breakthrough pain, started at 15 mg per day and increased to 20 mg per day
>
> See Joint Exhibit 9.

Thus, the Appellant inappropriately continued to prescribe narcotics to Patient 10, despite the patient's violation of one or more clinical instructions. For example, an April 2006 urine drug screen was negative for opiates, even though the Appellant noted on the urine report that it should have been positive for opiates. The record demonstrates that the Appellant received multiple reports that Patient 10 was selling and trading his controlled substances. Dr. Chenowith concluded that Patient 10 was a complex patient and probably should have been treated by a pain management specialist. Dr. Chenowith noted that Patient 10 violated the pain management agreement and the Appellant continued to prescribe oxycodone to him. State's Exhibit 7; Tr. 239-243.

The record also includes reliable, probative and substantial evidence supporting that the Appellant inappropriately prescribed sedating medications to Patient 10, despite the presence of a diagnosis of obstructive sleep apnea, and there was no documented indication that CPAP therapy was instituted. Dr. Chenowith stated that sedating medications are generally avoided when a patient is diagnosed with obstructive sleep apnea. She pointed out that the Appellant continued to prescribe sedating medications, including diazepam and oxycodone, to Patient 10, even while he suspected that Patient 10 had sleep apnea. Dr. Chenowith stated that the continuation of the sedating medication was below the minimal standard of care. See State's Exhibit 7.

Patient 11

The record is replete with reliable, substantial and probative evidence that the Appellant excessively prescribed narcotics to Patient 11. Dr. Chenowith stated that she found no justification noted by the Appellant in Patient 11's medical chart for the tripling of the amount of her narcotics, when comparing the prescription amounts the Appellant prescribed for her in September and October, 2005. Likewise, plaintiff's expert stated that the Appellant significantly increased the amount of oxycodone between October, 2005, and July, 2006, from 60mg to 240mg without any objective documentation to support the increase in dosages. Accordingly, Dr. Chenowith concluded that the escalation of medication fell below the minimal standard of care. Joint Exhibit 7; Tr. 267-271.

The record also includes reliable, probative and substantial evidence supporting that the Appellant inappropriately continued to prescribe Schedule II stimulants, despite the presence of possible contraindications, such as poorly controlled or uncontrolled hypertension, and/or failed to acknowledge and/or document the potential connection between hypertension and Schedule II stimulant prescribing to Patient 11. Patient 11's February, 2006, sleep study resulted in a diagnosis of "mild obstructive sleep apnea with significant REM associated oxygen desaturation."

Consequently, in February, 2006, the Appellant diagnosed pulmonary hypertension. Joint Exhibit 11. Patient 11 did not always take her anti-hypertensive medications. Joint Exhibit 11. Patient 11's medical chart reflects that the Appellant prescribed Adderall since Patient 11 had complained of being sleepy during the daytime. See Joint Exhibit 11. Dr. Chenowith explained that Adderall is a stimulant, usually used for Attention Deficit Disorder. Dr. Chenowith stated that Adderall may adversely affect blood pressure and "caution" is advised when using it. In her opinion, a failure to act or even acknowledge a potential connection between the blood pressures

and Adderall is less than the minimal standard of care. See State's Exhibit 7. Plaintiff's expert added that the Appellant's prescribing amphetamines to Patient 11 was inappropriate because she had "variably controlled" hypertension, was at high risk for substance abuse and was noncompliant.

Dr. Chenowith was concerned that the Appellant gave no consideration nor acknowledged that the Adderall XR may have been a contributing factor to Patient 11's nervousness and anxiety. Moreover, Dr. Chenowith concluded that the Appellant inappropriately continued to prescribe narcotics to Patient 11 despite the patient's violation of one or more clinical instructions. See Joint Exhibit 11. Dr. Chenowith stated that Patient 11 was not abiding by the terms of the pain management agreement and exhibited high-risk behaviors. She acknowledged that the Appellant reacted to certain violations but that he also continued to prescribe controlled substance medications for Patient 11, which conduct Dr. Chenowith found to be below the minimal standard of care. Tr. 258-266.

In addition, there is reliable, substantial and probative evidence that supports the Board's conclusion that the Appellant failed to document objective data to support narcotic prescriptions to Patients 1-8, 10, and 11. Likewise, there is reliable, substantial and probative evidence of Appellant's failure to use and/or document adequate use of disciplinary resources for treating pain in Patients 1-8, 10 and 11. There is reliable, probative and substantial evidence throughout the record supporting the Appellant's failure to recognize drug-seeking behavior and prescribing of controlled substances to Patients 1-3, 6-8, 10 and 11. Also, there is evidence to support that the Appellant's medical charting for Patients 1 through 11 was incomplete, often illegible and/or unprofessional and thus, below the minimum standard of care. The Hearing Examiner noted that the Appellant's charting could be improved by including medication lists in the progress notes, explaining assessments and detailing treatment plans. The Court agrees with Dr. Chenowith's

conclusion, as adopted by the Board, that Dr. Shank did not recognize the limits of his expertise. Dr. Shank treated and cared for his patients as if he were a pain management specialist, which he has purported to be in his brief. The record is clear that Dr. Shank does not possess these medical credentials.

Yet, the Appellant attacks the credentials of plaintiff's expert and alleges that she did not properly articulate the standard of care. Expert medical testimony is not mandatory in a medical disciplinary proceeding where the issue is whether a physician's conduct falls below a reasonable standard of medical care. See *Arlen v. State Medical Board of Ohio,* 61 Ohio St. 2d 168 (1980); see also *Reed v. State Medical Board of* Ohio, 162 Ohio App. 3d 429 (2005). Thus, the Board in this case did not have to rely on the expert's testimony since it was perfectly capable of determining on its own whether Dr. Shank's conduct fell below a reasonable standard of patient medical care and treatment.

The Board's primary mission is to protect the public. The Board is comprised of twelve members, a majority of whom are physicians and three non-physician public members**.** Each board member is appointed by the Governor and serves a five-year term. Thus, a majority of the Board's members are experts in their own right, since they are doctors and already possess the specialized knowledge needed to determine the acceptable standard of general medical practice. See *Arlen v. The State Medical Board of Ohio*, 61 Ohio St. 2d 168 (1980). This Court concludes that a majority of the Board members themselves possess the expertise necessary to determine if the Appellant fell below the minimum standards of practice and all other matters regarding Appellant's conduct that were before the Board.

The Appellant also asserts that he testified as an expert witness and that the Board should find his testimony to be more credible than Dr. Chenowith's testimony. When reviewing an order

of the medical board, courts must accord due deference to the Board's interpretation of the technical and ethical requirements of its profession. The purpose of the Ohio General Assembly in providing for administrative hearings in particular fields is to facilitate such matters by placing the decision on facts with boards or commissions composed of people equipped with the necessary knowledge and experience pertaining to a particular field. On questions of law, however, review is plenary. See *Leak v. State Med. Bd.*, 2011 Ohio 2483.

The legislature and the courts of Ohio have delegated comprehensive decision-making power to the Board. Such power includes, but is not limited to, the authority to rely on the Board's own knowledge when making a decision. It is well established that the Board may rely on its own expertise to determine whether a physician failed to conform to the minimum standards of care. The physicians on the twelve person Board are capable of both interpreting the technical requirements of the medical profession and determining whether that physician's conduct falls below the minimal standard of care. See *Pons v. Ohio State Med. Bd*. (1993), 66 Ohio St. 3d 619; see *also State Med. Bd. of Ohio v. Murray*, 66 Ohio St. 3d 527, 1993 Ohio LEXIS 1307.

The Appellant argues that the only competent evidence is Appellant's own expert testimony that his practices did not fall below the standards of care with respect to his patients. However, the Board did not find his testimony credible. The legislature and the courts of Ohio have delegated comprehensive decision-making power to the Board. Such power includes, but is not limited to, the authority to rely on the Board's own knowledge when making a decision rather than looking to the record for the opinion of an expert. Expert testimony as to a standard practice is not mandatory in a license revocation hearing, and the Board may rely on its own expertise to determine whether Dr. Shank failed to conform to minimum standards of care. Thus, the Appellant's reliance on the

holding in *Lawrence* is not applicable to the case *sub judice. Lawrence v. State Medical Board,* 1993 Ohio App. LEXIS 1437.

In *Lawrence,* the Board's expert witness, Dr. Craig Pratt, was a specialist in the area of anesthesiology and addiction. He was never asked whether he was familiar with the standard of care and treatment for a physician in the Appellant's situation, a general practitioner. Thus, the issues in that case focused on whether the plaintiff's expert testimony articulated the standards of care and treatment as to a specialist, as opposed to a general practitioner. Clearly, those facts and the holding of *Lawrence* do not apply to Dr. Shank's case. The proper standard for evaluating the Appellant's care and treatment of his patients is that knowledge known by a generalist physician, since neither Dr. Shank nor Dr. Chenowith are board-certified pain management specialists. Thus, this Court agrees with the Board's conclusion that Dr. Chenowith applied the proper standard.

Next, the Appellant asserts that since the Board's order was based on "unarticulated standards" and "incompetent expert testimony" that the Board's order violated his due process rights. The phrase "due process" expresses the requirement of "fundamental fairness." In defining the process necessary to ensure "fundamental fairness," the United States Supreme Court has recognized that the clause does not require that the procedures used to guard against an erroneous deprivation be so comprehensive as to preclude any possibility of error, and in addition, the Supreme Court has emphasized that the marginal gains from affording an additional procedural safeguard may be outweighed by the societal cost of providing such a safeguard. Thus, an appellant must make a showing of "identifiable prejudice." See *Ghassan Haj-Hamed v. State Medical Board*, 2007 Ohio App. LEXIS 2335.

The record demonstrates that once the Appellant was placed on notice, he was given the opportunity to request a hearing. The record reflects that the Appellant had an opportunity to be

heard in the hearing that was held on July 26 through July 29, 2011, and that he was represented by counsel and participated. There is nothing in the record demonstrating that Appellant's counsel asked for a continuance or objected on the record to the hearing going forward. Additionally, the Appellant was granted the opportunity to address the entire Board regarding his case. Clearly, there is no issue regarding procedural due process since the Appellant had notice and an opportunity to be heard regarding his conduct involving the care and treatment of eleven of his patients as falling below minimal standards of care. Moreover, the Appellant has not demonstrated an "identifiable prejudice."

The Appellant has made a baseless assertion since he has not set forth any findings of fact that were not set forth in the January 12, 2011 Notice Letter. Dr. Shank was informed that his conduct was in violation of R.C. 4731.22(B)(6) because his actions fell below the minimal standard of care and treatment of similar practitioners under the same or similar circumstances. There was a patient key that specifically listed all eleven (11) patients and identified the specific conduct of care and treatment in regard to each patient. The record clearly demonstrates that Dr. Shank, who had no credentials as a pain management specialist, was not appropriately responding to obvious "red flags" that patients needed to be referred to addiction and/or chronic pain specialists. The Tenth District Court of Appeals noted that a third party notification to a physician that a patient is selling his/her prescribed drugs is a "red flag" that warrants reduction in prescribing narcotics to that patient or, at the very least, further investigation. See *Griffin v. State Med. of Ohio,* 2011-Ohio-6089. Likewise, the conduct of a physician is suspect when the physician continues to prescribe narcotics to a patient who tests negative for those medications. *Id.*

The Court concludes that there is reliable, probative and substantial evidence supporting the Board's December 30, 2011 Entry of Order and that, upon a thorough review, all proceedings and the Board's order are in accordance with law.

DECISION

Based on the foregoing, and upon a review of the record, this Court concludes that there is reliable, probative and substantial evidence supporting the December 30, 2011 Entry of Order of the State Medical Board of Ohio. Moreover, this Court concludes that the Board's Order is in accordance with law. The Board's December 30, 2011 Order is hereby **AFFIRMED**.

THE COURT FINDS THAT THERE IS NO JUST REASON FOR DELAY. THIS IS A FINAL APPEALABLE ORDER**. Pursuant to Civil Rule 58, the Clerk of Court shall serve notice of this judgment and its date of entry upon all parties.**

IT IS SO ORDERED.

TIMOTHY S. HORTON, JUDGE

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Franklin County Court of Common Pleas

Date:	06-18-2012
Case Title:	MYRON LYLE SHANK MD -VS- OHIO STATE MEDICAL BOARD
Case Number:	12CV000643
Type:	ENTRY

It Is So Ordered.

/s/ Judge Timothy S. Horton

Court Disposition

Case Number: 12CV000643

Case Style: MYRON LYLE SHANK MD -VS- OHIO STATE MEDICAL BOARD

Case Terminated: 18 - Other Terminations

Final Appealable Order: Yes