



participated in the deliberations regarding this case: Thomas Cimonetti, M.D.; Karl F. Mech, M. D.; George Malouf, M.D.; Hilary T. O'Herlihy, M.D.; Alexander Williams, Jr., Esq.; and Robert L. Young, Jr., M.D. At the beginning of these hearings J. Roy Guyther, M.D. and Chris Papadopoulos, M.D., were members of the Commission and participated in a number of hearing sessions; their terms of appointment expired during the pendency of this case, and as a result neither of these two individuals participated in the Commission's deliberations or in this decision. Dr. O'Herlihy chaired each of the proceedings as the Chairman of the Commission. The Commission was advised by Ronald S. Gass and Varda N. Fink, Assistant Attorneys General. Thomas J. Kwiatkowski, Jr., Assistant Attorney General, was the administrative prosecutor on behalf of the State, and Judith O'Neill, Esq. and Thomas Morrow, Esq. appeared on behalf of the Respondent.

Following opening statements by Mr. Kwiatkowski and Ms. O'Neill, Mr. Kwiatkowski called the following witnesses to testify on behalf of the State: Maher W. Ishak, M.D.; Walter J. Alt, M.D.; and David S. McHold, M.D. He also introduced into evidence the documents listed in Appendix A. At the conclusion of the testimony of the various witnesses, Mr. Kwiatkowski concluded his case on behalf of the State.

Ms. O'Neill and Mr. Morrow called the following witnesses to testify on behalf of Respondent: Madeline Stoltz;

Ralph P. Stoltz; Margaret Irene Okham; Oliver T. Grahm; Dean Burk, Ph. D.; Shirley K. Phillips; Dwight Raymond Smith, M.D.; Paul Beals, M.D.; Ahmad Shamim, M.D. They also introduced into evidence the documents listed in Appendix B. Among the documents introduced were 106 affidavits of patients and former patients of the Respondent. At the conclusion of the testimony of the various witnesses, Ms. O'Neill and Mr. Morrow concluded their case on behalf of Respondent.

Closing arguments by Mr. Kwiatkowski and Ms. O'Neill were heard by the Commission on November 1, 1983, after which the hearing was adjourned. Proposed Findings of Fact and Conclusions of Law were requested by the Commission and filed by the parties on March 12, 1984. The Respondent submitted a Response to the State's Proposed Findings of Fact and Conclusions of Law on March 22, 1984.

After the conclusion of the hearing, on March 12, 1984, Respondent filed a Renewed Motion of Recusal and Mistrial which renewed a motion which had previously been made orally during the hearing. The Commission voted unanimously to deny Respondent's Motion.

#### FINDINGS OF FACT

On the basis of the entire record, the Commission finds:

1. The factual matters set forth in the foregoing section entitled "Procedural History" are found by the Commission.

as facts and are hereby incorporated into these Findings of Fact as if fully set forth herein.

2. Respondent is licensed to practice medicine in Maryland and has been subject to the jurisdiction of the Commission at all times relevant to this Order.

3. Respondent engages in the practice of general surgery and family practice medicine.

PROFESSIONAL INCOMPETENCE

4. Respondent admitted patient A.\* to Leland Memorial Hospital on August 20, 1979, with an diagnosis of chronic lymphocytic leukemia. The patient upon admission was found to have an enlarged spleen and liver, anemia, and dyspnea.

5. The patient's blood count immediately after admission showed a hemoglobin level of 7.0 and a white blood count of 369,000, clinical findings which are indicative of advanced and uncontrolled chronic lymphocytic leukemia.

6. Respondent ordered, inter alia, Butinol, Coramine, and Glycerine as treatment for the patient's condition, a treatment regime of which he had no personal knowledge or understanding. This treatment regime had been prescribed for the patient by an out-of-state physician who was unable to personally treat the patient during the patient's hospitalization.

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\* To protect patient confidentiality, the names of the patients corresponding to the code letter designations are contained in a separate sealed Appendix D.

7. If the patient and the family of the patient refused to allow Respondent to deviate from the treatment regimine of the patient's out of state physician, then Respondent failed to document that refusal in any manner in the patient's chart.

8. Based on the record and its collective medical and technical knowledge, the Commission finds that a reasonably competent physician would not order a treatment regimine of which he had no personal knowledge or understanding.

9. Respondent failed to obtain necessary, medically indicated consultations with an on site specialist in hemotology and/or oncology and, instead, sought consultation from the out-of-state physician who was not the physician of record and who was not present to observe the patient's physical condition.

10. Respondent failed to properly investigate the cause of a fever spike in the patient occuring on August 21, 1979.

11. The Respondent admitted patient B. to Leland Memorial Hospital on May 15, 1979, with a diagnosis of breast cancer. The patient upon admission was found to have a left breast lump and an enlarged left axillary node.

12. The patient's family history demonstrated multiple incidences of breast cancer in her close relatives.

13. Respondent surgically removed the patient's breast lump on May 16, 1979.

14. Prior to surgery Respondent failed to order or to perform standard medically indicated tests which would have been ordered by a reasonably competent physician, including a liver scan and bone scan, in order to determine whether the patient's breast cancer had metastasized. Respondent failed to document in any manner the patient's refusal to undergo such standard, medically indicated tests.

15. During surgery, Respondent failed to order or to perform standard, medically indicated tests upon the excized, malignant breast tissue which tests would have been performed by a reasonably competent physician. The standard medically indicated tests which Respondent failed to perform included estrogen receptor tests, a frozen section, and pathological tests on the axillary nodes. These tests were necessary to determine the nature and extent of the patient's disease and to determine an appropriate treatment plan. The Respondent failed to document in any manner the patient's refusal to allow a specimen of her excized tissue to be subjected to such standard, medically indicated tests.

16. Respondent admitted patient C. to Leland Memorial Hospital on August 1, 1979, with a diagnosis of abdominal distention and an admitting impression of small bowel obstruction.

17. Respondent ordered that the patient be maintained fully N.P.O. (i.e. no oral intake of food) with a nasogastric

tube from the time of admission to the time of abdominal surgery on August 3, 1979.

18. Respondent unreasonably and unnecessarily delayed the surgery of the patient despite the fact that there had been a finding of small bowel obstruction, a potentially life threatening condition which requires immediate surgical intervention.

19. Following surgery Respondent continued to order that the patient be maintained fully N.P.O. through the end of her hospitalization at Leland Memorial Hospital on August 25, 1979.

20. Despite the fact that the patient had been maintained fully N.P.O. since the time of admission, Respondent failed during the patient's entire post-operative stay at Leland Memorial Hospital to order hyperalimentation, which resulted in severe nutritional deficiencies in the patient and retarded the patient's ability to recover from the surgery.

21. Based on the record and its collective medical and technical knowledge the Commission finds that a reasonably competent physician would have ordered hyperalimentation post operatively for a patient presenting in C's condition.

22. During her post operative period of hospitalization recovery did not progress appropriately and her bowel remained distended.

23. Respondent unreasonably failed to seek consultation with another physician on C's failure to progress in a timely manner and failed to document in the patient's chart the consultation which finally occurred.

24. Respondent admitted patient D. to Leland Memorial Hospital on May 20, 1979 with a finding of breast tumor and an impression of breast cancer.

25. Respondent failed to perform tests through tissue examination in order to determine whether the tumor was malignant. Respondent failed to document in any manner in the patient's chart that the patient refused to allow such a standard medically indicated test to be performed.

26. Respondent failed to determine by ordering a liver or bone scan whether the patient's breast tumor, if malignant, had metastasized to any other body organs or area. Respondent failed to document in any manner in the patient's chart that the patient refused to allow such standard, medically indicated tests to be performed.

27. Respondent failed to order any estrogen receptor tests in order to determine whether the patient's breast tumor, to the extent it could have been malignant, was receptive to the production of estrogen by the ovaries. Respondent failed to document in any manner in the patient's chart that the patient refused to allow such a standard, medically indicated test to be performed.



28. Based on the record and its collective medical and technical knowledge the Commission finds that a reasonably competent physician would not have undertaken any treatment of a patient presenting with a breast tumor until the nature of the tumor was determined through the tests described in §§25-27 infra.

29. Assuming the tumor was malignant Respondent failed to perform necessary and appropriate surgery to remove the breast tumor, or to properly document in the patient's records his basis for failing to perform such necessary and indicated surgery.

30. Respondent performed a full bilateral oophorectomy (surgical removal of the ovaries) on the patient on May 21, 1979.

31. A full bilateral oophorectomy is medically indicated only when a malignant breast tumor is found to be receptive to the production of estrogen by the ovaries.

32. Based on the record and its collective medical and technical knowledge the Commission finds that a reasonably competent physician would perform an oophorectomy on a patient presenting in D's condition only when a breast tumor is determined through appropriate tests to be both malignant and receptive to the production of estrogen.

#### MAKING OR FILING A FALSE REPORT

33. Respondent executed and placed in the hospital records of D. (see §§22-27 infra.) an affidavit under oath in which he stated that the patient demonstrated a "rapidly

progressive malignancy with a high and predictable mortality rate" and that she was thus a "terminally ill cancer patient."

34. Respondent also stated in the affidavit that there was "no other recognized form of treatment" for the patient's condition, thereby permitting him to administer Laetrile as a treatment of last resort.

35. In a subsequent meeting with the Peer Review Committee of the Medical and Chirurgical Faculty of Maryland on January 19, 1982, Respondent admitted that the patient was not "terminally ill" and that he executed the affidavit solely for the purpose of allowing the administration of the otherwise prohibited drug, Laetrile, to the patient.

36. Respondent knew that the patient was not terminally ill and that other recognized forms of treatment were available when he executed the affidavit, but he knowingly and willfully made false statements solely for the purpose of administering an otherwise prohibited treatment to the patient.

#### CONCLUSIONS OF LAW

Based upon the foregoing Findings of Fact, the Commission, by a unanimous vote of those members considering this matter, hereby concludes as a matter of law that Respondent violated Sections 14-504(4) and (12) of the Health Occupations Article of the Annotated Code of Maryland because he is professionally incompetent and because he willfully and knowingly filed a false report or record in the practice of medicine.

ORDER

Upon the foregoing Findings of Fact and Conclusions of Law, and upon a unanimous vote of the members of the Commission considering this case, it is this 18<sup>th</sup> day of September, 1984,

ORDERED that Respondent's license to practice medicine in the State of Maryland is hereby SUSPENDED for a period of three years; and be it further

ORDERED that the foregoing suspension shall be STAYED and Respondent shall be placed on PROBATION when Respondent complies with the following conditions:

1. That Respondent at his own expense arrange for, undertake and complete a Commission approved six month re-education program consisting of three hundred hours of training in general medicine and 150 hours of training in oncology.

2. That Respondent shall arrange for the program in which his re-education is received to notify the Commission in writing that he has satisfactorily completed the program.

3. That upon receipt of such notice, the Commission shall STAY the suspension; and be it further

ORDERED that until Respondent has satisfactorily completed the re-education program described above, he is suspended and shall not engage in the practice of medicine; and be it further

ORDERED that Respondent shall cease engaging in the practice of medicine within three months of the date of this Order and that within this time Respondent shall arrange for the transfer of patients under his care to another physician; and be it further

ORDERED that if the suspension is stayed as a result of Respondent's compliance with the terms described above, then Respondent shall comply with the following CONDITIONS OF PROBATION:


1. Respondent shall submit to quarterly practice review by a reviewing committee designated and approved by the Commission;
2. Respondent shall arrange for the reviewing committee to submit reports of the reviews to the Commission;
3. Respondent shall properly utilize and order standard diagnostic tests when medically indicated and shall document in the patient's chart any refusal by the patient to submit to such tests;
4. Respondent shall practice medicine competently;
5. Respondent shall not file false reports or records in the practice of medicine; and be it further

ORDERED that after Respondent's suspension is stayed and Respondent is placed on probation then if Respondent violates any of the foregoing conditions of probation, or if a report submitted by the reviewing committee designated by the Commission

indicates that he is not practicing medicine competently, then the Commission, after notification, a hearing, and determination of violation, may withdraw the stay of suspension of his license or may impose any other disciplinary sanction it deems appropriate; and be it further

ORDERED that three years from the date of this Order, the Commission will entertain a petition for termination of Respondent's suspension and for reinstatement of his license to practice medicine without any condition or restriction whatsoever. If the Commission determines that termination of the suspension and complete reinstatement would not be appropriate at that time, it may modify one or more of the conditions upon which Respondent was placed on probation; and be it further

ORDERED that a copy of this Order shall be filed with the Board of Medical Examiners in accordance with §14-507 of the Health-Occupations Article of the Annotated Code of Maryland.

  
Hilary T. O'Herlihy, M.D.  
Chairman  
Commission on Medical  
Discipline of Maryland

APPENDIX A.

STATE'S EXHIBITS

STATE'S EXHIBIT NUMBER

- 1: Medical record and cover sheet  
from Leland Memorial Hospital  
for Patient B.
- 2: Chart of I from Leland Memorial Hospital.
- 3: and 4: Medical record charts for Patient J  
from Leland Memorial Hospital.
- 5: Charts of Patient E from Leland  
Memorial Hospital.
- 6: Chart from Leland Memorial Hospital  
for Patient F.
- 7: Chart from Holy Cross Hospital on G.
- 8: Chart from Leland Memorial Hospital on H.
- 9: Chart of Patient A from Leland Memorial Hospital
- 10: Chart of Patient C from Leland Memorial Hospital
- 11: Chart of Patient D from Leland Memorial Hospital

APPENDIX B  
RESPONDENT'S EXHIBITS

- 1: Synopsis of case
- 1: Copy of letter dated July 9, 1981 from Dr. Ishak to Dr. McHold and report of Dr. Ishak.
- 2: Copy of letter dated November 20, 1981 from Dr. McHold to Respondent.
- 3-8: Identified but never admitted.
- 9: Handwritten noted dated August 30, 1979 written by Paul Stoltz.
- 10: Book - Diet, Nutrition and Cancer (1982).
- 11: Identified but not admitted.
- 12: Copy of article - Research on Vitamins - Cancer Relationship Getting Big Boost, 247 JAMA\* 1799 (April 2, 1982).
- 13: Book - H.W. Manner, M.D.; et al., The Death of Cancer (1978).
- 14: Copy of article - Ringsdorf, W.M., Jr., et al. Sucrose, Neutrophilic Phagocytosis and Resistance to Disease, 52 Dental Survey 46 (December, 1979).

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\* Journal of the American Medical Association.

- 15: Copy of article - Beisel, W.R., et al., Single - Nutrient Effects on Immunologic Functions 245 JAMA 53 (January 2, 1981).
- 16: Copy of biographical synopsis of Dean Burk, Ph.D. taken from 38 Marquise Who's Who in America 22 (1974-1975).
- 17: Withdrawn.
- 18: Copy of chapter - Burk, D. and Winzler, R.J.. Vitamins and Cancer reprinted from Vitamins and Hormones, Volume II (1944).
- 19: Curriculum Vitae of Bruce Halstead, M.D. dated June, 1983.
- 20: Booklet - B.W. Halstead, M.D. Metabolic Cancer Therapy (R. Ed. 1980).
- 21: Booklet - B.W. Halstead, M.D., Amygdalin (Lartrile) Therapy (1977).
- 22: Booklet - H.W. Manner, Metabolic Therapy - C.
- 23: Booklet - J. Bland, The Justification for Vitamin Supplementation (1981).
- 24: Booklet - H.A. Nuper, Critical Survey of the State of Cancer Research with Special Reference to Long-Term Medical Therapy with Nitrilosides (1972).
- 25: Copy of a paper - Flavin, P.F. and Kolbye, A.C., Jr. Nutritional Factors With the Potential to Inhibit Critical Pathways of Tumor Promotion.
- 26: Copy of Journal - 35 Journal of Clinical Nutrition 2 (February 1982).



- 27: Copy of article - Beisel, W.R. et al. Single - Nutrient Effects on Immunologic Functions, 245 JAMA 53 (January 2, 1981).
- 28: Copy of Article - Beisel, W.R., Effects of Infection on Nutritional Status and Immunity, 39 Federation Proceedings 3105 (November, 1980).
- 29: Portion of Book - H.L. Newbold, M.D., Vitamin C. Against Cancer, pp. 27 - 29.
- 30: Portion of book - Merck Manual, pp. 1682 - 83, 11ed. (1966).
- 31: Copy of affidavit of James Cason dated August 14, 1982 submitted in support of Motion for Preliminary Injunction in Bradford et al. v. National Cancer Institute, et al. (N.D. Cal.) Civ. No. C-80-1113-WAI.
- 32: Portion of article to be published in the Journal of the International Academy of Preventive Medicine.
- 33: Curriculum Vitae of Dean Burk.
- 34: Copy of chapter - Burk, D and Winzler, R.J., Vitamins and Cancer reprinted from Vitamins and Hormones, Volume II. (1944).
- 35: Copy of article - Benade, L. et al. Synergistic Killing of Ehrlich Ascites Carcinoma Cells by Ascorbate and 3 - amino - 1, 2, 4, - triazole, 23 Oncology 33 (1969).
- 36: Copy of article - Cameron E. et al. The Orthomolecular Treatment of Cancer, 11 Chem. - Biol. Interactions 387 (1975).
- 37: Copy of article - Long, R.Y., A New Look at Cancer and Nutrition, 29 Journal of Applied Nutrition 18 (1977).

- 38: Copy of article - Nieper, Hans, M.D., New Horizons in Non-Toxic Cancer Therapy: Beta - Carotene, Lithium, Orotate, Anavit, Bromelaine, Benzaldehyde, Tumosterone, DHEA, and Ascorbate, Journal of IAPM5 (November 1982).
- 39: Copy of address - Warburg, O., The Prime Cause and Prevention of Cancer delivered at the meeting of Nobel - Laureates (June 30, 1966).
- 40: Booklet - P. Burk, Ph.D. A Brief on Foods and Vitamins (1975).
- 41: Copy of article - Burk D. "See How They Lie, See How They Lie.: 9 Cancer News Journal 3.
- 42: Copy of letter dated March 22, 1974 by Dean Burk to Seymour Perry, M.D. with attachments.
- 43A: Copy of report - Suguira, K., Effect of Amygdalen on Spontaneous Mammary Tumors in CD<sub>8</sub>F<sub>1</sub> Mice (March 1, 1974).
- 43B: Copy of report - March 5, 1974.
- 44: Copy of article - Chowka, P.B., The National Cancer Institute and the Fifty Year Cover-Up, New Ecologis (December 1978).
- 45: Copy of letter dated April 20, 1973 by Dean Burk to Frank J. Rauscher.
- 46: Copy of article - The "War on Cancer": Official Fictions and Harsh Facts, 4 Science and Government Report 1 (December 1, 1974).
- 47: Affidavit of Grace A. Willets dated July 18, 1983.  
Affidavit of Joan Gist dated July 8, 1983.

- 47:1-47  
.106 Affidavits admitted by Hilary T. O'Herlihy, M.D. in letter to counsel dated August 11, 1983.
- 48: Book - E. Revici, M.D. Research In Physiopathology as a Basis of Guided Chemotherapy (1961).
- 49: Book - R.A. Passwater, Cancer and Its Nutritional Therapies (1978).
- 50: Subpoena issued by Commission on Medical Discipline to Respondent dated July 31, 1981.
- 51: Copy of article - Levinson, S. Sepsis and Asepsis, Surgical Congress News (May, 1977).
- 52: Copy of chapter - J.C. Krantz, Jr. and C. Jelleff Carr, The Pharmacologic Principles of Medical Practice, Chapter 60 (1961).
- 53: Copy of article - Cameron E. and Pauling L., Supplemental Ascorbate in the Supportive Treatment of Cancer: Prolongation of Survival Times in Terminal Human Cancer, 73 Proceedings of the National Academy of Science 3685 (1976).
- 54: Copy of address delivered by Hardin B. Jones delivered to the American Cancer Society, (May 1977).
- 55: Copy of article - Medical Tribune (May 27, 1977).
- 56: Copy of article - Medical Tribune (July 22, 1981).
- 57: Copy of letter dated November 19, 1981 from the Commission to the Medical and Chirurgical Faculty of Maryland.
- 58: Copy of letter dated January 26, 1982 from Robert Dobart to David S. McHold, M.D.

59: Copy of letter dated January 26, 1982 from Karl  
Mech, M.D. to Respondent.

60: Copy of letter dated October 7, 1980 from Louis  
Brechi, M.D. to Commission.

IN THE MATTER OF  
AHMAD SHAMIM, M.D.

\* BEFORE THE  
\* COMMISSION ON MEDICAL  
\* DISCIPLINE OF MARYLAND

\* \* \* \* \*

APPENDIX C

A. States Proposed  
Findings of Fact

Ruling

1 - 3

accepted

4

accepted to the extent it  
is consistent with Finding  
of Fact 4

5

rejected because it is  
irrelevant to the decision  
of the Commission

6

accepted to the extent it  
is consistent with  
Findings of Fact 8 and 9

7

accepted to the extent it  
is consistent with Finding  
of Fact 10

8 - 10

rejected as irrelevant to  
the decision of the  
Commission

11

accepted to the extent it  
is consistent with Finding  
of Fact 16

12

accepted to the extent it  
is consistent with Finding  
of Fact 17

13

accepted to the extent it  
is consistent with Finding  
of Fact 18

A.	<u>States Proposed Findings of Fact</u>	<u>Ruling</u>
	14	accepted to the extent it is consistent with Finding of Fact 19
	15 - 18	rejected as irrelevant to the decision of the Commission
	19	accepted to the extent consistent with Findings of Fact 20 - 21
	20 - 23	accepted to the extent consistent with Findings of Fact 20 - 23
	24	accepted to the extent it is consistent with Findings of Fact 24
	25 - 27	accepted to the extent consistent with Findings of Fact 25 - 28
	28	accepted to the extent consistent with Findings of Fact 30
	29 - 30	accepted to the extent consistent with Findings of Fact 29 - 32
	31 - 34	accepted to the extent consistent with Findings of Fact 33 - 36
	35 - 55	rejected as irrelevant to the decision of the Commission
	56	accepted to the extent it is consistent with Findings of Fact 11

**A.        States Proposed  
Findings of Fact**

**Ruling**

57	accepted to the extent it is consistent with Findings of Fact 12
58	accepted to the extent it is consistent with Findings of Fact 13
59	accepted to the extent it is consistent with Findings of Fact 14
60	accepted to the extent it is consistent with Findings of Fact 15
61	accepted to the extent it is consistent with Findings of Fact 15
62 - 74	rejected as irrelevant to the decision of the Commission

**B.        Respondent's Proposed  
Findings of Fact**

**Ruling**

1 - 11	rejected as irrelevant to the decision of the Commission
12 - 13	accepted to the extent it is consistent with the Commission's Order as a whole
14	rejected as being contrary to the evidence as a whole
15 - 16	rejected as irrelevant to the decision of the Commission
17 - 18	rejected as being contrary to the evidence as a whole and Findings of Fact 10

A.

Respondent's Proposed  
Findings of Fact

Ruling

19	accepted
20 - 22	rejected as being contrary to the evidence as a whole and Findings of Fact 25 - 32
23	rejected as irrelevant to the decision of the Commission
24 - 25	rejected as being contrary to the evidence as a whole and Findings of Fact 18 - 23
26	rejected as being contrary to the evidence as a whole and Findings of Fact 9 and 23
27 - 28	rejected as irrelevant to the decision of the Commission
29 - 30	For Patient I, rejected as irrelevant to the decision of the Commission. For Patient D, accepted to the extent consistent with Findings of Fact 33 - 36
31 - 32	rejected as irrelevant to the decision of the Commission



IN THE MATTER OF                   \*     BEFORE THE MARYLAND  
AHMAD SHAMIM, M.D.               \*     BOARD OF PHYSICIAN  
Respondent                       \*     QUALITY ASSURANCE  
LICENSE NO. D10243               \*     CASE NO. 84-0139

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#### FINAL ORDER

#### BACKGROUND

This matter comes before the Board on a charge of violation of probation. The history of the case is briefly summarized as follows:

#### THE 1984 ORDER

On September 18, 1984, the Commission on Medical Discipline (the "Commission")<sup>1</sup> issued a Final Order ("the 1984 Order") regarding Ahmad Shamim, M.D. (the "Respondent").<sup>2</sup> Dr. Shamim was charged in 1982 with professional incompetence and the willful making of a false report or record in the practice of medicine. His hearing was conducted over the time period from August 3, 1982, through November 1, 1983.

In its order, the Commission found that Dr. Shamim ordered a treatment regimen for a patient suffering from chronic

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<sup>1</sup> The 1988 General Assembly, by Senate Bill No. 508 and House Bill No. 855, signed into law as Chapter 109, Acts of Maryland 1988, merged the functions of the former Commission on Medical Discipline and the former Board of Medical Examiners into the State Board of Physician Quality Assurance.

<sup>2</sup> A copy of the 1984 Order, without appendices, is attached to this Final Decision and incorporated herein as Attachment A.

lymphocytic leukemia which had been prescribed by an out-of-state physician and of which Respondent had no personal knowledge or understanding. 1984 Order, p. 4-5. For the same patient, Dr. Shamim failed to obtain necessary consultations from on site hematologists and/or oncologists and instead took directions from the out-of-state physician who was unable to observe the patient. Id.

A second patient treated by Dr. Shamim was diagnosed as having breast cancer. Prior to his surgical removal of a cancerous lump, Dr. Shamim failed to perform standard medically necessary tests on this patient to determine whether the cancer had metastasized. If the patient refused to allow such tests, then Dr. Shamim failed to so indicate in the patient's chart. 1984 Order, p. 6.

A third patient, with a small bowel obstruction, did not receive necessary immediate surgical intervention and received inadequate post-operative care which retarded the patient's ability to recover from the surgery. 1984 Order, p. 7.

For a fourth patient, also diagnosed with breast cancer, Dr. Shamim failed to perform tissue examination to determine if a tumor was malignant, failed to order a liver or bone scan to determine if the cancer had metastasized, failed to order any estrogen receptor tests, and failed to perform necessary surgery of the tumor. If the patient refused to allow such tests or operation, her medical record failed to document their refusal. Dr. Shamim performed a full bilateral oophorectomy (surgical removal of the ovaries), even though such surgery was found by

the Commission to be appropriate only after data from the estrogen receptor tests, which were not done. 1984 Order at p. 8-9.

In addition to the findings of incompetent care, the Commission found that an affidavit, executed by Dr. Shamim on the fourth patient for the purpose of allowing use of the otherwise prohibited substance Laetrile, indicating that the patient was terminally ill, was false in that the patient was not terminally ill. 1984 Order at p. 9-10. Dr. Shamim admitted the falsity of the statement. Id.

Based upon these factual findings, the Commission concluded that Dr. Shamim was professionally incompetent and had knowingly and willfully filed a false report or record in the practice of medicine. The Commission ordered a three year suspension as a sanction, but agreed to stay the suspension following implementation of a reeducation program and subject to certain conditions of probation. The Commission stated it would entertain a petition for termination of the suspension and for reinstatement of the license after three years, but reserved the option of later modifying the conditions of probation.

On April 30, 1985, the suspension of Dr. Shamim was stayed and he returned to the practice of medicine subject to the terms of the probation. On May 23, 1990, Respondent petitioned for termination of his probationary status. At the time of this Petition, the Board was in the process of issuing the charges initiating the hearing which resulted in this order.

THE CURRENT CHARGE- VIOLATION OF PROBATION

On June 13, 1990, the Board of Physician Quality Assurance (the "Board") issued charges of Violation of Probation from the 1984 Final Order. Specifically, the Board charged that Respondent violated the following Conditions of Probation:

3. Respondent shall properly utilize and order standard diagnostic tests when medically indicated and shall document in the patient's chart any refusal by the patient to submit to such tests;
4. Respondent shall practice medicine competently.

THE ADMINISTRATIVE HEARING

A hearing before an Administrative Law Judge ("ALJ") commenced on October 4, 1990 and continued on October 9, 10, 11, and 12, 1990. Present at the hearing were: Respondent; Debra G. Woodruff, Assistant Attorney General, Administrative Prosecutor for the Board, and Henry E. Schwartz, Esquire, Counsel for Respondent. At the hearing, the State introduced the following into evidence:

State Exhibits 1 through 33 - Patient files number 1 through 33

State Exhibit 34 - List of patients' names on above files

State Exhibit 35 - C.V. for Pablo Dibos, M.D. who testified for the State

Respondent introduced the following into evidence:

Respondent Exhibit 1 - Consent to Treatment form and Authorization for Medical Treatment on Respondent's letterhead

Respondent Exhibit 1a - Consent to Treatment form and Authorization for Medical Treatment with Laetrile therapy exclusion on Respondent's letterhead

Respondent Exhibit 2 - List of patients' names, identifying numbers, names of 257 additional patients' affidavits

- Respondent Exhibit 3 - C.V. of Dr. Grace Ziem
- Respondent Exhibit 4 - C.V. for Dr. Alan R. Gaby
- Respondent Exhibit 5 - Reference Book Nutritional Therapy in Medical Practice article
- Respondent Exhibit 6 - PMS and Candidiasis: Study Explores Possible Link, Jay S. Schinfeld, M.D.
- Respondent Exhibit 7 - Hypothyroidism and Depression, Gold, M.D., Potash, M.D., and Extein, M.D.
- Respondent Exhibit 8 - Treatment with Thyroid Hormone letter by Alan R. Gaby, M.D., published in American Journal of Medicine
- Respondent Exhibit 9 - Hypothyroidism - The Unsuspected Illness, Barnes, M.D. and Galton
- Respondent Exhibit 10 - Neuropsychiatric Disorders Caused by Cobalamin Deficiency in the Absence of Anemia or Macrocytosis, Lindenbaum, M.D., Heaton, M.D., Savage, M.D., Brust, M.D., Garrett, M.D., Podell, B.A., Marcell, B.S., Stabler, M.D., and Allen, M.D.
- Respondent Exhibit 11 - A Pilot Study of Vitamin B12 in the Treatment of Tiredness, Ellis and Nasser
- Respondent Exhibit 12 - Treatment of Trigeminal Neuralgia with Vitamin B12, Surtees, M.D., and Hughes, M.D.
- Respondent Exhibit 13 - The Effect of Vitamin B12 and Folic Acid in the Treatment of Viral Hepatitis, Campbell, M.D., and Pruitt, M.C.
- Respondent Exhibit 14 - Cyanocobalamin in Chronic Bell's Palsy, Mitra and Nandi
- Respondent Exhibit 15 - Nocturnal Cramps, letter from Aitchison in New Zealand Medical Journal
- Respondent Exhibit 16 - Vitamin B12 in Acute Subdeltoid Bursitis, Klemes, M.D.
- Respondent Exhibit 17 - Agent Might Protect Sulfite-Sensitive Asthmatics, article in Family Practice News
- Respondent Exhibit 18 - Vitamin B12 in Asthma, article in

Journal of the American Medical Association

- Respondent Exhibit 19 - Cyanocobalamin (B12) Comparison of Aqueous and Repository Preparations in Urticaria; Possible Mode of Action, Simon, M.D., and Edmonds, B.S.
- Respondent Exhibit 20 - Assessment of Vitamin B12 Status in CSF, letter to Editor of newsletter
- Respondent Exhibit 21 - Virucidal Activity of Vitamin C: Vitamin C for Prevention and Treatment of Viral Diseases, Murata
- Respondent Exhibit 22 - The Parenteral Administration of Magnesium Sulphate in Hypertension, Zohman, M.D. and Sternberg, M.D.
- Respondent Exhibit 23 - C.V. of William G. Crook, M.D.
- Respondent Exhibit 24 - C.V. of Irwin Rosenberg
- Respondent Exhibits 25 - Consents of Witnesses to waive  
through 40 confidentiality of their medical records
- Respondent Exhibit 41 - Vitamin B12 Deficiency and Early Rise in Mean Corpuscular Volume, Hall, M.D.
- Respondent Exhibit 42 - Lhermitte's Sign in Cobalamin (Vitamin B12) Deficiency, Butler, M.D., Taylor, M.D., and Diehl, M.D.
- Respondent Exhibit 43 - Multiple Vitamin C Effects Described, article in Medical Tribune
- Respondent Exhibit 44 - Terminal Ca Survival Leap with Ascorbate Megadoses, article by Horwitz in Medical Tribune
- Respondent Exhibit 45 - X-Rays May Boost Cardiovascular Disease Risk, article
- Respondent Exhibit 46 - C.V. for Broda G. Barnes, M.D. and information from the Research Foundation
- Respondent Exhibit 47 - Essential Hypertension, Its Control by a New Method, Menof
- Respondent Exhibit 48 - Chronic Arthritis, Swaim, M.D.
- Respondent Exhibit 49 - Excerpt from Dr. Wright's Book of Nutritional Therapy, Wright, M.D.

Respondent Exhibit 50 - The Effect of Folic Acid on Collateral Circulation in Diffuse Chronic Arteriosclerosis, Kobias, M.D.

Respondent Exhibits 51- Excerpt from What Your Doctor Didn't and 52 Learn in Medical School, Berger, M.D.

Respondent Exhibit 53 - Excerpt from The Scientific Validation of Herbal Medicine, Mowrey, Ph.D.

There were also 262 Affidavits submitted by patients of Respondent for inclusion into the record, marked as Respondent Exhibit 54, and an additional list of reference books forwarded to the ALJ by counsel for Respondent on October 25, 1990, marked as Respondent Exhibit 55.

Respondent testified on his own behalf. Also testifying as experts for Respondent were Grace Ziem, M.D.; Alan Gaby, M.D., and W. G. Crook, M.D.

The Administrative Law Judge issued her Recommended Decision on January 7, 1991. Respondent filed timely exceptions pursuant to COMAR 10.01.03.35.

#### EXCEPTIONS TO THE RECOMMENDED DECISION

The Board has before it the Recommended Decision, the exceptions filed by Respondent and Respondent's and State's oral argument.<sup>3</sup> Respondent took general exception to Paragraphs # 6,

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<sup>3</sup> The following Board members were present and considered this case: Israel H. Weiner, M.D., Chair; Frank A. Gunther, Jr., Vice Chair; Bernard S. Kleiman, M.D.; Ira N. Brecher, M.D.; John T. Lynn, M.D.; Claude D. Hill, M.D.; J. Andrew Sumner, M.D.; Lawrence A. Jones, M.D.; Harvey B. Kalin, M.D., and Christine J. Moore. Absent were Peter E. Dans, M.D., Secretary; John F. Strahan, M.D.; Sheila K. Riggs and Reynaldo L. Lee-Elacer, M.D. The terms of members Kleiman and Hill expired prior to the adoption of this order.

8, 10, 11, 12, 13, 14, 15, 24-47, 49-56 of the Findings of Fact and to all of the Conclusions of Law of the Recommended Decision. A memorandum argument was filed by the Respondent on four legal issues. These issues reduce to three: (A) the legal standard used in evaluating whether competent medicine was being practiced; (B) the legal burden to be borne by the prosecution in proving violation of probation; and (C) whether the prosecution met the burden of proof.

No exceptions or answer to Respondent's exceptions were filed by the Administrative Prosecutor. Since the arguments made in Respondent's exceptions do not specifically challenge the proposed findings of fact and conclusions of law as much as the legal framework for the resolution of this matter, they will be addressed prior to the Findings of Fact, Conclusion of Law and Order.

#### BOARD DETERMINATION ON RESPONDENT'S EXCEPTIONS

This matter comes before the Board on a charge of violation of probation. This Board has not previously determined exceptions following a violation of probation proceeding. We have little precedent to guide us in the administrative arena. While not determinative, the developing law on probation in the psychiatric civil commitment and criminal arenas provide assistance as to the maximum constraints which could govern our decisions in this area. Cf. McDonnell v. Commission on Medical Discipline, 301 Md. 426, 436 (1984).

A violation of probation hearing is a two stage proceeding. See Bergstein v. State, 322 Md. 506 (1991). The first issue to



be addressed is whether the violation occurred. Unlike charges under the Maryland Medical Practice Act, Health Occupations Article § 14-404, in which a statutory standard is at issue, a violation of probation proceeding entails a determination of whether specific terms of a prior order of our predecessor administrative board were violated. Only if the answer is in the affirmative is the second issue of disposition faced.<sup>4</sup>

A. The Legal Standard

1. Competency- In his exceptions, Respondent challenges the formulation of the issue of competence as articulated by the administrative law judge, the administrative prosecutor, and the expert witness presented by the prosecution. (Memorandum in Support of Respondent's Exception, pp.1-11.)

For this proceeding, the slate is not blank. The 1984 Order outlined the basis for the prior Commission taking action against Respondent's license. Attachment A to this order. Respondent engages in the practice of general surgery and family practice medicine. Attachment A, p. 4, paragraph 3. The Commission's 1984 Order found and recited numerous instances in which Respondent failed to undertake necessary diagnostic inquiries and procedures prior to treating his patients. See discussion of the 1984 Order supra at pp. 1-3. The Commission suspended Respondent's license, but allowed for a stay of that action predicated upon his undertaking a reeducation program in general

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<sup>4</sup> In this order, any remaining issue of disposition will be explored immediately before the Order portion.

medicine and oncology. Attachment A, p. 11. The obvious imperative of the prior Order was that Respondent must follow basic regimens of medical care in treating his patients, including the contemporaneous recording in the patient's chart of any refusal by the patient to submit to such tests. Attachment A, Conditions 3 & 4 of the Order of Probation.

The Commission's 1984 Order became final and Respondent undertook the reeducation program. He secured a stay of that 1984 Order suspending him predicated upon his complying with the conditions of probation, two of which he is now charged with violating. At issue, therefore, is not whether Respondent violated the Maryland Medical Practice Act as determined in a de novo proceeding involving the grounds of incompetency or practice below the standard of care, but, instead, whether he violated an order entered by the Commission, after a full hearing, to address specific deficiencies found in his practice of medicine.

In these circumstances, competency is determined by the Board when viewing the record as a whole and in light of the prior Order, including the testimony, both of the treating doctor and outside experts, the medical records, and other hearing evidence. There are no magic words or special techniques in this fact finding. The issue is whether incompetence is proven or disproved based upon review of specific patient records.

2. Unconventional Medicine- Respondent seeks that the Board employ a special standard when examining the competency of treatment provided by Respondent to his patients. Respondent's Memorandum at pp. 5-18. He cites State Board of Medical

Examiners of Florida v. Robert J. Rogers, M.D., 387 So.2d 937 (1980) and an Alaska statute codified at § .08.64.326, in support of a special standard which he argues should be used to judge the competency of practitioners of "unorthodox" medicine.

Respondent's Memorandum, p. 5.

The Florida case involved a physician who was being disciplined by the state medical board for the use of chelation therapy in his medical practice. Chelation therapy is a treatment proposed for arteriosclerosis involving injections of chelating agents into the blood stream which are intended to remove calcium deposits. The Florida medical board voted to reprimand Dr. Rogers and prohibit his use of chelation therapy. In reversing the Florida board, the Florida court found from the record that Dr. Rogers provided full informed consent to his patients regarding the unproven efficacy of the treatment, the treatment was not harmful and no fraud or deception was employed with the patients. Under those circumstances, the Rogers court held that Florida could not proscribe the physician's use of the treatment. 387 So. 2d 937, 939.

The highest court of North Carolina came to a different conclusion in a recent case involving the practice of homeopathy by a physician. A lower appellate court sought to engraft upon their medical practice act a requirement that a patient had to be harmed before their state medical board could discipline a physician for not adhering to acceptable and prevailing medical practices. In re Guess, 95 N. C. App. 435, 382 S.E. 2d 459 (1989). The Supreme Court of North Carolina reversed. In re

Guess, 327 N.C. 833, 393 S.E. 833, 839 (1990), cert. denied 111 S. Ct. 754; See also Guess v. Board of Medical Examiners, 967 F.2d 998 (4th Cir. 1992).

The Alaska statute, Alaska Stat. §08.64.320 (1990), prohibits its state licensing board from taking disciplinary action against a physician based upon incompetence due to use of unconventional therapies without proof of demonstrable physical harm to a patient.

While helpful in developing a context for evaluating the competency issue, neither the Florida or North Carolina court decisions, nor the Alaska statute, defines our standard for evaluating competency in the medical practice of Dr. Shamim.

His 1984 Order enumerated numerous instances of tests not performed or evaluations not made which resulted in deficient medical care being given. That order provided for a sanction, but also contained rehabilitative provisions of which Dr. Shamim has availed himself.

By entering the order in 1984, the Commission was engaged in the administration of the standards of the profession. Licensing is a means employed by the state to control competence and integrity in a profession. Koch, Administrative Law and Practice §2.33 (1985). Maryland has long recognized the authority of the state to itself regulate or to delegate regulation of the practice of medicine to an outside body. See e.g. Commission on Medical Discipline v. Stillman, 291 Md. 390 (1981); Aitchison v. State, 204 Md. 538, 544-46 (1953). The authority to regulate includes the capacity to determine what activities do and do not

constitute the practice of medicine. Hitchcock v. State, 213 Md. 273, 280 (1957). The purpose of disciplinary proceedings against a licensed professional is not to punish the offender, but rather to act as a catharsis for the profession and a prophylactic for the public. McDonnell v. Commission on Medical Discipline 301 Md. at 436.

Respondent's competency is not being evaluated for his use of unconventional therapies. At issue is how he performs general medical care. Dr. Shamim was fully apprised in 1984 as to these standards by which his practice would be judged. 1984 Order. Nothing in the 1984 Order prohibits him from practicing unorthodox or unconventional therapies, including nutritional, holistic or preventative medicine. This Board is aware that physicians often disagree on the proper diagnosis or method of treatment to be employed with a patient. We also recognize that many advances in science come from novel ways of looking at problems or from serendipitous discovery.

However, when alternative therapies are employed, it is particularly important to emphasize the principle of informed consent. A physician treating a mentally competent adult under non-emergency circumstances cannot perform surgery or administer other therapy without the consent of the patient. Williams v. Wilzack, 319 Md. 485 (1990); Sard v. Hardy, 281 Md. 432 (1977). Maryland law imports a strong duty on the physician to secure informed consent prior to treatment. Id. This duty takes full account of the probability that unlike the physician, the patient is ordinarily untrained in medicine and therefore depends

completely on the trust and skill of the physician for the information upon which the patient makes a medical treatment choice. Sard v. Hardy, 281 Md. at 439. It requires the physician to reveal to the patient the nature of the ailment diagnosed, the proposed medical treatment alternatives, the probabilities of success and the risks of failure or side effects. Id. at 440.

We previously determined that Dr. Shamim's medical practice must take place in the informed consent context of the Respondent explaining the medical options to the patient, both those recognized as standard in the profession and alternative therapies, and then proceeding to treat, with deviations from the standard acknowledged in the medical record or chart of the patient. 1984 Order. This is the standard outlined for the Respondent in 1984 and under which he has been licensed since 1985.

Accordingly, based upon the foregoing reasoning, the Board overrules the exceptions of Respondent as they relate to the administrative law judge's substantive legal standard on the issue of competency raised by the charges of violation of Conditions 3 & 4 of the 1984 Order.

B. The Burden of Proof-

Respondent argues that the administrative law judge employed the wrong quantum of proof in determining the facts in this hearing. Respondent's Memorandum, p. 18-19. He contends that the "clear and convincing" standard found in Health Occupations § 14-405(b) applies rather than the "preponderance of evidence"

standard used by the administrative law judge. Recommended Decision, p. 11.

Both tests have support in the law. The "reasonable satisfaction" test, translated as equivalent to preponderance of the evidence, applies in criminal probation revocation proceedings. Baynard v. State, 318 Md. 531 (1990). Where a higher standard has been set by statute or regulation, however, that standard governs. See Bergstein v. State, 76 Md. App. 554 (1988).

Under the Administrative Procedure Act, the preponderance of the evidence standard ordinarily applies. Bernstein v. Real Estate Commission, 221 Md. 221 (1959). But, in its revision of the Maryland Medical Practice Act in 1988, the statute governing hearings for "... an action under §14-404 ..." was modified to reflect that they were to be conducted in accordance with the Administrative Procedure Act "... except that factual findings shall be supported by clear and convincing evidence." Health Occupations § 14-405. A probation revocation proceeding is not an original action under Health Occupations §14-404, but instead is a derivative action arising out of the alleged violation of the disposition portion of a medical practice act order. As such it is quite similar to a violation of probation proceeding.

After this review of the law, the Board, at least for this proceeding, adopts the more careful route and therefore will sustain the exception made by Respondent, and apply the more stringent clear and convincing evidence standard to evaluate the evidence presented at the hearing.

C. Proof at the Hearing-

The procedural law governing hearings before the Board makes it the ultimate fact finder. Health Occupations § 14-405 & 406. See also Board of Appeals, Department of Employment and Training v. Mayor and City Council of Baltimore, 72 Md. App. 427 (1987). The Board is thus required to review the hearing evidence to determine whether Respondent violated the conditions of the probation. The Board may use its expertise, technical competence, and specialized knowledge in the evaluation of the evidence. State Government § 10-208.

The type of evidence and individuals testifying were previously summarized. Final Order at 4-7. See also the Recommended Decision of the Administrative Law Judge.

The testimony of Dr. Pablo Dibos, the expert witness presented by the Administrative Prosecutor, noted deficiencies in the diagnosis, treatment and medical record documentation of Dr. Shamim. Tr. at pp. 41- 595. Several witnesses, including Dr. Alan Gaby, testified that scientific literature, including that introduced into evidence, supports many of the treatment methods utilized by Dr. Shamim. See e.g. Tr. at pp. 1017- 1271 and Respondent's Exhibits 5-22. A number of Dr. Shamim's patients executed affidavits which were entered into evidence and testified on his behalf at the hearing.

In resolving the evidence introduced at the hearing, the Board has drawn upon its own medical knowledge, when appropriate, and weighed the conflicting medical opinions provided. We draw



conclusions regarding the validity of diagnosis and treatment only in the context of the treatment of specific patients.

#### FINDINGS OF FACT

The Board finds, by clear and convincing evidence, as follows:

1. On September 18, 1984, the Commission ordered that Respondent "shall cease engaging in the practice of medicine within three months of the date of this order" for a period of three years because Respondent was professionally incompetent based on his treatment of several cancer patients and because Respondent willfully and knowingly filed a false report in the practice of medicine based on his false certification that a patient was terminally ill in order to place the patient on Laetrile. The Final Order provided that the cessation of practice would be stayed if the Respondent complied with certain conditions. (Exhibit A of Charging Document)

2. On April 30, 1985, the cessation of practice was stayed and Respondent resumed the practice of medicine, on probation, subject to the following conditions of probation as set forth in the Final Order:

- (1) Respondent shall submit to quarterly practice review by a committee designated and approved by the Commission;
- (2) Respondent shall arrange for the reviewing committee to submit reports of the reviews to the Commission;
- (3) Respondent shall properly utilize and order standard diagnostic tests when medically indicated and shall document in the patient's chart any refusal by the patient to submit to such tests;
- (4) Respondent shall practice medicine competently;

(5) Respondent shall not file false reports or records in the practice of medicine. (Exhibit A of Charging Document)

3. At all times relevant, Respondent was subject to the conditions of probation.

Patients 1 through 33

4. The care rendered to Patient #1 by Respondent was deficient.

a. The care rendered to Patient #1 with regard to the management of the patient's complaint of a lump in her left nipple was deficient.

i. Patient #1 had cancer of the breast in 1981 and a resultant lumpectomy in 1982 at George Washington Hospital. (State Exhibit 1)

ii. Patient #1 saw Respondent on September 12, 1985 with concern about a small lump in her left nipple, and Respondent noted "no masses felt." (State Exhibit 1)

iii. Although Respondent testified that the patient was under the care of the oncology unit at George Washington Hospital for treatment related to her breast cancer, the record documents only the performance of the surgery in 1982 and does not make reference to follow-up care provided by the hospital at the time she saw Respondent for the lump on her left nipple in 1985. (State Exhibit 3 and T. 146)

iv. Although Respondent testified that the lump was in the skin of the breast and not in the tissue itself, there is no description of the lump contained in the patient's medical record.

v. The medical record does not indicate that Respondent ordered any mammograms for the patient or the patient's reluctance to undergo any further mammograms. (State Exhibit 1)

vi. On October 1, 1985, Respondent ordered a CEA test for patient which is not recognized as useful in follow-up of patients with breast cancer. (T. 68, 69, 71, 75)

b. The care rendered to Patient #1 by Respondent with regard to the patient's complaint of staining in her pants was deficient.

i. On October 12, 1984, this patient related that she "noticed staining in pants past few months, off and on, especially upon running and jogging. Urine and stool negative. Has urgency and frequency of urine." (T. 80)

ii. The standard of care in the diagnosis of colon cancer in a patient whose complaint is rectal bleeding is: physical exam, digital exam, proctoscopic exam, and, if necessary, barium enemas, x-ray studies or colonoscopy. (T. 120)

iii. There is no indication in the medical record of a physical examination of the rectal area. (T. 81)

iv. The medical record does not substantiate that the Respondent ordered occult blood study.

v. CEA (a test used where there is a history of colon cancer) was ordered by Respondent for Patient #1 who had no history of colon cancer rather than the traditional diagnostic procedure described above. (State Exhibit 1)

c. The care rendered to Patient #1 by Respondent with regard to the management of uncontrolled blood pressure was deficient.

i. Patient #1's blood pressure measurements noted in the record from 1985 through 1988 were, variously: 150/90; 160/100; 154/84; 106/90; 148/96; 140/90; 140/90; and 150/104.

ii. Respondent made a diagnosis of "mild hypertension." (State Exhibit 1)

iii. Other than "blood pressure caps," which were prescribed in 1985, there is no other reference to medication nor other treatment ordered for Patient #1 to control her blood pressure. (T. 115)

d. Injections of multiple vitamin and minerals administered to Patient #1 by the Respondent had no therapeutic value as the medical record fails to document any deficiency in the supplements prescribed.

e. The care rendered to Patient #1 by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there was any laboratory test or history to substantiate the diagnosis of candidiasis. (T. 131)

ii. Respondent prescribed Nystatin for this patient without indication. (T. 131)

5. The care provided to Patient #2 by Respondent was deficient.

a. Patient #2 sought treatment from Respondent on September 12, 1986, at which time the latter's impressions were: iatrogenic hypothyroidism, arthritis; numbness of legs and hands; heart palpitations; mild headaches; chronic digestive disorders; ear ringing; varicose veins; low memory; hair loss; sweet cravings; and possible systemic candidiasis.

b. The care described in the record for Patient #2 was deficient with regard to the ordering of injections of calcium and magnesium.

i. Respondent did not obtain serum calcium and magnesium levels.

ii. Respondent did not determine that there was, in fact, a calcium or magnesium deficiency before prescribing the injections. (State Exhibit 2)

c. The care described in the record for Patient #2 was deficient with regard to the patient's complaints of palpitations.

i. On September 12, 1986, Patient #2 first came to Respondent who noted in the history that she had a thyroid problem and was taking synthetic thyroid medication. (State Exhibit 2)

ii. At the time of her initial visit, the patient complained of heart palpitations. (State Exhibit 2)

iii. The record does not document that Respondent performed an adequate heart examination in view of the complaint of palpitations (listening to the heart for 30-60 seconds for heart irregularities), did not order an EKG, and did not order a

laboratory test to obtain the level of thyroid hormone in the blood. (T. 160-162 and State Exhibit 2)

d. The care provided to Patient #2 by Respondent is deficient with regard to the diagnosis and treatment of Candidiasis.

i. The physical examination did not note any physical evidence of any lesions of candida nor any mention of symptoms which might suggest a vaginal yeast infection. (State Exhibit 2 and T. 164)

ii. The prescription for oral Nystatin, which would be indicated for oral or esophageal candidiasis, is not documented to be required for Patient #2. (T. 164)

e. The care provided to Patient #2 by Respondent is deficient with regard to her anemia.

i. The patient, at the time the care at issue was provided was about 67 years old. (State Exhibit 2)

ii. The patient's initial hematocrit, when she first saw Respondent in September 1986, was 39.7. (State Exhibit 2 and T. 166)

iii. The patient's hematocrit on June 4, 1987, according to a laboratory test, was 34.5; on September 25, 1987, it was 33.2; and in November, 1988, her hematocrit was 34.7. (State Exhibit 2 and T. 166)

iv. The medical records for June 4, 1987 refer to the hematocrit of 34.5, but the medical records for the subsequent dates do not make reference to the low hematocrit. (T. 126)

v. A physician should investigate the cause for a low hematocrit by asking the patient if there has been any change in color of the stools or any change in bowel habits, a rectal examination should be performed, and stools for occult blood should be ordered in order to exclude any serious conditions which might be the cause of the low hematocrit.

vi. Liver and iron injections were ordered for the patient beginning on March 2, 1987, before a diagnosis of one of the reasons for the anemia level had been determined. (State Exhibit 2)

vii. The treatment of the anemia with liver, iron and B6 and B12 injections before a diagnosis of the cause of the anemia has been determined is deficient practice of medicine.

(T. 175) Dr. Dibos' expert testimony was, in part:

This is totally unjustified, medically. This is what we teach medical students not to do. This is -- first, you have to diagnose and then treat. The process cannot be reversed. This is a very firm rule in medicine.

There are very few instances where you go ahead and treat without a diagnosis. Very few. And those are called therapeutic trials. But you do that cognizant of the fact that you did not know what's wrong with the patient. You write it down. I don't know what's wrong with this patient, but I'm going to try this just in case.

That is a valid approach, but not for problems such as anemia, where the work-up of these patients is clear cut, ingrained, it's not controversial. There are controversies in medicine, there are various ways of doing things, but there are not controversies here. They are clear cut, established guidelines as to how you approach anemia. (T. 175)

f. The care provided to Patient #2 by Respondent with regard to her complaints involving an episodic illness on July 19, 1988 was deficient.

i. The patient's complaints, on that day, were "Eight days ago was sick with cough, congestion. No phlegm. Was given antibiotic." (State Exhibit 2)

ii. Respondent examined the patient's lungs and noted, "Chest, some ronchi in front." (State Exhibit 2)

iii. Respondent diagnosed "Tracheitis" on the basis of his examination. (State Exhibit 2)

iv. Treatment prescribed by Respondent was "Continue with diet and nutritional supplement," and the patient received multiple intramuscular vitamin injections. (State Exhibit 2)

v. The medical record does not document any temperature, blood count, or any reference to the patient's having taken an antibiotic when the illness first appeared. There is no evidence of any specific treatment done for the diagnosis of tracheitis. (l. 181)

6. The care provided to Patient #3 by Respondent was deficient.

a. Patient #3 first visited Respondent on March 21, 1988, complaining of dry skin with a history of spring allergies, infrequent headaches and intermittent constipation. (State Exhibit 3)



b. The care provided to Patient #3 by Respondent with regard to the diagnosis and treatment of Candidiasis was deficient.

i. Respondent diagnosed Candidiasis without any laboratory test or history to substantiate the diagnosis. (T. 194 and State Exhibit 3)

ii. Respondent prescribed Nystatin without any confirmation of the diagnosis of Candidiasis. (T. 194 and 195 and State Exhibit 3)

c. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #3 as there is no indication in the medical record that this patient was deficient in the substances prescribed.

7. The care provided to Patient #4 by Respondent was deficient.

a. Patient #4 was 48 years old when he visited Respondent on May 28, 1987, with complaints of high blood pressure for the past six years. Respondent's impressions were: "Peripheral vascular disease, intermittent claudication, leg pains, history of hypertension, low energy and fatigue and environmental sensitivities, wool, nylon, et cetera. Possible chronic candidiasis." Respondent prescribed Nystatin oral capsules, multiple "B" vitamin and folic acid injections, and magnesium injections for Patient #4. (State Exhibit 4)

b. The care provided to Patient #4 by Respondent with regard to the diagnosis and treatment of Candidiasis was deficient.

i. There was no indication of laboratory tests or history to confirm the diagnosis of Candidiasis. (T. 199)

ii. Nystatin oral tablets were prescribed without indication. (T. 200)

c. The care provided to Patient #4 by Respondent with regard to the diagnosis of hypertension was deficient.

i. When Patient #4 first saw Respondent on May 28, 1987, he had a history of high blood pressure and was noted to have been on high blood pressure medication for several years. (State Exhibit 4 and T. 201)

ii. The medical record does not make reference to what the anti-hypertensive medication was or whether Patient #4 should continue it. And, when the blood pressure began to increase, the medical record does not comment as to whether the medication should be changed. Additionally, the medical record does not make reference to an examination of the fundi, urine analysis, or any other test to determine if the hypertension is affecting any of Patient #4's organs. (T. 203)

iii. From May 28, 1987 to May 3, 1988, Patient #4's blood pressure was noted to have been in the normal range. (State Exhibit 4 and T. 201)

iv. Beginning on July 27, 1988, Patient #4's blood pressure was noted to have increased: July 27, 1988, 160/90; August 3, 1988, 150/90; August 24, 1988, 165/106; September 1, 1988, 150/100; September 7, 1988, 156/100; September 19, 1988, 150/100 and 144/90; September 26, 1988, 150/90 and 160/100; March 22, 1989, 150/104 and 148/94; April 3, 1988

150-154/90; April 8, 1989, 134/84 and 144/88; April 22, 1989, 144/84 and 130/78; May 3, 1989, 160/84 and 140/88; May 13, 1989, 150/80 and 154/84; and June 9, 1989, 144/88 and 140/90. These readings indicate mild hypertension. (State Exhibit 4 and T. 202)

v. Although elevations in blood pressures are noted beginning on July 27, 1988, the medical records do not indicate any treatment except for "B.P. caps by Nature's Way, 2 caps twice/day with water" on April 1, 1989. (State Exhibit 4)

d. The care provided to Patient #4 by Respondent with regard to the laboratory indication of low calcium is deficient.

i. On June 3, 1987, Patient #4's laboratory tests indicated that his serum calcium was 8.5. (State Exhibit 4)

ii. Normal levels for serum calcium are 8.7 to 10.6. (State Exhibit 4)

iii. Most of Respondent's other patients were treated with injections of calcium notwithstanding the serum level of calcium noted in their laboratory tests.

iv. Respondent testified that injections of calcium and magnesium were often a general part of his treatment regimen.

v. Although Patient #4's serum calcium level was below normal, he was not treated with injections of calcium. (State Exhibit 4)

e. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #4 as

there is no indication in the medical record that this patient was deficient in the substances prescribed.

8. The care rendered to Patient #5 by Respondent was deficient.

a. Patient #5 first visited Respondent on April 29, 1988 with complaints of feeling tired; muscle weakness of legs and thighs, especially on the left side; trouble with eyes, bleeding gums; lowered energy; possible allergy to dust, carpet dust, sensitivity to bug spray; and left lower leg soreness. On April 29, 1988, Patient #5 also complained of occasional black stools. (State Exhibit 5)

b. The care provided to Patient #5 by Respondent with regard to his neurological complaints was deficient.

i. On April 29, 1988 Patient #5 complained of muscle spasm and weakness in the neck, back and legs. (State Exhibit 5)

ii. Respondent noted that the neurological examination was "within normal limits," but did not note any pertinent negatives regarding muscle strength and deep tendon reflexes or sensation to pinprick. (T. 210)

c. The care rendered to Patient #5 by Respondent with regard to his June 6 and 13, 1989 complaints of intermittent numbness on the left side of the face and left side of the body was deficient.

i. The patient had given a history of previous radiation to the head. (State Exhibit 5)

ii. The medical record does not indicate that Respondent performed an examination of the thyroid gland. (T. 218 and State Exhibit 5)

d. The care rendered to Patient #5 by Respondent with regard to his initial complaint of occasional black stools was deficient.

i. Respondent attributed the occasional black stools to "iron" without having any laboratory or history confirmation. (State Exhibit 5)

ii. The medical record does not indicate any rectal examination or tests for occult blood in order to diagnose the cause of the occasional black stools. (State Exhibit 5 and T. 211)

e. The care rendered to Patient #5 by Respondent with regard to the prescription for sublingual B12 is deficient.

i. The blood chemistry test of May 29, 1987 indicate that Patient #5's B12 level was 345, within the normal range of 232-1138. (State Exhibit 5)

ii. There is no medical indication for the use of sublingual Vitamin B12. (T. 212)

f. The care rendered to Patient #5 by Respondent with regard to his complaint of GI flare up on February 16, 1989 was deficient.

i. The medical record does not describe the GI flare up in any detail or address any resulting diagnostic tests or treatment for it. (State Exhibit 5 and T. 218)

ii. The treatment indicated in the medical record on that date refers only to continued injections of multiple Vitamin "B" and folic acid and the continued use of Nystatin and nutritional supplements. (State Exhibit 5 and T. 218 and 219)

g. The care rendered to Patient #5 by Respondent with regard to his complaint of fleeting dizziness on February 26, 1989, was deficient.

i. The medical record does not describe any diagnostic tests or treatment addressing this complaint. (State Exhibit 5)

ii. The treatment indicated in the medical record on that date refers only to continued injections of multiple Vitamin "B" and folic acid and the continued use of Nystatin and nutritional supplements. (State Exhibit 5)

9. The care rendered to Patient #6 by Respondent was deficient.

a. Patient #6 first visited Respondent on March 15, 1988, with complaints of low energy and hypertension for many years. The medical record indicates that this patient had been taking Inderide for hypertension for the "past few years" and had been on Dyazide and other drugs. The patient was also noted to be obese, and suffered from constipation, skin rash on the back, and hemorrhoids. (State Exhibit 6)

b. The care rendered to Patient #6 by Respondent with regard to his hypertension was deficient.

i. Patient #6 had a history of high blood pressure and had taken medication for it. (State Exhibit 6)

ii. Patient #6 indicated that she wished to get off of blood pressure drugs. (State Exhibit 6)

iii. The medical record notes that the patient was taking Inderide on an irregular basis. 4/7/88: "has started to decrease the B.P. drug since last week;" 4/15/88: "no blood pressure medications for two days;" 4/22/88: "still taking one Inderide - 1 every 3rd day or so ...;" 4/29/88: "off Inderide completely..." (State Exhibit 6)

iv. The medical record does not indicate that Respondent explained to the patient the necessity of taking blood pressure medication as prescribed or that he adequately supervised the discontinuation of the medication. (T. 233)

v. On March 15, 1988, Patient #6's blood pressure was noted to be 150/100, indicating mild hypertension. (State Exhibit 6 and T. 222)

vi. On April 7, 1988, Respondent noted that patient had started to decrease the BP medication. (State Exhibit 6)

vii. On April 15, 1988, the medical record indicates a blood pressure of 150/90 and that "no blood pressure medications for two days." (State Exhibit 6)

viii. On April 22, 1988, the patient's blood pressure was 140/84 and 134/80. (State Exhibit 6)

ix. On April 29, 1988, the medical record indicates that the blood pressure medication had been stopped completely. (State Exhibit 6)

x. On May 9, 1988, the patient's blood pressure was 152/90; and it continued to increase: on May 10, 1988, 150/86; on August 9, 1988, 140/86 and 144/90; on December 13, 1988, 150/98; on April 18, 1989, 158/98 and 150/90; on May 2, 1989, 154/86 and 144/84. (State Exhibit 6)

xi. A rise in the diastolic measurement from 80 in April of 1988 to the 90's in May of 1988 is a significant rise in blood pressure. (T. 227)

xii. Although the patient was noted to be obese, the record does not indicate any instruction to the patient with regard to weight reduction and its effect on high blood pressure. (T. 227)

xiii. Respondent's only treatment of the elevation in blood pressure was a prescription for over the counter blood pressure capsules by Nature's Way. (State Exhibit 6)

xiv. Though the patient did not have a serious hypertension problem, Respondent's failure to address the elevation in blood pressure indicates a deficiency in his care and treatment of her. (T. 234)

c. The care rendered to Patient #6 by Respondent with regard to his potassium level was deficient.

i. Laboratory tests showed the patient's potassium level to be low: 1/11/88 - 3.2; 2/04/88 - 3.1; 3/02/88 - 3.4 when normal readings are 3.7-5.3. (State Exhibit 6 and T. 229)

ii. Respondent prescribed liquid "K" plus for Patient #6 on May 10, 1988. (State Exhibit 6 and T. 230)



iii. The medical record does not indicate any repeat level of potassium after the prescription of liquid "K" plus for the low potassium. (State Exhibit 6 and T. 231)

d. The care rendered to Patient #6 with regard to the diagnosis and treatment for Candidiasis was deficient.

i. There are no laboratory tests or history to confirm a diagnosis of Candidiasis. (State Exhibit 6 and T. 231)

ii. Respondent prescribed Nystatin vaginal suppositories without any vaginal examination or vaginal culture to indicate a need for this medication. (State Exhibit 6 and T. 231)

iii. Respondent prescribed Nystatin oral powder and tablets without any indication. (T. 231)

e. The care rendered to Patient #6 by Respondent with regard to the treatment with injections of multiple vitamins, folic acid, calcium and magnesium was deficient.

i. The medical records indicate that the patient received multiple injections of calcium and magnesium. (State Exhibit 6 and T. 232)

ii. The medical records do not indicate any deficiencies of these vitamins and minerals. (State Exhibit 6 and T. 232)

iii. The Nutrient Mineral Levels Analysis Report of 4/21/88, done by hair analysis, indicates that Patient #6 was at least 2 standard deviations below normal levels of zinc, and yet, the medical records do not indicate that zinc was prescribed for this patient. (State Exhibit 6)

iv. The Nutrient Mineral Levels Analysis Report indicates that Patient #6 was above normal in calcium level, and yet, the medical records indicate that she received multiple injections of calcium. (State Exhibit 6)

v. The Toxic Mineral Levels reported in the Mineral Analysis Report indicates that the patient had toxic levels of aluminum, and yet, the medical records do not indicate that Respondent addressed this in his treatment of her. (State Exhibit 6)

10. The care rendered to Patient #7 by Respondent was deficient.

a. Patient #7 sought treatment from Respondent from April 11, 1988 to July 11, 1988, reporting to Respondent that she had undergone a radical mastectomy in 1987 and had about 15 radiation treatments in Tehran. Respondent's impressions were: post-operative status for cancer of the right breast; arthritis in the knees; mild lower backache, myalgia, legs; asthma and allergies; hematuria and nocturia and urinary frequency; and mild GI disorder, flatulence. Respondent ordered hair analysis, laboratory blood tests, and he prescribed apricot kernels. (State Exhibit 7)

b. The care rendered to Patient #7 by Respondent with regard to diagnosis and treatment of Candidiasis was deficient.

i. There is no diagnosis in the medical record of Candidiasis, but there is a prescription for Nystatin oral powder and tablets. (State Exhibit 7 and T. 244)

ii. There is no indication in the medical record as to the reason for prescribing Nystatin for this patient. (T. 244)

c. The care rendered to Patient #7 by Respondent with regard to her complaints of hematuria, nocturia, and urinary frequency was deficient.

i. Patient first complained of urinary problems on April 11, 1988. (State Exhibit 7)

ii. The medical record does not indicate that Respondent ordered a complete urinalysis for this patient on April 11, 1988, when she complained of hematuria, nocturia, and urinary frequency. (State Exhibit 7)

iii. Patient was seen on 4/11/88, 4/20/88, and 4/27/88, and no mention is made of any tests, diagnosis, or treatment for the urinary problems. (State Exhibit 7)

iv. On May 4, 1988, the medical record does not indicate any complaints with regard to urinary problems, and it does indicate that a urine dip stick test was done. (State Exhibit 7)

v. On May 18, 1988, the medical record indicates that "urine shows no blood today". (State Exhibit 7)

d. The care rendered to Patient #7 by Respondent with regard to her history of breast cancer is deficient.

i. The medical record does not indicate that Respondent ordered a mammogram for this patient. (State Exhibit 7 and T. 247)

ii. The only medical record notation of a breast examination was on July 11, 1988, which is noted to be "unremarkable". (State Exhibit 7)

iii. The medical record does not indicate that the Respondent informed the patient as to the necessity of mammograms or noted her refusal to submit to them. (State Exhibit 7)

iv. The medical record does not indicate whether the patient was being followed for her history of breast cancer by any other physician. (T. 249)

e. The care rendered to Patient #7 by Respondent with regard to the multiple injections of vitamins and minerals were deficient.

i. The hair analysis done on April 21, 1988, indicated that her level of calcium was above normal; her level of magnesium, sodium, potassium, copper, manganese, chromium, cobalt, selenium, silicon, vanadium, gold, silver, tin, and zirconium were below normal. (State Exhibit 7)

ii. The serum level of potassium and sodium done on May 1, 1988, indicates that the serum levels were normal. (State Exhibit 7)

iii. The multiple vitamin and mineral injections prescribed by Respondent failed to address the majority of the "deficiencies" noted on the hair analysis. (State Exhibit 7)

iv. There is no indication in the medical record that the patient suffered from anemia so as to require a liver supplement, which was prescribed and given by injection to the patient. (State Exhibit 7)

v. The medical record does not indicate that Patient #7 was deficient in vitamin B12, and yet, Respondent prescribed sublingual vitamin B12 for this patient. (State Exhibit 7)

vi. There is no therapeutic value in utilizing sublingual vitamin B12.

11. The care rendered to Patient #8 by Respondent was deficient.

a. Patient #8 began in treatment with Respondent in 1982 for fatigue, weight loss, arthritis of the right knee, and prostate enlargement. On September 5, 1988, Patient #8 returned to Respondent complaining of redness and inflammation of the right large toe; multiple insect bites on thighs; and flare-up of pain in the knees. (State Exhibit 8)

b. The care rendered to Patient #8 by Respondent with regard to his enlarged prostate was deficient.

i. The medical record does not substantiate that a rectal examination was conducted. (State Exhibit 8)

ii. The medical record does not substantiate that either a serum acid phosphatase or prostatic specific antigen tests were ordered to determine if there was a prostatic cancer. (State Exhibit 8 and T. 253)

iii. The CEA test ordered by Respondent is not reliable in the diagnosis of prostatic cancer due to the possibility of false elevation in patients with prostatic enlargement. (T. 260)

c. The care rendered to Patient #8 by Respondent with regard to his complaint of "redness and inflammation, red foot, large toe times three; four days..." was deficient as Respondent failed to order a serum uric acid test to rule out gout. (T. 259-260)

d. The care rendered to Patient #8 by Respondent with regard to his complaint of dizziness was deficient.

i. On September 6, 1988, the medical record indicates that the patient's blood pressure was low (100/60), he was dizzy and he "appears pale". (State Exhibit 8)

ii. The medical record does not substantiate that an orthostatic blood pressure was taken. (State Exhibit 8)

iii. The low blood pressure readings from September 5, 1985 to September 6, 1988 (118/60, 88/50 and 100/60) were indicative of an anemia, and Respondent's medical records do not indicate that he ordered a repeat hemoglobin and hematocrit to determine the degree of the anemia present in the patient. (State Exhibit 8 and T. 257-8)

e. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #8 as there is no indication in the medical record that this patient was deficient in the substances prescribed.

i. There is no demonstrable therapeutic use for sublingual Vitamin B12.

12. The care rendered to Patient #9 by Respondent was deficient.

a. Patient #9, who had been a patient of Respondent from 1977 to 1983, returned to Respondent for care on March 22, 1988, at which time Respondent's impressions were: fatigue, low energy - anemia; dysmenorrhea, PMS, menorrhagia; thyroid enlargement and underactive thyroid; constipation and bloating; mild headache; right leg pain, sweet craving; environmental sensitivities and possible chronic Candidiasis. (State Exhibit 9)

b. The care rendered to Patient #9 by Respondent with regard to diagnosis and treatment of Candidiasis was deficient.

i. The medical record does not indicate any laboratory or history confirming the diagnosis of Candidiasis. (State Exhibit 9 and T. 273)

ii. Respondent prescribed Nystatin oral powder and tabs and vaginal suppositories without any indication. (T. 273)

c. The care rendered to Patient #9 by Respondent with regard to the patient's anemia was deficient.

i. The laboratory studies done on March 23, 1988 substantiated that the patient had low hematocrit, low hemoglobin, low blood indices, and low serum iron. (State Exhibit 9 and T. 273)

ii. Between March 23, 1988 and May 18, 1989, (the next notation by Respondent in the chart), the medical record does not indicate that any diagnostic studies or investigation into the cause of the anemia was attempted by Respondent. (T. 274)

iii. Respondent began prescribing injections of liver and iron for the patient on March 22, 1988. (State Exhibit 9)

iv. Respondent prescribed multiple vitamin and mineral injections (B6, B12, Bx, Folic Acid) without any indication of deficiency reported in the laboratory tests. (State Exhibit 9)

d. The care rendered to Patient #8 by Respondent with regard to her complaints on March 22, 1988 of PMS, menorrhagia and dysmenorrhea was deficient.

i. Respondent did not note a referral to a gynecologist until June 22, 1989. (State Exhibit 9 and T. 275)

ii. The medical record does not indicate that a vaginal examination was performed by Respondent. (State Exhibit 9)

13. The care rendered to Patient #10 by Respondent was deficient.

a. Patient #10 sought treatment from Respondent from April 27, 1988 to December 21, 1988. On April 27, 1988, Respondent's impressions were: recurrent colds; allergies and environmental sensitivities; dermatitis-jock itch; low energy; GI disorders (flatulence); mild lower backache and muscle stiffness; sweet craving and chronic Candidiasis. Respondent ordered a hair analysis at that time. (State Exhibit 10)

b. The care rendered to Patient #10 with regard to the diagnosis and treatment of Candidiasis was deficient.



i. The medical record does not indicate that there was any laboratory or history substantiation for the diagnosis of Candidiasis. (State Exhibit 10)

ii. Respondent prescribed Nystatin oral powder without indication. (State Exhibit 10)

iii. Respondent prescribed Nystatin topical cream without any diagnostic testing of the dermatitis to determine that it was, in fact, fungal. (State Exhibit 10)

c. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #10 as there is no indication in the medical record that this patient was deficient in the substances prescribed.

i. There is no demonstrable therapeutic use for sublingual Vitamin B12. (T. 278)

d. The care rendered to Patient #10 with regard to the use of hair analysis was deficient.

i. Hair analysis is not recognized as an efficacious way of measuring the levels of vitamin and mineral deficiencies.

ii. The only recognized medical use for hair analysis is to measure for toxic amounts of arsenic.

iii. The hair analysis noted that this patient was deficient in selenium.

iv. The medical record does not indicate that Respondent directed any treatment toward the noted deficiency of selenium in this patient.

14. The care rendered to Patient #11 by Respondent was deficient.

a. Patient #11 first saw Respondent on May 18, 1987, at which time Respondent's impressions were: Alzheimer's disease; depression, agitation, nervousness, and fatigue; urinary frequency; environmental sensitivities and food allergies; sweet craving; mild arthralgia and muscle aches; and possible chronic Candidiasis. (State Exhibit 11)

b. The care rendered to Patient #11 by Respondent with regard to the diagnosis and treatment of Candidiasis was deficient.

i. The medical record does not indicate that there was any laboratory or history substantiation for the diagnosis of Candidiasis.

ii. Respondent ordered Nystatin oral powder and tablets without indication. (T. 283)

c. The care rendered to Patient #11 by Respondent with regard to the injections of calcium and magnesium was deficient.

i. The medical record note for April 28, 1988 states, "daughter states that calcium and magnesium seem to be of some help - will give calcium and magnesium injections."

ii. The laboratory test results of June 12, 1987 indicate that the patient's serum levels of calcium and magnesium were high.

iii. The medical record does not have any substantiation that deficiencies in these minerals existed for

this patient, and yet, Respondent prescribed injections at the request of the daughter of the patient.

d. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that this patient was deficient in the substances prescribed.

15. The care rendered to Patient #12 by Respondent was deficient.

a. Patient #12 sought treatment from Respondent on a regular basis from 1978 to 1988. On April 12, 1988, Respondent's impressions were: right adnexal inflammations; menstrual irregularities, mild dysmenorrhea and PMS; anemia; lower backache; environmental sensitivities; and possible chronic Candidiasis. (State Exhibit 12)

b. The care rendered to Patient #12 by Respondent with regard to the diagnosis and treatment of Candidiasis was deficient.

i. There were no diagnostic tests or history to substantiate a diagnosis of Candidiasis.

ii. Respondent prescribed Nystatin oral powder and capsules with no indication. (T. 300 and State Exhibit 12)

c. The care rendered to Patient #12 by Respondent with regard to her gynecological problems was deficient.

i. Respondent noted menorrhagia, PMS, irregular periods and dysmenorrhea in the patient records throughout the medical record.

ii. The medical record does not indicate that Respondent referred the patient to a gynecologist or that he referred her and she refused. (T. 302 and 307)

iii. Respondent did perform a pelvic examination, and ordered a PAP smear and CEC on February 14, 1986. (State Exhibit 12)

iv. Respondent prescribed raspberry leaf tea, bioflavinoids, and bee propolis, and injections of vitamins for this patient on March 19, 1986. (State Exhibit 12 and T. 305)

v. The prescribed treatment ordered on March 19, 1986, for this patient with regard to her gynecological problems are not generally recognized by the medical community as correcting menstrual irregularities. (T. 306)

d. The care rendered to Patient #12 by Respondent with regard to her symptoms of severe headache, fever, dizziness and nausea was deficient.

i. On 10/21/88, the patient complained of the above symptoms to Respondent.

ii. Though such information is important, the record does not indicate that the Respondent noted the patient's temperature or pulse on the medical record. (T. 309)

iii. Respondent ordered injections of Vitamins I.V. and I.M., fluids, steam inhalations on 10/21/88. (State Exhibit 12)

iv. On November 25, 1988, the patient reported a temperature of 102, congestion and cough.

v. Respondent ordered a throat culture on that date and continued I.V. Vitamin C and I.M. multiple Vitamin E, iron and liver injections.

vi. On November 28, 1988, the patient complained of continued temperature of 102, congestion, cough and sore throat.

vii. On that date, though the medical record notes the throat culture of 11/25/88 to be normal, the Respondent prescribed Ampicillin.

viii. The use of the antibiotic Ampicillin for a viral infection is not appropriate. (T. 312)

e. The care rendered to Patient #12 by Respondent with regard to the treatment of her anemia was deficient.

i. The patient's hematocrit was noted to be low (31.9 to 34.6) from February 16, 1984 through April 18, 1988 indicating mild anemia. (State Exhibit 12 and T. 301)

ii. The only treatment noted in the medical record with regard to the anemia of the patient was I.M. injections of liver and iron on 45 occasions from December 17, 1984 to to November 25, 1988.

iii. There is no indication in the medical record that the etiology of the anemia was ever identified or addressed.

f. The care rendered to the patient by Respondent with regard to injections of calcium was deficient.

i. The blood study done on April 18, 1988 indicated that the patient's calcium level was within the normal range (9.2). (State Exhibit 12)

ii. Respondent ordered calcium injections for the patient on April 21, 1988, notwithstanding the normal levels of this mineral noted on the laboratory report. (State Exhibit 12)

iii. On April 21, 1988, injection of calcium 10 cc was not indicated. (T. 314)

g. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that this patient was deficient in the substances prescribed.

16. The care rendered to Patient #13 by Respondent was deficient.

a. Patient #13 sought treatment from Respondent on April 8, 1988 at which time Respondent's impressions were: chronic cough, tachycardia, dyspnea, fatigue, nervousness, environmental sensitivities, chronic constipation, right inguinal hernia, myalgia and arthralgia, sweet craving, and possible chronic candidiasis. (State Exhibit 13)

b. The care rendered to Patient #13 with regard to a history of active immune response and inflammatory reaction was deficient.

i. Blood tests of this patient by a prior provider indicated an active immune response: Sedimentation Rate of 118 on 10/28/86; 117 on 11/12/86; 96 on 1/12/87; and 96 on 4/15/87, all of which are very high rates. (T. 330)

ii. On October 28, 1987, FANA titer was 1:1280 indicating an inflammatory reaction.

iii. Sedimentation rate is a non-specific measurement of the rapidity with which the cells in the blood settle. When the numbers are high, it is generally an indication of an inflammatory process. (T. 329)

iv. The standard of care when a sedimentation rate is high is to repeat the test to see if the condition which was causing it was still present, and the medical record does not indicate that Respondent ordered a repeat test. (T. 330)

c. The care rendered to Patient #13 by Respondent with regard to diagnosis and treatment of her complaints of myalgia and arthralgia was deficient.

i. The standard of care for complaints of myalgia and arthralgia is to examine the joints very carefully, looking for signs of inflammation and deformity, describing the extent to which joints ache and any deformities of the joints, to obtain sedimentation rates; and to obtain radiographs of the affected joints. (T. 333)

ii. There is no detailed description in the medical record of the physical findings of Respondent's examinations of this patient's joints. (T. 334)

iii. The medical record does not substantiate that Respondent ordered the blood tests and SED rate tests appropriate for these complaints.

iv. At the time the Patient #13 first visited Respondent, there was no information in the medical record with regard to the patient's prior treatment by a rheumatologist.

(1) Patient #13 had been seen by a rheumatologist since October, 1986.

(2) The patient was last seen by the rheumatologist about one year prior to his visit to Respondent.

v. The medical record does not document that the Respondent referred the patient to a rheumatologist or that he made a referral which was refused by the patient. (T. 344)

d. The care rendered to this patient by Respondent with regard to the diagnosis and treatment of Candidiasis was deficient.

i. There is no diagnostic or history substantiation for the diagnosis of Candidiasis. (T. 334)

ii. Respondent ordered Nystatin oral powder and tablets and Nizoral without indication. (T. 334)

e. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that this patient was deficient in the substances prescribed.

17. The care rendered to Patient #14 by Respondent was deficient.

a. On October 20, 1988, Patient #14 saw Respondent whose impressions were: perleche - right corner of mouth; mild muscle tension of neck; environmental sensitivities; possible chronic candidiasis. (T. 347)

b. The care of this patient by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.



i. There is no laboratory confirmation nor any history to substantiate a diagnosis of candidiasis. (T. 358)

ii. Respondent prescribed Nystatin and Nizoral without indication.

c. The care of this patient by Respondent with regard to the diagnosis and treatment of his skin condition was deficient.

i. The medical record does not document that Respondent obtained any skin scrapings and cultures to ascertain whether the dermatitis was fungal or bacterial. (T. 349)

ii. Respondent ordered Nystatin (an antifungal) on February 17, 1987. (T. 349)

iii. On September 9, 1987, the dermatitis was described as "worse." (State Exhibit 14)

iv. On September 19, 1987, Respondent ordered Nizoral tabs and topical cream for this patient.

v. On August 3, 1988, though the Respondent failed to note the status of the dermatitis on the patient's hands, Respondent ordered Nizoral cream. (T. 350)

vi. On January 26, 1989, Respondent prescribed Retin-A because of symptoms of "scaly rash with intense itching and burning on skin of face and has left wrinkles and scars." Retin-A is prescribed for the treatment of acne and wrinkling of the skin through aging. There is no diagnosis in the medical record of a condition for which Retin-A would be an appropriate medication. (T. 353)

vii. The standard of care in treatment of skin disorders is to attempt to treat the condition for a reasonable period of time, from weeks to months, and, if the treatment fails or if the condition does not improve, then the patient should be referred to a dermatologist for a diagnosis. (T. 353)

viii. Respondent continued to see this patient until June 27, 1987, and there are no further notes in the medical record regarding the patient's skin condition or the efficacy of the treatment prescribed by Respondent. (T. 353 and 354)

ix. There is no indication in the medical records that Respondent ever made a diagnosis of the patient's skin problems. (T. 353)

x. Although the record indicates that Respondent's treatment for this patient's skin problems was not effective, the record does not document that a referral to a dermatologist was made or that such a referral was made and refused by the patient.

d. The care rendered to this patient with regard to the diagnosis and treatment of tendonitis and traumatic arthritis was deficient.

i. On May 8, 1986, Respondent made the diagnosis of tendonitis and traumatic arthritis and prescribed local moist heat and some enzymes. (State Exhibit 14)

ii. On May 15, 1986, Respondent applied a splint to the patient's thumb without first having ordered an x-ray. (T. 356 - 358)

(1) The application of a splint is appropriate when a fracture is suspected.

(2) An x-ray is appropriate when a fracture is suspected.

iii. On June 5, 1986, three weeks after the injury to the thumb, Respondent ordered an x-ray of the patient's left thumb, and the radiologist's report indicated no bone, joint, or soft tissue abnormality to the left thumb.

iv. The medical record does not document how the thumb looked at the time of the injury or when the splint was applied, nor does it describe the range of motion of the thumb on either date. (T. 360)

e. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #14 as there is no indication in the medical record that this patient was deficient in the substances prescribed.

18. The care rendered to Patient #15 by Respondent was deficient.

a. Patient #15 sought treatment from Respondent on September 25, 1985, at which time the impressions of Respondent were: osteoporosis; food allergies; nervousness; and thyroid condition. Respondent ordered a hair analysis and EXEC IV blood test, and prescribed Nystatin, calcium, multiple B Vitamin injections and folic acid injections. (State Exhibit 15)

b. The care rendered to Patient #15 by Respondent with regard to the diagnosis and treatment of her thyroid condition was deficient.

i. The October 7, 1985 blood tests revealed a slightly low T4 (4.4), a low T-uptake (.60), and an increased R-T3 uptake (42.94). (State Exhibit 15 and T. 367)

ii. Respondent prescribed thyroid medication for this patient without indication. (T. 368)

iii. In response to a phone call by the patient on December 23, 1985, the thyroid medication was increased without any indication in the medical record that the thyroid function was checked prior to the change in medication. (T. 369)

iv. On March 5, 1986, there is an increase in thyroid medication without any indication in the medical record that the thyroid function was checked prior to the change in medication. (State Exhibit 15)

v. On October 6, 1986, additional blood studies were ordered, the results of which contrasted with the 1985 results in that the T-4 was now in the normal range and the T-uptake was even higher. (State Exhibit 15 and T. 370)

vi. The standard of care is for a competent physician to comment on the results of the thyroid test, and the Respondent's medical records do not contain any comment on the results of the 1986 blood studies. (T. 370)

c. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that this patient was deficient in the substances prescribed.

d. On October 1, 1986, Respondent ordered sublingual Vitamin B12 without indication.

e. The care rendered to this patient by Respondent was deficient with regard to the prescription of Nystatin on November 8, 1988.

i. The patient had complained of a sore rash on the upper lip.

ii. The medical record does not indicate any description of the rash, how long it has been present, whether or not it was recurring or whether any diagnosis of the rash was made prior to the prescription of Nystatin (an antifungal medication). (T. 371)

19. The care rendered to Patient #16 by Respondent was deficient.

a. Patient #16 sought treatment from Respondent in 1981 for skin lesions described as basal cell carcinoma in the laboratory report dated 1/24/81. On January 19, 1987, Respondent's impressions were: skin lesion - left temple; mild arthritis. Hair analysis and EXEC IV blood tests were ordered.

b. The care rendered to this patient by Respondent with regard to the skin lesions was deficient.

i. This patient had a history of basal cell carcinoma confirmed by laboratory study. (State Exhibit 16)

ii. Respondent did not document that he did any scrapings or cultures of the skin lesion on January 19, 1987 and the medical record does not describe or identify the lesion. (T. 378)

\* iii. Respondent did not refer the patient to a Dermatologist or document that he made such a referral and the patient refused. (T. 377)

iv. Respondent treated the lesion with topical application of Selenium, which is not identified as a valid treatment for basal cell carcinoma by the medical community. (T. 376-377)

v. The medical record does not contain any further reference to the lesion on the left temple until January 2, 1988. (State Exhibit 16)

(1) On January 22, 1988, Respondent noted: "skin lesion on left temple almost completely disappeared."

(2) On October 24, 1988, Respondent noted "small skin lesion on left forehead seems to go down somewhat with Vitamin E or aloe or other topical remedies."

vi. On March 6, 1989, the patient complained of a new skin lesion on the chest wall and Respondent prescribed Nystatin without any indication in the record that a diagnosis of the lesion was made to substantiate that the use of an anti-fungal medication such as Nystatin would be appropriate. (T. 378)

c. The care rendered to Patient #16 by Respondent with regard to the injuries she suffered in an automobile accident on April 12, 1987, was deficient.

i. On April 13, 1987, this patient stated that she was involved in a car accident on the night before and that

her chest wall and upper abdomen hit the steering wheel. (State Exhibit 16 and T. 378)

ii. Respondent noted only "no gross findings on exam" in the medical record, and he did not describe either the examination he did or his physical findings. (T. 379 and 385)

iii. A chest x-ray is a pertinent test for a person who sustains a chest trauma, and the medical record does not indicate that the Respondent ordered a chest x-ray to rule out any possibility of fractured ribs. (T. 379 and 385)

iv. An EKG is a pertinent test for a person who sustains a chest trauma, and the medical record does not indicate that Respondent ordered an EKG for this patient after the injury she sustained to the chest wall. (T. 379 and 383)

d. The care rendered to this patient with regard to indigestion and epigastric distress was deficient.

i. Patient complained of indigestion and epigastric distress on September 15, 1987, at which time Respondent ordered an upper abdominal sonogram.

ii. Respondent, at that time, did not note any treatment plan for these complaints. (State Exhibit 16)

iii. On January 22, 1988, the patient again complained of epigastric discomfort, and Respondent noted only that the sonogram had not yet been taken.

iv. The April 25, 1988, note indicates that the sonogram was negative, but there is no indication of treatment addressing the problem. (State Exhibit 16)

20. The care rendered to Patient #17 by Respondent was deficient.

a. Patient #17 sought treatment from Respondent on April 14, 1987, at which time the impressions noted in the record were: hyperthyroidism; nervousness; low energy; depression; anxiety; headaches; PMS; recurrent vaginal yeast infections; sweet craving; acne; environmental sensitivities; mild digestive disorders; upper and lower backache, and possible chronic candidiasis. A hair analysis was ordered, medical records were requested and Nystatin oral powder and vaginal suppositories were prescribed.

b. The care rendered to Patient #17 by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. Respondent's medical records do not document that any vaginal smears or other laboratory tests were conducted to substantiate the diagnosis of candidiasis. (T. 387)

ii. Respondent prescribed Nystatin without indication. (T. 387)

c. The care rendered to Patient #17 by Respondent with regard to the treatment of thyroid dysfunction was deficient.

i. On September 14, 1987, Respondent noted "cutting down on Propylthiouracil (PTU) to 2-4/day (used to take 6/day)." (State Exhibit 17)

ii. PTU is a drug which is effective in the treatment of overactive thyroids. (T. 388)



iii. On October 19, 1987, the patient's T3 was 239 (normal 100-109). (State Exhibit 17 and T. 389)

iv. On November 27, 1987, the patient took three PTU per day. (State Exhibit 17)

v. On February 24, 1988, Respondent noted: "off Propylthiouracil x 2 months." (State Exhibit 17)

vi. The standard of care with regard to the decrease of PTU for a patient requires that the patient be closely monitored for pulse, blood pressure and various physical signs and laboratory tests, and to order thyroid function tests as the medication is continually decreased. (T. 389)

vii. The medical record does not document who advised the patient to discontinue the PTU.

viii. The medical record does not document that any blood tests were ordered for this patient during the time that her thyroid medication was being decreased. (T. 389)

d. The care rendered to this patient by Respondent with regard to her complaints of episodic illnesses was deficient.

i. Upper respiratory tract infections were reported to Respondent by this patient on seven (7) occasions (5/13/87, 8/10/87, 9/16/87, 11/27/87, 12/7/87, 12/9/87, and 2/9/89). (State Exhibit 17 and T. 388)

ii. There are no temperatures recorded in the medical records for those dates (T. 388) and the medical record does not indicate that any tests or cultures were performed to

diagnose and treat the upper respiratory tract infection. (State Exhibit 17)

21. The care rendered to Patient #18 by Respondent was deficient.

a. Patient #18, who had a history of eight prior admissions to psychiatric hospitals, sought treatment from Respondent on January 13, 1988, at which time the latter's impressions were: chronic depression and anxiety; fatigue and phobias; headaches; mild digestive disorders; mild environmental sensitivities; sweet and carbohydrate craving; possible chronic candidiasis. The record noted that the patient had been taking six (6) 300 mg Lithium per day for a few weeks but had stopped taking all drugs two (2) weeks ago. Respondent ordered EXEC IV, Lithium, HDL and TSH blood tests. Respondent prescribed multiple B Vitamins and folic acid injections and Nystatin oral powder and tablets.

b. The care rendered to Patient #18 by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not document that any laboratory tests or history were obtained to substantiate the diagnosis of candidiasis. (State Exhibit 18)

ii. Respondent prescribed Nystatin for this patient without indication. (T. 394-395)

c. The care rendered to this patient by Respondent with regard to the prescription of thyroid medication was deficient.

i. The blood studies ordered for this patient indicated normal thyroid studies. (State Exhibit 19 and T. 395)

ii. Respondent ordered one half a grain of thyroid medication on the basis of the patient's axillary temperatures. (State Exhibit 18)

iii. As this patient had a history of psychiatric disorders, the administration of thyroid medication was contraindicated. (T. 396)

iv. The blood test done on March 11, 1988 indicated that the patient had a high free thyroxin index (T7) of 14.5 (normal 5-12), and Respondent, on March 29, 1988, prescribed thyroid medication for this patient. (State Exhibit 18)

d. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that this patient was deficient in the substances prescribed.

e. The care rendered to this patient by Respondent with regard to the patient's psychiatric problems was deficient. (T. 401)

i. The patient complained of phobias and panic attacks within one month of Respondent's prescribing thyroid medication for him, and Respondent's medical records do not address this problem. (T. 397)

ii. The medical record does not document that the Respondent referred this patient to a psychiatrist or that he made such a referral which was refused by the patient. (State Exhibit 18)

iii. The blood tests done on March 11, 1988 indicated that the last dose of lithium was taken at 12:00 p.m. on March 10, 1988, at which time the serum lithium level was less than 0.05 mEq/l (normal 0.5-1.5). (State Exhibit 18)

iv. The medical record, on June 22, 1988, indicates that the patient has taken Tofranil, but the record does not indicate who ordered the medication. (T. 397)

v. On January 23, 1989, Respondent ordered Noripramin and Elavil (anti-depressants) for the patient, but there was no diagnosis to justify the prescriptions, and no description of the symptoms or reference to the patient's psychiatric problems. (T. 398)

vi. On June 5, 1989, Respondent prescribed Elavil and Lithium for the patient without any indication in the medical record as to the reason for the change in the psychiatric medication. There is no information in the medical record addressing the psychiatric symptoms. (T. 399)

22. The care rendered to Patient #19 by Respondent was deficient.

a. Patient #19 sought treatment from Respondent from May 10, 1985 to June 24, 1989. The May 10, 1985, medical record notes that Respondent's impressions were: lower back pain and sciatica; recurrent sore throats and post nasal drip; low energy; and possible systemic candidiasis. The Respondent requested medical records, ordered a hair analysis, and prescribed multiple B vitamin, folic acid, calcium injections, and Nystatin oral powder.

b. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #19 as there is no indication in the medical record that this patient was deficient in the substances prescribed.

i. Respondent prescribed the multiple B Vitamin and folic acid injections on 62 occasions from May 10, 1985, to June 4, 1989. (State Exhibit 19)

ii. There is no laboratory verification that the patient was deficient in any of the vitamins prescribed. (State Exhibit 19)

iii. Respondent administered calcium injections to this patient on 20 occasions between May 10, 1985 and November 1, 1988, notwithstanding the normal levels of calcium noted in her blood tests and hair analysis. (State Exhibit 19)

iv. Respondent administered magnesium injections to this patient on five occasions between May 30, 1986 and November 1, 1988, without any indication that she was deficient in this mineral. (State Exhibit 19)

c. The care rendered to this patient by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. There were neither laboratory tests nor history to substantiate a diagnosis of candidiasis. (T. 416 and State Exhibit 19)

ii. Respondent prescribed Nystatin without indication. (T. 416)

d. The care rendered to Patient #19 by Respondent with regard to the diagnosis and treatment of the urinary tract symptoms was deficient.

i. On October 30, 1986, the patient reported symptoms suggesting a urinary infection. Respondent performed a dipstick urinalysis which indicated blood (2+). (State Exhibit 19)

ii. Respondent ordered a Vitamin C injection and prescribed fluids, cranberry and aloe juices, and Pyridium, a bladder anesthetic. (State Exhibit 19 and T. 407)

iii. Intravenous Vitamin C is not appropriate treatment for a suspected urinary tract infection. (T. 410)

(1) Vitamin C has ascorbic acid, and thus acidifies the urine. (T. 417)

(2) Vitamin C may be an aid in the treatment of urinary tract infections, but it is doubtful whether it is an efficacious treatment for urinary tract infection. (T. 417)

iv. The medical record does not indicate that a diagnosis was made. (State Exhibit 19 and T. 410)

v. The standard of care for the diagnosis and treatment of symptoms such as those presented by this patient requires the determination of the amount of leukocytes in the urine and a culture prior to prescribing any medications. (T. 409)

vi. The medical record does not document that the Respondent ordered a microscopic urinalysis to rule out a urinary tract infection although the standard of care requires that a

physician obtain a culture and begin treatment after the results of the culture are obtained. (State Exhibit 19)

e. The care rendered to this patient by Respondent with regard to the prescription for iron and liver injections was deficient.

i. This patient had a hysterectomy in January 1985. (State Exhibit 19)

ii. The blood studies relied upon by Respondent for his prescription of liver and iron for this patient were obtained the day after the hysterectomy was performed. (State Exhibit 19 and T. 411)

iii. The medical record does not indicate that a repeat blood study was performed in July 1985 when the liver and iron injections were prescribed for this patient. (State Exhibit 19)

iv. The blood studies which were done for this patient on July 1, 1985, July 3, 1985, June 11, 1986, April 13, 1987, and April 27, 1988 indicated that her liver and iron levels were within normal limits. (State Exhibit 19)

v. Respondent continued to prescribe liver and iron injections on 55 occasions until June 24, 1989. (State Exhibit 19 and T. 413)

f. The care rendered to Patient #19 with regard to her symptoms of soreness in her left breast was deficient.

i. On August 5, 1987, this patient complained of "soreness of the left breast for the past few weeks." (State Exhibit 19 and T. 413)

ii. After examination, Respondent noted "possibly some tissue changes but no definite well defined nodules."  
(State Exhibit 19)

iii. Respondent ordered a mammogram and prescribed apricot kernels, intestinal cleansing, and observation. (State Exhibit 19)

iv. There is no medical indication for the use of intestinal cleansing for the symptoms of breast soreness. (T. 414-415)

v. Respondent reported that the mammogram was negative.

vi. On October 9, 1987, the patient had "no complaints about breast problems," and there is no other reference to this problem in the chart through June 1989. (State Exhibit 19)

vii. There is no indication in the medical record that the Respondent performed regular breast examinations for this patient. (State Exhibit 19)

g. The care rendered to Patient #19 by Respondent for symptoms of a sore throat was deficient.

i. On February 2, 1987, the patient complained of a sore throat, and there is no temperature recorded in the medical chart. (State Exhibit 19 and T. 415)

ii. On February 9, 1987, the patient complained of a sore throat and there is no temperature recorded in the medical chart. (State Exhibit 19)



iii. Respondent prescribed I.V. Vitamin C for this patient without indication. (T. 415)

23. The care rendered to Patient #20 by Respondent was deficient.

a. Patient #20 sought treatment from Respondent on January 23, 1984 at which time Respondent's impressions were: diabetes; glaucoma; overweight; arthralgia and low energy. Respondent ordered hair analysis, fasting blood sugar ("FBS"), T3, T4 and urinalysis. Respondent prescribed weekly injections of multiple B Vitamins and folic acid, which the patient received on 15 occasions until December 4, 1984, when Respondent prescribed calcium in addition to the other injections.

b. The care rendered to this patient by Respondent with regard to the treatment of her diabetes was deficient.

i. On January 23, 1984, this patient's FBS was 128 (normal 65-110) and the patient's weight was 160 lbs. (T. 149)

ii. On October 15, 1984, after ten months of treatment with Respondent, the patient's FBS was 193 and her weight was 173 lbs. (T. 420)

iii. The patient's FBS' were measured as follows:  
11/27/85 - 174; 4/11/86 - 258; 3/9/87 - 344, and 2/23/89 - 266.  
(State Exhibit 20)

iv. Respondent, notwithstanding the continued elevation of this patient's FBS, continued to treat this patient without insulin. On May 7, 1985, Respondent noted "condition

under control without insulin" even though the patient's urine sugar was 3- at that time. (State Exhibit 20)

v. On May 7, 1985, April 28, 1988 and November 14, 1989, Respondent noted that the patient's high glucose levels were attributable to episodic, recent dietary indiscretions by the patient before each visit. (State Exhibit 20)

vi. The medical record does not indicate that the Respondent advised the patient of the importance of adhering to the diet. (T. 422)

vii. Although dietary treatment alone can be an appropriate approach to the control of diabetes, if those efforts fail within a few months span, other measures should be employed in order to control the diabetes. (T. 421 and 426)

viii. The medical record does not indicate that the patient was advised to take insulin for the control of her diabetes or that she refused to take insulin for the control of her diabetes. (State Exhibit 20 and T. 427-428)

ix. There is no indication in the medical record that oral hypoglycemics were utilized or recommended in this case. (State Exhibit 20 and T. 428)

c. The care rendered to Patient #20 by Respondent with regard to the prescription of thyroid medication was deficient.

i. On December 4, 1984, Respondent prescribed thyroid medication on the basis that the patient had taken thyroid medication previously, from ages 13 through 31. (State Exhibit 20 and T. 422)

ii. The medical record does not indicate that any current thyroid studies were ordered by Respondent. (T. 422)

iii. The thyroid studies of February 8, 1984 were within normal limits. (State Exhibit 20)

d. The care rendered to this patient by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there are any vaginal cultures or laboratory tests or history to substantiate the diagnosis of candidiasis. (State Exhibit 20)

ii. Respondent prescribed Nystatin and Nizoral without indication. (T. 423)

e. The care rendered to Patient #20 by Respondent with regard to the symptoms of occasional chest pain was deficient.

i. As a diabetic, this patient was at risk for cardiac disease. (T.423)

ii. On December 9, 1987, this patient complained of occasional chest pain to Respondent. (State Exhibit 20)

iii. The medical record does not indicate that the Respondent performed a cardiopulmonary examination, ordered an EKG, or referred this patient to a cardiologist. (T. 424)

iv. The patient was not seen by Respondent again until April 29, 1988, when the patient again reported chest pain for the past three (3) days. (State Exhibit 20)

v. The medical record does not indicate that Respondent performed a cardiopulmonary examination, ordered an

EKG, or referred the patient to a cardiologist. (State Exhibit 20)

vi. On January 14, 1989, the patient again complained of chest pain, and at this time, Respondent ordered a stress test. (State Exhibit 20)

44. The care rendered to Patient #21 by Respondent was deficient.

a. Patient #21 began seeing Respondent in 1980. On December 17, 1986, Respondent made the following diagnoses: histiocytoma, recurrent; arthritis and backache; post-stroke paralysis left hand.

b. The care rendered to this patient by Respondent with regard to her previous and other medical treatment was deficient.

i. This patient's chart contains references to treatment by other physicians and hospitals for angina, hypertension, peripheral vascular disease and renal disease. (State Exhibit 21)

ii. The medical record record of Respondent did not maintain a current list of the patient's problems or the patient's current medications prescribed by other health care providers. (State Exhibit 12)

iii. The maintenance of a current list of medications prescribed by other health care providers is important so that possible adverse drug reactions might be avoided.

c. The care rendered to Patient #21 by Respondent with regard to the prescription for Nystatin was deficient as there was no indication that this patient was diagnosed as having candidiasis. (T.440)

d. The care rendered to this patient by Respondent with regard to the prescription of thyroid medication was deficient.

i. The medical record does not indicate that a thyroid function test was performed prior to the prescription of thyroid medication. (State Exhibit 21)

ii. Respondent prescribed thyroid medication on the basis of an axillary temperature of 97 degrees. (State Exhibit 21)

e. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that this patient was deficient in the substances prescribed.

f. The care rendered to Patient #21 by Respondent with regard to the administration of a CEA test on September 5, 1985 was deficient.

i. This patient had a history of histiocytoma, a tumor composed of histocytes. (T. 437)

ii. The CEA is not consistent with the histiocytoma. (T. 437)

g. The care rendered to this patient with regard to the December 17, 1986 administration of amygdalin (laetrile) was deficient because, in 1986, it was not approved for general use

by the FDA, and, in 1986, there was no evidence that there was any indication for amygdalin therapy in medicine. (T. 439)

45. The care rendered to Patient #22 by Respondent was deficient.

a. Patient #22 sought treatment from Respondent on April 18, 1988, at which time the latter's impressions were: myelofibrosis - severe anemia and pancytopenia; chronic cardiac arrhythmia; muscle weakness and fatigue; post nasal drip and cough; G.I. disorder and reflux esophagitis; prostate enlargement and urinary frequency; sugar craving; possible chronic candidiasis. Respondent ordered hair analysis, injections of multi-B vitamins, folic acid, liver and iron and prescription of Nystatin.

b. The care rendered to this patient with regard to the treatment for myelofibrosis was deficient.

i. The standard of care with regard to the treatment of myelofibrosis and severe anemia requires that the physician determine the severity of the anemia, the severity of the leukopenia, and the severity of the thrombocytopenia. (T. 446)

ii. The medical record does not indicate that Respondent adequately monitored the patient's status as there is no indication that blood tests were ordered. (State Exhibit 22)

iii. Myelofibrosis, the invasion of the blood cells by fibrous tissue, generally requires transfusion of blood in order to address the deficiencies created by the disease. (T. 447)

iv. The medical record does document that the patient refused to have blood transfusions. (May 16, 1988). (State Exhibit 22)

v. Nystatin and hair analysis have no purpose in the above diagnoses. (T. 445)

vi. Although the patient's iron levels were within normal limits, Respondent prescribed iron injections on April 18, 1988. (T. 448)

vii. Respondent ordered intestinal cleansing for this patient on April 22, 1988 without indication. (T. 449)

viii. Respondent administered I.M. vitamin injections and I.V. vitamin C and magnesium injections on 19 occasions in less than a 90 day period (April 18, 1988 to July 5, 1988) and this care was deficient as there is no indication that there was any follow-up blood testing to verify whether this treatment plan was effective. (T. 452)

c. The care rendered to Patient #22 by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there was any laboratory testing or history to substantiate a diagnosis of candidiasis. (State Exhibit 22)

ii. Respondent prescribed Nystatin without indication.

44. The care rendered to Patient #23 by Respondent was deficient.

a. Patient #23 sought treatment from Respondent on November 3, 1987, at which time the latter's impressions were: chronic G.I. disorders; fatigue, anxiety, nervousness; headaches - dizziness and visual difficulties; mild hypertension; anal dermatitis; environmental sensitivities; sweet cravings - possible chronic candidiasis. Respondent requested the patient's medical records, ordered multi-B vitamin and folic acid injections, and prescribed Nystatin oral powder, tablets and topical cream.

b. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #23 as there is no indication in the medical record that this patient was deficient in the substances prescribed.

c. The care rendered to this patient by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there were any laboratory tests or history, other than sweet cravings, to substantiate a diagnosis of candidiasis. (State Exhibit 23)

ii. Respondent prescribed Nystatin without any indication. (T. 457)

45. The care rendered to patient #24 by Respondent was deficient.

a. Patient #24 sought treatment from Respondent on January 20, 1988 at which time the latter's impressions were: hypertension; obesity; low energy; arthralgia - right elbow,



muscle cramps-legs; G.I. disorders; varicose veins; sweet and carbohydrate craving - possible chronic candidiasis. Respondent ordered hair analysis, requested medical records, prescribed multiple B vitamins and folic acid injections, and prescribed Nystatin oral powder and tablets.

b. The care rendered to this patient by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate any laboratory tests or history to substantiate a diagnosis of candidiasis.

ii. The Respondent prescribed Nystatin without indication.

c. The care rendered to this patient with regard to the management of her hypertension was deficient.

i. The patient reported having been diagnosed with hypertension "5-10" years prior to her first visit to Respondent. (State Exhibit 24)

ii. The patient reported having taking Inderal for one year until about one month prior to the initial visit to Respondent. (State Exhibit 24)

iii. The medical record notes that this patient had taken Hylorel and Inderal and a diuretic, with resulting nervousness, tachycardia and palpitations from the medications. (State Exhibit 24)

iv. On January 20, 1988 the patient's blood pressure was recorded as 180/120 in both arms and her weight was recorded as 218 lbs. (State Exhibit 24)

v. The standard of care with regard to the treatment of a patient with a significantly elevated blood pressure and history of hypertension requires that the physician inquire whether the patient is taking her blood pressure medications, advise the patient to lose weight if the patient's weight was excessive, and adjust the medications. (T. 461)

vi. The medical record does not indicate any treatment or medication prescribed for the hypertension.

vii. The next office note, on April 26, 1988, states, "off all drugs - feeling much better..." and notes that the blood pressure is 170/110 and weight was 202 lbs. There is no indication in the medical record of any treatment or medication prescribed for the hypertension.

viii. Although the medical record does note that the patient was no longer taking blood pressure medication, it does not indicate that she was advised to lose weight as an effort to control the blood pressure. (T. 461)

ix. The blood pressure readings of 180/120 and 170/110 in a four month period indicate that the patient's blood pressure placed her at an increased risk of heart attack or stroke and was not under control. (T. 461)

d. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #24 as

there is no indication in the medical record that this patient was deficient in the substances prescribed.

46. The care rendered to Patient #25 by Respondent was not deficient.

a. The medical record and testimony presented at the hearing substantiated that the care rendered to this patient by Respondent with regard to the treatment of breast tenderness in 1985 was not deficient as the patient was being treated by a gynecologist for this problem during the period in dispute.

b. The medical record and testimony presented at the hearing substantiated that the care rendered to this patient by Respondent with regard to the treatment of an upper respiratory infection on March 26, 1986 was not deficient as Respondent prescribed an appropriate medication for her cough and did not order an antibiotic without first obtaining a culture.

c. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to Patient #25 as there is no indication in the medical record that this patient was deficient in the substances prescribed.

47. The care rendered to Patient #26 by Respondent was deficient.

a. Patient #26 sought treatment from Respondent on March 30, 1988, at which time the latter's impressions were: angina; peripheral vascular disease; gangrene left big toe; pain in the left foot and leg; possible diabetes (by history); weight loss; mild constipation; lower backache; environmental sensitivities; fatigue; sweet craving; possible chronic

candidiasis. Respondent ordered a hair analysis, EXEC IV and HDL, requested medical records, ordered multiple B vitamin and folic acid injections, and prescribed Nystatin oral powder and tablets.

b. The care rendered to this patient with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there were any laboratory tests or history to substantiate a diagnosis of candidiasis.

ii. The Respondent prescribed Nystatin without indication.

c. The use of Sub-lingual vitamin B12 has no medical indication. (T. 486)

d. The care rendered to this patient with regard to his complaints regarding the history of angina was deficient.

i. History of angina was noted in the medical record at the time of the initial visit on March 30, 1988. (State Exhibit 26)

ii. On April 27, 1988, the medical record notes that the patient's pulse was 76 and irregular and that the patient's family reported that he had not taken his prescribed medications for the past few days. (State Exhibit 26)

iii. The standard of care requires that an EKG be done at this time so that the treating physician would be better able to assess the patient's condition. (T. 485)

iv. The failure of Respondent to order an EKG in response to the finding of an irregular heart beat on April 27,

1988 prevented Respondent from having sufficient data on which to base his decisions with regard to the care of the patient. (T. 485)

v. The medical record does not indicate that a cardiopulmonary examination was performed on April 27, 1988. (State Exhibit 26)

e. The care rendered to Patient #26 with regard to the abnormal electrolyte findings of the April 5, 1988 blood tests was deficient.

i. On April 5, 1988, this patient had blood tests done, the results of which indicated abnormal electrolytes: BUN 45; Creatinine 2.4; Sodium 12224, Chloride 88; glucose 116. (State Exhibit 26)

ii. On April 12, 1988, Respondent excised an infected toenail from the right big toe of this patient. (State Exhibit 26)

iii. The April 12, 1988 medical record notes the abnormal electrolyte results. (State Exhibit 26)

iv. The standard of care for a patient whose electrolyte results are abnormal requires that the physician investigate the causes of the apparent renal failure, i.e. dehydration, and then to do other blood tests for serum electrolytes to determine the cause of the apparent renal failure. (T. 481)

v. The medical record does indicate if the patient was dehydrated, or if other causes for the apparent renal failure were investigated. (T. 482)

vi. Respondent prescribed Natra-Bio kidney drops for this patient in response to the abnormal electrolyte results and recommended a diet high in fiber, low in fat and salt and sugar free. (T. 482)

vii. At the April 27, 1988 visit, when the patient's family reported that the patient was depressed and had stopped taking his prescription medications for the past few days, Respondent told the patient that he should continue on his medications, and he added sublingual B12, Cr-syme, Hawthorn Berry Caps, and Biocardiozyme-Torte to the patient's treatment regimen. (T. 483)

viii. The medical record does not indicate that the Respondent attempted to determine the cause of the kidney failure or to obtain serum electrolytes. (T. 481)

ix. On April 28, 1988, the daughter of this patient called Respondent and advised him that the patient was cold and clammy and did not look well. Respondent advised her to take the patient to the hospital. The patient died several hours later at the hospital. (State Exhibit 26)

48. The care rendered to Patient #27 by Respondent was deficient.

a. Patient #27 sought treatment from Respondent on June 14, 1984 for episodes of nervousness, anxiety, depression and insomnia; fatigue; low energy; leg cramps; arthralgia - left shoulder; constipation; skin lesions of face; and mild prostatic enlargement. Respondent ordered hair analysis, injections of

multiple B vitamins and folic acid, and prescribed Nystatin oral powder.

b. The care rendered to this patient by Respondent with regard to his prostatic enlargement was deficient.

i. Respondent treated this patient for a period of two and a half years for prostatic enlargement by prostatic massage alone. (State Exhibit 27)

ii. The medical record does not indicate the size, consistency, tenderness or presence of any masses in the prostate during the entire course of treatment. (State Exhibit 27 and T. 496)

iii. The medical record does not indicate a diagnosis of the prostatic condition, or a description of the prostate at the time prostatic massage was begun. (T. 507)

iv. The only mentions in the record of the effects of the prostatic massage treatment are comments regarding the patient's nocturia and occasional mention of the stream. (State Exhibit 27)

v. The medical record does not indicate that Respondent ever referred this patient to a urologist. (State Exhibit 27)

vi. The medical record for April 29, 1987, indicates that the patient was having increased difficulty with urination. (State Exhibit 27)

vii. On May 7, 1987, the medical record indicates that the Respondent prescribed Ampicillin for this patient as the result of a phone call in which the patient stated he had a

"recurrence of symptoms again since last night." (State Exhibit 27)

viii. On May 21, 1987 the prescription for Ampicillin was renewed by Respondent. (State Exhibit 27)

ix. The medical record for November 4, 1987 indicates that the patient consulted a urologist four days prior and presented at Respondent's office with an indwelling Foley catheter. There is no mention of the name of the urologist nor any indication that a report from the urologist was sought by Respondent. (State Exhibit 27)

x. The medical records for November 12, 19 and 25, 1987 indicate that the patient still had a catheter. There is no further mention of the prostate condition. (State Exhibit 27)

xi. The medical record for December 24, 1987 indicates that the patient had a TUR under spinal on December 18 at Laurel Hospital and was discharged on December 23. (State Exhibit 27)

xii. The medical record does not contain any indication that the TUR undergone by the patient in December, 1987 was the result of a referral by Respondent, and there is no record of the operating physician's name or any report from the surgeon in the medical record. (State Exhibit 27)

xiii. Prostatic massage, alone, is a viable treatment for speeding up the course of treatment for transient inflammation of the prostate, but it is not known to be effective for the treatment of chronic prostatic enlargement. (T. 493)



c. The care rendered to this patient by Respondent with regard to his irregular heart beat was deficient.

i. On February 25, 1987, this patient was seen by a cardiologist at Washington Adventist Hospital on referral by Respondent.

(1) The cardiologist, in his report to Respondent, stated that: "He should not be allowed to have a rapid ventricular rate from this atrial fibrillation because if it persists for a very long time it can cause ventricular dysfunction...."

ii. On August 27, 1987 the medical record indicates "irregular heart beats" (Pulse 76 - irregular).

iii. The medical record for that date does not indicate that any cardiopulmonary examination was done, that an EKG was ordered, that any further investigation of this problem was addressed, or that he was again referred to a cardiologist. (T. 499)

iv. Respondent prescribed Kelp tablets for this patient on that date. (State Exhibit 27)

v. On July 21, 1988, the patient's pulse was 80 and irregular, and Respondent prescribed magnesium sulfate. There is no indication in the medical record that any further investigation, EKG, or referral to a cardiologist was ordered at that time. (T. 499)

d. The care rendered to this patient with regard to the use of Nystatin was deficient as the medical record does not

indicate that there was any laboratory test or history to substantiate a diagnosis of candidiasis. (T. 499)

49. The care rendered to Patient #28 by Respondent was deficient.

a. Patient #28 sought treatment from Respondent on February 29, 1988; at which time the latter's impressions were: prostate carcinoma; hypertension and arrhythmia; G.I. disorders and diverticulitis; fatigue, low energy, low equilibrium; hand tremors and nervousness; decreased hearing; sweet craving - possible chronic candidiasis. Respondent ordered a pubic hair analysis, requested medical records, prescribed multiple B vitamin, folic acid, liver, calcium, and magnesium injections; and prescribed Nystatin oral powder and tablets.

b. The care rendered to this patient by Respondent with regard to his hypertension was deficient.

i. On March 14, 1988, the blood pressure of this patient was 150/96 and the medical record noted: "cutting down on Dyazide - did not take it today." (State Exhibit 28)

ii. The medical record for March 14, 1988 also notes that this patient's potassium (K) level in January of 1988 was 3.2 but that the patient was not aware of that fact. (State Exhibit 28)

iii. The standard of care in the treatment of hypertension is to advise the patient of the importance of taking the anti-hypertensive medication. (T. 517)

iv. The medical record does not indicate that the Respondent advised this patient of the importance of taking his

hypertensive medications (Dyazide and Cardizem) as prescribed.  
(T. 516)

v. Some hypertensive medications can cause low potassium, and therefore it is important to measure the serum potassium levels in patients who are taking hypertensive medications. (T. 518)

vi. The medical record does not indicate that Respondent had the serum potassium levels checked for this patient. (T. 518)

50. The care rendered to Patient #29 by Respondent was deficient.

a. Patient #29 sought treatment from Respondent on February 5, 1981. A history and physical on January 19, 1987 indicated the following diagnoses: arthritis and backache; digestive disorders; sinus condition; urinary frequency; environmental sensitivities; and possible chronic candidiasis. This patient was noted to be allergic to aspirin on each page of the record. Respondent ordered hair analysis, EXEC IV, axillary temperatures, and injections of multiple B vitamins, folic acid, calcium and magnesium.

b. The care rendered to this patient with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate any laboratory test or history to substantiate a diagnosis of candidiasis. (T. 521)

ii. The Respondent prescribed Nystatin without indication. (T. 521)

c. The care rendered to Patient #29 by Respondent with regard to his prescription for sublingual vitamin B12 on March 16, 1987 was deficient. (T. 521)

i. There is no indication in the medical record that this patient was deficient in that vitamin. (T. 522)

ii. Use of sublingual Vitamin B12 for this patient has no therapeutic value.

d. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that she was deficient in the substances prescribed.

e. The care rendered to this patient by Respondent with regard to the prescription of Willow Bark was deficient.

i. The patient was noted on the chart to be allergic to aspirin. (T. 522)

ii. Willow Bark contains salicylates, an active ingredient in aspirin. (T. 523)

iii. Although the patient was not reported to have any adverse reaction to the Willow Bark, it is not demonstrated in the medical record whether this was because she was not actually allergic to aspirin or because she did not actually take the Willow Bark. (T. 523)

51. The care rendered to Patient #30 by Respondent was deficient.

a. Patient #30 sought treatment from Respondent on March 28, 1988, at which time the latter's impressions were: chronic dermatitis; chronic G.I disorders; PMS; food allergies

and environmental sensitivities; nervousness and muscle tension (neck and shoulders); fibrocystic breasts; sweet craving; possible chronic candidiasis. Respondent ordered hair analysis, EXEC IV, HDL, pap smear and axillary temperatures. Respondent prescribed multiple B vitamin and folic acid injections, and Nystatin oral powder, tablets and vaginal suppositories.

b. The care rendered to this patient by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there were any vaginal cultures or laboratory tests or history to substantiate the diagnosis of candidiasis. (T. 526)

ii. The Respondent prescribed Nystatin without indication. (T. 526)

c. The care rendered to this patient by Respondent with regard to her fibrocystic disease was deficient.

i. The patient's initial history states that she has fibrocystic disease, and Respondent noted "lumps in breast." (State Exhibit 30)

ii. The standard of care for the medical treatment of patients with fibrocystic disease is to obtain a mammogram. (T. 527)

iii. The medical record does not indicate that Respondent ordered a mammogram or that the patient refused to have a mammogram. (T. 527)

d. The care rendered to Patient #30 by Respondent with regard to her elevated lymphocyte found was deficient.

i. On May 31, 1988, Respondent noted that this patient's lymphocytes were 67 (normal 10-49). (State Exhibit 30)

ii. Elevation in lymphocytes may be non-specific, but may indicate that there is a disease process going on in the patient. (T. 527)

iii. The standard of care is to obtain a repeat lymphocyte count to determine if there is an error or if the count is continuing to elevate or go down. (T. 528)

iv. The medical record does not indicate that Respondent addressed this condition either by further investigation or by formulating a treatment plan. (State Exhibit 30)

e. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that he was deficient in the substances prescribed.

52. The care rendered to Patient #31 by Respondent was deficient.

a. Patient #31 sought treatment from Respondent in 1980. On July 16, 1984, Respondent's impression was chronic candidiasis. Respondent prescribed Nystatin oral powder and an anti-yeast program. Respondent prescribed calcium gluconate and multiple vitamin B and folic acid injections.

b. The care rendered to this patient by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there was any laboratory test or history to substantiate a diagnosis of candidiasis. (T. 532)

ii. The Respondent prescribed Nystatin without indication. (T. 532)

c. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that he was deficient in the substances prescribed.

d. The care rendered to this patient with regard to the administration of thyroid medication was deficient.

i. The laboratory results of April 26, 1988 indicate that the patient's thyroid function was within normal limits. (State Exhibit 31)

ii. On December 9, 1988, Respondent prescribed Armour Thyroid 1 grain for this patient, and on April 10, 1989, Respondent increased the thyroid medication to 1-1/4 grains per day. (State Exhibit 31)

iii. The medical record does not contain any information regarding further thyroid study tests prior to the increase in thyroid medications, and there is no reference in the medical record regarding any axillary temperatures on which Respondent may have relied in determining this patient's need for thyroid medication. (State Exhibit 31)

iv. The use of thyroid medication where there is no medical indication for its use can be dangerous. (T. 532 and 537)

e. The care rendered to this patient by Respondent with regard to dysuria was deficient.

i. On July 24, 1984, this patient complained of dysuria, frequency and blood tinged urine. (State Exhibit 31)

ii. Respondent prescribed Pyridium, a bladder anesthetic, and ordered a urinalysis and culture and sensitivity. (State Exhibit 31)

iii. Pyridium does not treat the cause of urological disorders -- it merely alleviates the discomfort.

iv. The medical record makes no further reference to the urological complaints, and there is no mention in Respondent's notes of the results of the urine culture and sensitivity.

53. The care rendered to Patient #32 by Respondent was deficient.

a. Patient #32 sought treatment from Respondent on June 25, 1985 at which time the latter's impressions were; chronic digestive disorders and constipation; headaches, backaches; low energy and depression; TMJ syndrome; possible chronic candidiasis. Respondent ordered a hair analysis and prescribed Nystatin. Respondent also prescribed injections of multiple Vitamin B and folic acid on 67 occasions.

b. The care rendered to this patient with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there was any laboratory test or history to substantiate a diagnosis of candidiasis. (T. 539)



ii. Respondent prescribed Nystatin without indication. (T. 539)

c. The care rendered to this patient with regard to the prescription of thyroid medication was deficient.

i. On May 2, 1985, another physician ordered a thyroid function test, the results of which were within normal limits. (State Exhibit 32 and T. 539)

ii. On October 22, 1985, Respondent prescribed Armour Thyroid (1/2 grain) based on decreased axillary temperatures which were recorded on October 10, 1985 as 97.4, 96.9, and 97.

iii. Axillary temperature is not an indication for initiation of thyroid therapy in light of normal thyroid function tests. (T. 540)

d. The care rendered to this patient by Respondent with regard to her urological symptoms was deficient.

i. On November 17, 1987, this Respondent recorded the patient's complaints as "her brain sometimes does not follow what she wants to do -- like a blockage that happens suddenly and patient cannot function as she wants to." (State Exhibit 32 and T. 540)

ii. The standard of care for complaints regarding brain function is to get a further history, investigate other areas such as mental condition, and do a neurological examination. (T. 541)

iii. Other than the recordation of the patient's complaints, the medical record does not indicate that any further

investigation or treatment plan was formulated with regard to this complaint. (T. 541)

e. The care rendered to this patient by Respondent with regard to her flare-up of upper abdomen discomfort was deficient.

i. On December 1, 1987, the patient complained of a flare-up of left upper abdomen discomfort. (State Exhibit 32)

ii. Respondent prescribed rectal Nystatin. (State Exhibit 32 and T. 542)

ii. The medical record does not indicate that Respondent examined the patient's abdomen or made any attempt to investigate the etiology of the complaint prior to prescribing rectal Nystatin. (T. 542)

54. The care rendered to Patient #33 by Respondent was deficient.

a. Patient #33 sought treatment from Respondent on March 2, 1988 at which time the latter's impressions were: arthralgia; fatigue; nervousness, irritability; dizziness; depression; environmental and chemical sensitivities; digestive disorders; anal dermatitis; nocturia; alcohol craving; possible chronic candidiasis. Respondent ordered a hair analysis, requested hospital records, prescribed Nystatin and weekly injections of multiple B vitamins and folic acid.

b. The care rendered to this patient by Respondent with regard to the diagnosis and treatment of candidiasis was deficient.

i. The medical record does not indicate that there was any laboratory test or history to substantiate the diagnosis of candidiasis. (T. 545)

ii. The Respondent prescribed Nystatin without indication. (T. 545)

c. The administration of multiple Vitamin B and mineral injections is of no therapeutic value to this patient as there is no indication in the medical record that he was deficient in the substances prescribed.

d. The care rendered to this patient by Respondent with regard to the elevation in his ketones, as noted in the laboratory test of April 29, 1988, was deficient.

i. The standard of care for a result indicting an elevation in ketones is to have the ketone analysis repeated to determine if the problem was episodic or persistent. (T. 547)

ii. The medical record does not indicate that a ketone analysis was done subsequent to the results indicating the elevation in ketones. (T. 547)

55. Respondent failed to utilize and order standard diagnostic tests when medically indicated as follows:

a. Respondent failed to order blood tests to substantiate deficiencies in vitamins and minerals which he prescribed for his patients; he neglected to order laboratory tests to substantiate diagnoses of candidiasis for which he prescribed Nystatin and Nizoral;

b. Respondent failed to order mammograms for patients with fibrocystic disease and histories of breast cancer;

c. Respondent prescribed thyroid medication notwithstanding normal thyroid function tests;

d. Respondent failed to counsel some patients with regard to the importance of taking anti-hypertensive medication as prescribed;

e. Respondent failed to counsel some patients with regard to the importance of taking medication in order to control diabetes;

f. Respondent failed to make diagnoses before initiating treatment in some patients; and he neglected to ascertain the levels of various vitamins and minerals in his patients before prescribing regular injections of them.

#### CONCLUSION OF LAW

Based upon the foregoing Findings of Fact, by a majority of the full authorized membership of the Board, there is clear and convincing evidence for the Board to determine as a matter of law that Respondent violated the following terms of the probation of the Order of the Commission on Medical Discipline dated September 18, 1984:

3. Respondent shall properly utilize and order standard diagnostic tests when medically indicated and shall document in the patient's chart any refusal by the patient to submit to such tests;
4. Respondent shall practice medicine competently.

#### BOARD DETERMINATION ON DISPOSITION

For the disposition, the Administrative Hearing Officer recommended revocation. The Board has decided instead to suspend Dr. Shamim's license to practice medicine. Even the suspension may be stayed shortly if the Respondent demonstrates to the Board that he is now complying with the terms of the 1984 Order.

In the dispositional phase, the focus is on protection of the public. However, we tailor the disposition to the individual respondent, recognizing rehabilitative as well as punitive objectives. See Bergstein v. State, 322 Md. 506 (1991); McDonnell v. Commission on Medical Discipline, 301 Md. 426, 436 (1984). Even in the criminal arena, violation of the conditions of probation does not necessarily mandate imposition of the suspended sentence. Baynard v. State, 318 Md. 531 (1990).

We raise without exception from either side the issue as to whether we have the authority in a medical disciplinary proceeding<sup>5</sup> to impose a disposition, upon violation of probation and without new charges, which is more severe than the original order. A violation of probation proceeding is a derivative action. A more severe disposition is prohibited following a violation of criminal probation. Williams v. State, 72 Md. App. 233 (1987). The patient cases presented to us and our findings

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<sup>5</sup> A Colorado court has held that in state medical board proceedings the only restriction is that the sanction not be arbitrary and capricious or a gross abuse of discretion. Board of Medical Examiners v. Robertson, 751 P.2d 648 (Colo. App. 1987).

demonstrate that much of the practice of Dr. Shamim is not based on currently accepted scientific medicine. While his failure to adhere to proven medical techniques raises concern, our objective in adjudicating the disposition of this case is to permit fairly wide latitude to Dr. Shamim in the use of unconventional treatments provided that he engages in appropriate medical inquiry, extensive implementation of informed consent principles, and documents these diagnostic inquiries and informed consent procedures contemporaneously in patient medical records. His treatment should be consistent with his own diagnostic evaluations and the results of testing initiated by him.

In our review of this case and present in our record, we note that many of Dr. Shamim's patients fervently believe that they are receiving good medical care from him and have expressed distress that his medical license is at risk. While we cannot be governed alone by these sentiments, we are leaving the door slightly ajar to permit Dr. Shamim to attempt to meet our concerns as voiced in the 1984 Order and these proceedings. Dr. Shamim may have taken heed from the initiation of this action. Due to the passage of time the facts as to his standard of care may have changed. If so, he is invited to petition the Board as provided in the following order.

#### ORDER

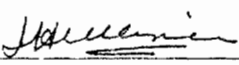
Based upon the foregoing Findings of Fact and Conclusion of Law, it is, this 14 day of December, 1992, by a majority of the full authorized membership of the Board:

ORDERED, that Respondent's license to practice medicine in the State of Maryland is hereby **SUSPENDED**, effective January 16, 1993, for up to the remainder of the three year period of suspension ordered in 1984 which was not previously stayed; but be it further

ORDERED, that Respondent may petition the Board immediately for a stay of this order if he is able to present satisfactory evidence to the Board through its Case Resolution Conference that his current practice adequately reflects general medical standards of care and that any variation from those standards is with the informed consent of the patient and made evident by a contemporaneous notation in the patient's medical record; and be it further

ORDERED, that Respondent's Motion to Terminate Probationary Status is dismissed as moot; and be it further

ORDERED, that this is a Final Order and as such will be considered a PUBLIC DOCUMENT pursuant to § 10-611 et seq. of the State Government Article of the Annotated Code of Maryland.

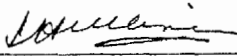
  
Israel H. Weiner, M.D.  
Chair

**NOTICE OF RIGHT TO APPEAL**

Pursuant to § 14-408(b) of the Health Occupations Article of the Annotated Code of Maryland, you have a right to take a direct judicial appeal. Any appeal shall be made as provided for under the Administrative Procedure Act of the State Government Article

and the B series of the Maryland Rules of Procedure covering  
judicial review of a final administrative order.

12/14/92  
Date

  
Israel H. Weiner, M.D.  
Chair



IN THE MATTER OF	*	BEFORE THE MARYLAND
AHMAD SHAMIM, M.D.	*	STATE BOARD OF PHYSICIAN
RESPONDENT	*	QUALITY ASSURANCE
LICENSE NUMBER: D10243	*	CASE NUMBER: 84-0139
	*	

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TERMINATION OF PROBATION

On September 18, 1984, the Commission on Medical Discipline<sup>1</sup> (the "CMD") issued an Order<sup>2</sup> suspending the Respondent's medical license.

On April 30, 1985, the suspension of the Respondent's medical license was stayed and certain conditions of probation were imposed.

On June 13, 1990, the Board charged the Respondent with violating the terms of probation outlined in the September 18, 1984 Order.

On December 19, 1992, the Board issued a Final Order<sup>3</sup> which suspended the Respondent's medical license.

On August 16, 1994, the Board issued an Order of

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<sup>1</sup>On July 1, 1988, the General Assembly merged the functions of the Commission on Medical Discipline and the Board of Medical Examiners into the Board of Physician Quality Assurance.

<sup>2</sup>The Order dated September 18, 1984, is incorporated by reference into this Order terminating probation and available upon request.

<sup>3</sup>The Final Order dated December 19, 1992, is incorporated by reference into the Order terminating probation and available upon request.

Reinstatement ("Order")<sup>4</sup> which imposed probation for a three (3) year period subject to certain terms and conditions.

On September 18, 1996, the Respondent met with the Case Resolution Conference (the "CRC") to address the peer review report and, in general, the Respondent's overall compliance with the terms of the Order.

On September 5, 1997, the Respondent's attorney submitted a letter requesting consideration for termination of the Respondent's probation.

On October 15, 1997, the Board's CRC convened to address the Respondent's request for termination of probation. The CRC recognized the Respondent's individual circumstances pertaining to his case and recommended to the Board that probation be terminated.

At its meeting on November 19, 1997, the Board ratified the recommendation of the CRC.

#### FINDINGS OF FACT

1. The Respondent's license to practice medicine in the State of Maryland is subject to certain terms and conditions of probation pursuant to the Order issued by the Board on August 16, 1994.

2. In accordance with the Order, the Respondent has

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<sup>4</sup>The Order of Reinstatement dated August 16, 1994, is incorporated by reference into this Order terminating probation and available upon request.

maintained a supervisory relationship with Jack Teitelbaum, M.D. since the execution of the Order of Reinstatement.

3. On June 11, 1996, the Board received the results of the peer review conducted on the Respondent's medical practice.

4. The Respondent is eligible to petition for termination of probation effective August 16, 1997.

5. On October 15, 1997, the Respondent appeared before the Board's CRC with a request for termination of probation.

6. At its meeting on November 19, 1997, the Board concluded that the Respondent's probation be terminated and that he be licensed to practice medicine without conditions.

#### CONCLUSION OF LAW

Based on the foregoing Findings of Fact, the Board concludes that as a matter of law the Respondent has complied with the conditions and terms imposed under the probationary period.

#### ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 19<sup>th</sup> day of November, 1997;

ORDERED that the probation imposed by the Order of Reinstatement dated August 16, 1994, is hereby TERMINATED and is of no further force or effect; and it is further

ORDERED that this Termination of Probation is a PUBLIC  
document pursuant to Maryland State Gov't Code Ann. §10-611 et.  
Seq.

11-19-97  
Date

Suresh C. Gupta  
Suresh C. Gupta, M.D.  
Chair