VIRGINIA:

BEFORE THE DEPARTMENT OF HEALTH PROFESSIONS

IN RE: LOIS RAE MARCH, M.D.
License No.: 0101-039564

ORDER

In accordance with Section 54.1-2409 of the Code of Virginia (1950), as amended, ("Code"), I, Robert A. Nebiker, Director of the Virginia Department of Health Professions, received and acted upon evidence that the license of Lois Rae March, M.D., to practice medicine in the State of Georgia was voluntarily surrendered by Consent Order of Voluntary Surrender entered November 14, 2005. Said surrender to have the same effect as a revocation in the State of Georgia. Said revocation to take place on December 1, 2005. A certified copy of the Consent Order of Voluntary Surrender (with attachment) is attached to this Order and is marked as Commonwealth's Exhibit No. 1.

WHEREFORE, by the authority vested in the Director of the Department of Health Professions pursuant to Section 54.1-2409 of the Code, it is hereby ORDERED that the privilege of Lois Rae March, M.D., to renew her license to practice medicine and surgery in the Commonwealth of Virginia be, and hereby is, SUSPENDED.

Upon entry of this Order, the license of Lois Rae March, M.D., will be recorded as suspended and no longer current. Should Dr. March seek reinstatement of her license pursuant to Section 54.1-2409 of the Code, she shall be responsible for any fees that may be required for the reinstatement and renewal of her license prior to issuance of her license to resume practice.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.
COMMONWEALTH of VIRGINIA

Department of Health Professions
6603 West Broad Street, 5th Floor
Richmond, Virginia 23230-1712

CERTIFICATION OF DUPLICATE RECORDS

I, Robert A. Nebiker, Director of the Department of Health Professions, hereby certify that the attached Consent Order of Voluntary Surrender entered November 14, 2005 (with attachment), regarding Lois Rae March, M.D., are true copies of the records received from the Composite State Board of Medical Examiners for the State of Georgia.

[Signature]

Date: January 4, 2006

Robert A. Nebiker
BEFORE THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

STATE OF GEORGIA

IN THE MATTER OF:

LOIS MARCH, M.D.,
License No. 46310,

Respondent.

DOCKET NO.: 2006 0014

CONSENT ORDER OF VOLUNTARY SURRENDER

On or about August 1, 2005, a Notice of Hearing was issued by the Office of State Administrative Hearings, based on a referral by the Composite State Board of Medical Examiners ("Board"). Said Notice of Hearing contained numerous allegations concerning my medical practice. Subsequently, the Notice was amended to include other allegations concerning my medical practice. I, Lois March, M.D., holder of License No. 46310 to practice medicine in the State of Georgia pursuant to O.C.G.A. Ch.34, T. 43, as amended, in settlement of the pending case filed against me as provided in the Notice of Hearing and Amendment, do hereby freely, knowingly and voluntarily surrender said license to the Composite State Board of Medical Examiners.

I hereby acknowledge that this surrender shall have the same effect as a revocation of my license, and I knowingly forfeit and relinquish all right, title and privilege of practicing medicine in the State of Georgia, unless and until such time as my license may be reinstated, in the sole discretion of the Board. I acknowledge that I have read and understand the contents of this Voluntary Surrender. I have had legal counsel in this matter and understand that I have a right to a hearing in this matter. I hereby freely, knowingly and voluntarily waive the right to a hearing. I also understand that should the Board entertain any request for reinstatement, the Board shall have access to the entire investigative file in this matter, and any subsequent investigation.
I further understand, and the Board agrees, that the two-year waiting period to apply for reinstatement of Respondent’s license to practice medicine as provided in Board Rule 360-2-.07 shall be waived provided that at the time of my application for reinstatement I have not had any contact with Dan Raber or his family, or any practices involving the use of bloodroot as a form of treatment since the effective date of this Order. In the event that I have had contact with Dan Raber, his family or practices involving the use of bloodroot, the Board shall not consider any reinstatement application for a period of two (2) years from the date of this surrender.

I further understand and agree that upon applying for reinstatement, it shall be incumbent upon me to demonstrate to the satisfaction of the Board that I am able to practice medicine with reasonable skill and safety to patients, and that the Board may investigate my conduct since the time of the surrender of my license. I agree that in order to demonstrate that I am able to practice with reasonable skill and safety that I shall submit along with my application for reinstatement the results of: (1) a 96-hour inpatient mental and physical examination at a facility pre-approved by the Board conducted no more than 3 months preceding the date of the application, and (2) a comprehensive evaluation of my clinical skills and abilities at a clinical skills assessment program pre-approved by the Board conducted no more than 3 months preceding the date of the application. I also understand and agree that the Board may ask that I appear before a committee of the Board prior to considering the reinstatement application.

In consideration of any application for reinstatement, I understand and agree that the Board shall have the discretion to reinstate my license to practice medicine in the State of Georgia, and to place upon me any conditions that the Board may deem appropriate including probation with terms, conditions, and/or limitations, or to deny the reinstatement of my license to practice
medicine in this State. If the application is denied, I understand that I shall have the opportunity to appear before the Board with legal counsel as in a non-contested case.

This Order shall become effective upon acceptance and docketing by the Board. I understand that this document will be considered to be a public record entered as the final disposition of disciplinary proceedings presently pending against me, and that this action shall be considered to be and may be disseminated as a final order of the Board.

I understand that my license will be deemed revoked on December 1, 2005, and I will have until December 1, 2005 to notify my patients and make other arrangements for their medical care.

This _7_ day of _November_, 2005.

[Signature]

LOIS MARCH, M.D.
Respondent

Sworn to and subscribed this _7_ day of _November_, 2005.

NOTARY PUBLIC
My commission expires: _February 8, 2007_.

ACCEPTANCE OF SURRENDER

The voluntary surrender of License No. 46310, as provided herein, is hereby accepted by the Composite State Board of Medical Examiners, this _14_ day of _November_, 2005.

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

BY: _[Signature]_
M. VINAYAK KAMATH, M.D.
President

(BOARD SEAL) ATTEST: _[Signature]_
LASHARN HUGHES
Executive Director

Page 3 of 3
BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS

STATE OF GEORGIA

IN THE MATTER OF

LOIS MARCH, M.D.,
LICENSE NO. 46310,

Respondent

* * *

DOCKET NUMBER 20060014

MATTERS ASSERTED AND
STATUTES AND RULES INVOLVED

Pursuant to O.C.G.A. 50-13-13, the Composite State Board of Medical Examiners ("the Board") hereby provides Respondent with the matters asserted and the statutes and rules involved for purposes of revoking the Respondent's license. The matters asserted below, if correct, constitute sufficient grounds for the revocation of Respondent's license to practice as a physician.

MATTERS ASSERTED

1.

Lois March ("Respondent") was issued license number 46310 to practice as a physician in the State of Georgia on September 3, 1998. She was so licensed at all times relevant herein.

2.

The Respondent is a medical doctor whose specialty area of practice is ear, nose and throat medicine.
3.

In 2003-2005, the Respondent saw and treated several patients who sought treatment for cancer or suspected cancer from Dan Raber ("Raber"), a person not licensed to practice medicine.

4.

The patients were brought to the Respondent by Raber or referred to her by Raber.

5.

At all times, the Respondent knew or should have known that the patients were receiving treatment for cancer or suspected cancer from Raber, who was not licensed to practice medicine.

6.

At all times, the Respondent knew or should have known that Raber was not licensed to practice medicine.

7.

At all times, the Respondent knew or should have known that Raber was treating the patients for cancer or suspected cancer even though he was not licensed to practice medicine.

8.

At all times, the Respondent knew or should have known that the patients were being subjected to treatment of their cancer or suspected cancer by Raber with bloodroot or compounds containing bloodroot.
9.

At all times, the Respondent knew or should have known that treatment of cancer or suspected cancer with bloodroot or compounds containing bloodroot is not an acceptable medical treatment of cancer.

10.

At all times, the Respondent knew or should have known that Raber was selling bloodroot and/or compounds containing bloodroot to patients as a cure for cancer.

11.

At all times, the Respondent was knew or should have known that bloodroot and/or compounds containing bloodroot is a caustic, tissue destroying substance that eats away human skin and flesh. The Respondent observed the loss of skin and flesh in the patients that she treated.

12.

At all times, the Respondent knew or should have known that bloodroot, and/or compounds containing bloodroot, would inflict horrific loss of skin and flesh on the patients that Respondent saw and to whom the Respondent was providing pain medication so that they could continue to receive the bloodroot treatment.

13.

At all times, the Respondent knew or should have known that bloodroot and/or bloodroot compounds would inflict horrendous
pain and suffering in the patients that Respondent saw and to whom the Respondent was providing pain medications so that they could continue to receive the bloodroot treatment.

14.

At all times, the Respondent knew or should have known that the patients required pain management treatment for their horrendous pain and suffering in order to endure the bloodroot treatment provided by Raber.

15.

At all times, the Respondent knew or should have known that Raber needed the Respondent to provide pain management treatment to the patients so that the patients could continue to receive the bloodroot treatment from Raber.

16.

At all times, the Respondent knew or should have known that her pain management treatment, including giving prescriptions for pain medications, narcotics and controlled substances of the patients, was given to facilitate the continued bloodroot treatment provided by Raber.

17.

At all times, the Respondent knew or should have known that her pain management treatment of the patients was given to facilitate the unlicensed practice of medicine by Raber.
18.

The Respondent did not report Raber’s illegal, unlicensed practice of medicine to the Board or any local law enforcement agency. Instead, the Respondent aided and abetted Raber’s illegal unlicensed practice of medicine.

19.

The Respondent knew or should have known that certain female patients sought treatment from Raber for breast cancer. The Respondent knew or should have known that Raber’s unlicensed practice of medicine with bloodroot mutilated their breasts and caused excruciating pain.

20.

The Respondent knew or should have known that Raber’s unlicensed practice of medicine with bloodroot mutilated the patients and caused excruciating pain.

21.

The Respondent knew or should have known that Raber performed surgery on the forehead of J.B., a patient with a reported history of basal cell carcinoma of the forehead. The Respondent knew or should have known that Raber cut the patient’s forehead until he exposed the patient’s skull. At the time of surgery, the Respondent was speaking to Raber by telephone as he was performing the surgery to the patient’s forehead.
22.

The Respondent provided medications and therapeutic support for Raber's bloodroot treatment which treatment caused tissue destruction and pain. The pain management and therapeutic support provided by the Respondent enabled Raber to continue the use of the bloodroot treatment on the patients.

23.

The Respondent failed to properly diagnosis and treat the patients. The Respondent failed to properly maintain records on the patients.

24.

The Respondent assisted Raber in his unlicensed practice of medicine. The Respondent knew or should have known that the patients were given treatment by Raber for cancer or suspected cancer.

25.

The Respondent assisted Raber in his treatment of cancer or suspected cancer with bloodroot which is not a medically recognized form of treatment for cancer.

26.

The Respondent utilized Raber to supervise and manage the patients to whom Respondent had provided prescriptions for drugs and controlled substances.
In 2001, the Respondent treated the minor patient, T.B., for allergies. The Respondent directed that the patient and her mother bring in substances from their home in vials. The Respondent's course of treatment for the allergies was to have the patient hold up one of the vials while the Respondent tapped on her back. The Respondent's course of treatment also was to have the patient rub her stomach in a circular motion with one hand and tap over her heart with the fingers of the other hand. The Respondent informed the patient and her mother that these acts would rid her body of allergies.

S.K. was a patient of Respondent's in October 2003. Medical records show that S.K. went to the Respondent with a reported case of breast cancer for pain management after starting bloodroot treatment.

A Board appointed peer reviewer evaluated Respondent's diagnosis, treatment, and recordkeeping of patient S.K., and concluded that the diagnosis, treatment, and recordkeeping of patient S.K. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:
(a) The minimum standard of care of diagnosis for a patient who reported a history of breast cancer would require obtaining pathology or biopsy reports to confirm the history of breast cancer. The Respondent failed to obtain pathology or biopsy reports to confirm the reported history of breast cancer;

(b) The minimum standard of care for diagnosis and treatment of a patient with wound injury to her breast would include removal of dressings on the injury and to provide wound care. The Respondent failed to remove the dressings or to provide wound care;

(c) The minimum standard of care for diagnosis and treatment for a physician specializing in ear, nose, and throat medicine would require such physician not to provide medications for pain and withdrawal therapy. The Respondent provided medications for pain and for withdrawal therapy outside the scope of her ENT specialty;

(d) The minimum standard of care for treatment would require not prescribing such an amount of narcotics that the patient suffered from withdrawal and risked addiction. The Respondent prescribed such a large amount of narcotics that the patient suffered from withdrawal and risked addiction;

(e) The minimum standard of care for treatment would require that the Respondent not provide medical/therapeutic support for destructive therapy administered by a person not
licensed to practice medicine nor to allow the patient to receive narcotic and pain management medications under the supervision of such an unlicensed person. The Respondent provided ongoing medical/therapeutic support for the destructive therapy administered by a person not licensed to practice medicine and allowed the patient to receive narcotic and pain management medications under the supervision of such unlicensed person.

30.

J.B. was a patient of Respondent in January 2004. Medical records show that J.B. went to Respondent for cellulitis and pain management with an undocumented history of cell carcinoma of the forehead.

31.

A Board appointed peer review evaluated Respondent’s diagnosis, treatment, and recordkeeping of patient J.B., and concluded that the diagnosis, treatment, and recordkeeping of patient J.B. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:

(a) A minimum standard of care for diagnosis of a patient reporting a history of basal cell carcinoma would require obtaining pathology or biopsy reports to confirm the reported
history. The Respondent failed to obtain pathology or biopsy reports to confirm the reported history of basal cell carcinoma;

(b) A minimum standard of care for diagnosis of a patient with cellulitis and an ongoing wound would require antibiotics possibly culture directed and wound care and dressings/debridement. The Respondent failed to require antibiotics possibly culture directed and failed to provide wound care and dressings/debridement.

(c) A minimum standard of care for treatment would require that no medical/therapeutic support be provided for tissue destructive therapy administered by a person not licensed to practice medicine. The Respondent provided medications and therapeutic support for the tissue destructive bloodroot therapy administered by an unlicensed person.

32.

J.H. was a patient of Respondent’s in May and June 2002. Medical records show that J.H. went to Respondent for treatment with a reported history of metastatic breast cancer with dysphagia and aspiration.

33.

A Board appointed peer reviewer evaluated Respondent’s diagnosis, treatment, and recordkeeping of patient J.H. and concluded that the diagnosis, treatment, and recordkeeping of patient J.H. departed from and failed to conform to the minimum
standard of acceptable and prevailing practice in the following ways:

(a) The standard of care of diagnosis of a patient with a reported history of neck mass, dysphagia, and TVC paralysis requires workup with biopsy, CT chest, and panendoscopy before an accurate diagnosis of metastatic breast cancer is made. The Respondent failed to obtain such a workup on the patient;

(b) The standard of care of treatment would not be to use prevacid to resolve dysphagia and aspiration, or to prescribe duragesic patches that could suppress respiration and cause worsening of aspiration. The Respondent, however, used prevacid and duragesic patch in the treatment of the patient;

(c) The standard of care of treatment would not be to provide pain management in support of tissue destructive therapy of unknown efficacy by a person not licensed to practice medicine. The Respondent, however, provided such treatment in support of tissue destructive therapy of unknown efficacy by a person not licensed to practice medicine;

M.B. was a patient of Respondent in December 2002. Medical records show that M.B. went to Respondent for pain management with an undocumented history of melanoma of the shoulder/back.

A Board appointed peer reviewer evaluated Respondent's diagnosis, treatment, and recordkeeping of patient M.B., and concluded that the diagnosis, treatment, and recordkeeping of patient M.B. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:

(a) The standard of care for diagnosis and treatment of a patient with an undocumented melanoma of the shoulder/back, which is outside the scope of normal ENT practice, is not to provide pain management for painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine. The Respondent, however, as a physician specializing in ENT practice, provided pain management to the patient with an undocumented melanoma of the shoulder/back for support of painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine.
M.C. was a patient of Respondent in January and February 2003. Medical records show that M.C. went to Respondent for pain management of an undocumented metastatic breast cancer.

A Board appointed peer reviewer evaluated Respondent's diagnosis, treatment, and recordkeeping of patient M.C., and concluded that the diagnosis, treatment, and recordkeeping of patient M.C. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:

(a) The standard of care of diagnosis and treatment of a patient with an undocumented metastatic breast cancer, which is outside the scope of normal ENT practice, is not to provide pain management for painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine. The Respondent, however, as a physician specializing in ENT practice, provided pain management to the patient with an undocumented metastatic breast cancer for support of painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine;

(b) The standard of care of recordkeeping would require documentation of a prescription for hydrocodone/APAP 10-
325 #60, and supporting notes and diagnosis noted. The Respondent failed to document such a prescription and any supporting notes and diagnosis;

(c) The standard of care of treatment would require adequate discharge planning for the patient. The Respondent inadequately performed discharge planning for the patient via telephone and internet monitoring only.

38.

K.S. was a patient of Respondent in January 2003. Medical records show that K.S. went to Respondent with a history of medullary cancer of the thyroid for pain management.

39.

A Board appointed a peer reviewer evaluated Respondent’s diagnosis, treatment, and recordkeeping of patient K. S., and concluded that the diagnosis, treatment, and recordkeeping of patient K.S. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:

(a) The standard of care for diagnosis and treatment of a patient with an undocumented history of medullary cancer of thyroid is not to provide pain management for painful unproven bloodroot therapy, that causes tissue destruction, by a person not licensed to practice medicine. The Respondent provided pain management to the
patient with an undocumented history of medullary cancer of the thyroid for support of painful unproven bloodroot therapy that caused tissue destruction by a person not licensed to practice medicine;

(b) The standard of care for treatment of a patient with an undocumented history of medullary cancer of the thyroid would be to obtain a biopsy to confirm such cancer. The Respondent failed to obtain a biopsy to confirm such cancer;

(c) The standard of care for treatment of a patient with an open neck wound the size that patient K.S. had would require biopsy specific inpatient treatment and reconstruction and not just narcotics and telephone support. The Respondent failed to treat the patient with biopsy specific inpatient treatment and reconstruction, but only provided narcotics and telephone support.

40.

C.S. was a patient of Respondent in February 2003. Medical records show that C.S. went to Respondent for pain management with an undocumented history of breast cancer.

41.

A Board appointed peer reviewer evaluated the Respondent's diagnosis, treatment, and recordkeeping of patient C.S. and concluded that the diagnosis, treatment, and recordkeeping of
patient C.S. departed from and failed to conform to the minimum
standard of acceptable and prevailing practice in the following
ways:

(a) The standard of care for the treatment of a patient with
an undocumented history of breast cancer is not to
provide pain management for painful unproven blood root
therapy that causes tissue destruction by a person not
licensed to practice medicine. The Respondent, however,
provided pain management for painful unproven bloodroot
therapy that causes tissue destruction administered by an
unlicensed person;

(b) The standard of care for the treatment of pain management
is not to rely on an unlicensed person to supervise and
manage the pain that the physician is treating. The
Respondent, however, relied on an unlicensed person to
supervise and manage the patient’s pain that the
physician was treating.

42.

L.B. was a patient of Respondent in February 2003. Medical
records show that L.B. went to Respondent for pain management
with an undocumented history of breast cancer.

43.

A Board appointed peer reviewer evaluated Respondents’
diagnosis, treatment, and recordkeeping of patient L.B. and
concluded that the diagnosis, treatment, and recordkeeping of patient L.B. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:

(a) The standard of care for diagnosis and treatment of a patient with an undocumented history of breast cancer, which is outside the scope of normal ENT practice, is not to provide pain management for painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine. The Respondent, however, as a physician specializing in ENT practice, provided pain management to the patient with an undocumented history of breast cancer for support of painful unproven bloodroot therapy by such an unlicensed person;

(b) The standard of care for diagnosis would require diagnosis and biopsy of supraclavicular suspicious nodes. The Respondent failed to diagnose and biopsy such supraclavicular suspicious nodes.

G.C.B. was a patient of Respondent in March 2005. Medical records show that G.C.B. went to Respondent for a neck lesion.

A Board appointed peer reviewer evaluated Respondent’s diagnosis, treatment, and recordkeeping of patient G.C.B., and
concluded that the diagnosis, treatment, and recordkeeping of patient G.C.B. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:

(a) The standard of care for recordkeeping of a patient with a neck lesion that is excised is to document follow-up for suture removal and contact to discuss pathology results. The Respondent failed to document follow-up for suture removal and contact to discuss pathology results.

46.

B.C. was a patient of Respondent in September and October 2003. Medical records show that B.C. went to Respondent for pain management with an undocumented breast cancer.

47.

A Board appointed peer reviewer evaluated Respondent’s diagnosis, treatment, and recordkeeping of patient B.C., and concluded that the diagnosis, treatment, and recordkeeping of patient B.C. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:

(a) The standard of care for diagnosis and treatment of a patient with an undocumented history of breast cancer, which is outside the scope of normal ENT practice, is not to provide pain management for painful unproven bloodroot
therapy that causes tissue destruction by a person not licensed to practice medicine. The Respondent, however, provided pain management to the patient with an undocumented history of breast cancer for support of painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine;

(b) The standard of care for diagnosis of a patient with a supraclavicular mass would be to biopsy for diagnostic purposes and obtain pretreatment laboratory results. The Respondent failed to biopsy for diagnostic purposes or obtain pretreatment laboratory results.

48.

M.A. was a patient of Respondent in December 2003. Medical records show that M.A. went to Respondent with an undocumented history of breast cancer for pain management and for a possible urinary tract infection.

49.

A Board appointed peer reviewer evaluated Respondent's diagnosis, treatment, and recordkeeping of patient M.A., and concluded that the diagnosis, treatment, and recordkeeping of patient M.A. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:
(a) The standard of care for diagnosis and treatment of a patient with an undocumented history of breast cancer, which is outside the scope of normal ENT practice, is not to provide pain management for painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine. The Respondent, however, as a physician specializing in ENT practice, provided pain management to the patient with an undocumented history of breast cancer for support of painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine;

(b) The standard of care for treatment of pain management is not to prescribe excessive amounts of narcotics to patients. The Respondent, however, prescribed in excess of 200 pills of narcotics in a short period of ten days to facilitate the patient’s painful treatment with bloodroot;

(c) The standard of care for diagnosis of a patient with a history of undocumented breast cancer would be to obtain a biopsy and pathology report to confirm the cancer. The Respondent failed to obtain a biopsy and pathology report to confirm the cancer;

(d) The standard of care for recordkeeping for a patient who undergoes urinalysis would be to document contact with
the patient after the results were obtained and to
document the medications for treatment. The Respondent
failed to document contact with the patient and the
medications for treatment after the urinalysis.

50.

B.G. was a patient of Respondent in April-July 2004 and
January 2005. Medical records show that B.G. went to Respondent
pain management with multiple basal cell cancers of the face,
neck, and ears and acinic keratosis.

51.

A Board appointed peer reviewer evaluated Respondent's
diagnosis, treatment, and recordkeeping of patient B.G., and
concluded that the diagnosis, treatment, and recordkeeping of
patient B.G. departed from and failed to conform to the minimum
standard of acceptable and prevailing practice in the following
ways:

(a) The standard of care for diagnosis and treatment of a
patient is not to provide pain management for painful
unproven bloodroot therapy that causes tissue destruction
by a person not licensed to practice medicine. The
Respondent, however, provided pain management to the
patient for support of painful unproven bloodroot therapy
that causes tissue destruction by a person not licensed
to practice medicine.
(b) The standard of care for diagnosis would be to send in biopsy or margins on suspected basal cell cancers of the patient's face, neck and ears for pathology reports. The Respondent failed to send in biopsies or margins on such suspected basal cell cancers for pathology reports;

(c) The standard of care for recordkeeping would require documentation of pain medications, patient counseling, and patient consents. The Respondent's medical records on this patient are incomplete, handwritten, very difficult to read; do not document the dose, brand, and duration of pain medication; do not document patient counseling; and do not document patient consent to office procedures.

52.

R.L. was a patient of Respondent from September-November 2004. Medical records show that R.L. went to Respondent with multiple skin lesions for pain management.

53.

A Board appointed peer reviewer evaluated Respondent's diagnosis, treatment, and recordkeeping of patient R.L., and concluded that the diagnosis, treatment, and recordkeeping of patient R.L. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:
(a) The standard of care for diagnosis and treatment is not to provide pain management for painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine. The Respondent, however, provided pain management to the patient for support of painful unproven bloodroot therapy that causes tissue destruction by a person not licensed to practice medicine;

(b) The standard of care for diagnosis of a patient who presents with exposed bone and joint in his shoulder caused by bloodroot therapy would be to refer the patient to orthopedic treatment. The Respondent failed to refer the patient who had such exposed bone and joint to orthopedic treatment;

(c) The standard of care for recordkeeping of a patient from whom the physician removes areas of his torso would be to document patient consent, pathology reports, and details of the areas removed. The Respondent failed to document such patient consent, pathology reports, and details of the areas of the torso removed.

N.R. was a patient of Respondent in October 2004. Medical records show that N.R. went to Respondent with a left axilla mass with a history of lymphoma.
A Board appointed peer reviewer evaluated Respondent’s diagnosis, treatment, and recordkeeping of patient N.R., and concluded that the diagnosis, treatment, and recordkeeping of patient N.R. departed from and failed to conform to the minimum standard of acceptable and prevailing practice in the following ways:

(a) The standard of care for recordkeeping for a patient who undergoes an office biopsy of a mass in the left axilla would be to document patient consent and to document the exact location of the biopsy site. The Respondent failed to document the patient’s consent and to document the exact location of the biopsy site.

D.R. was a patient of Respondent from in or about 2002 to in or about 2005. Medical records show D.R. went to Respondent for treatment of various complaints, including back lesions, hypogonadism with testosterone injections, CHF, pharygitis, sinusitis, and hyperglycemia.

A Board appointed peer reviewer evaluated Respondent’s diagnosis, treatment, and recordkeeping on patient D.R., and concluded that the diagnosis, treatment, and recordkeeping of patient D.R. departed from and failed to conform to the minimum
standard of acceptable and prevailing practice in the following ways:

(a) The standard of care for recordkeeping would be to document the results of all tests performed and to document appropriate information on controlled substances that are prescribed. The Respondent failed to document the test results of a sleep study performed in July 2002 and failed to document appropriate information, including office notes, history, or diagnosis for prescriptions of a controlled substance, hydrocodon/apap 7.5 #750, that Respondent called in for the patient on or about August 26, 2002 and January 24, 2003.

STATUTES AND RULED INVOLVED

O.C.G.A. § 43-1-19 states, in part:

"(a) A professional licensing board shall have the authority to refuse to grant a license to an applicant therefor or to revoke the license of a person licensed by that board or to discipline a person licensed by that board, upon a finding by a majority of the entire board that the licensee or applicant has:

(6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice of harmful to the public, which conduct or practice materially affects the fitness of the licensee or applicant to practice as a business or profession licensed under this
title, or of a nature likely to jeopardize the interest of
the public, which conduct or practice need not have
resulted in actual injury to any person or be directly
related to the practice of the licensed business or
profession but shows that the licensee or applicant has
committed any act or omission which is indicative of bad
moral character or untrustworthiness; unprofessional
conduct shall also include any departure from, or failure
to conform to, the minimal reasonable standards of
acceptable and prevailing practice of the business or
profession licensed under this title;

(7) Knowingly performed any act which in any way
aids, assists, procures, advises, or encourages any
unlicensed person or any licensee whose license has been
suspended or revoked by a professional licensing board to
practice a business or profession licensed under this title
or to practice outside the scope of any disciplinary
limitation placed upon the licensee by the board;

(8) Violated a statute, law, or any rule or
regulation of this state, any other state, the professional
licensing board regulating the business or profession
licensed under this title, the United States, or any other
lawful authority (without regard to whether the violation
is criminally punishable), which statute, law, or rule or
regulation relates to or in part regulates the practice of a business or profession licensed under this title, when the licensee or applicant knows or should know that such action is violative of such statute, law, or rule; or violated a lawful order of the board previously entered by the board in a disciplinary hearing, consent decree, or license reinstatement;...

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

(5) Revoke any license."

O.C.G.A. § 43-34-37, states, in part:

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

(4) Committed a crime involving moral turpitude, without regard to conviction; the conviction of a crime involving moral turpitude shall be evidence of the
commission of such crime. As used in this paragraph, the term 'conviction' shall have the meaning prescribed in paragraph (3) of this subsection. For the purpose of this chapter, a conviction or plea of guilty or of nolo contendere to a charge or indictment by either federal or state government for income tax evasion shall not be considered a crime involving moral turpitude;

(7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term 'unprofessional conduct' shall include any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to the patient as determined by the minimal standards of acceptable and prevailing medical practice or by rule of the board;

(9) ...; or knowingly performed any act which in any way aids, assists, procures, advises, or encourages any unlicensed person or entity to practice medicine...;

(10) Violated or attempted to violate a law, rule, or regulation of this state, any other state, the board, the
United States, or any other lawful authority without regard to whether the violation is criminally punishable, which law, rule or regulation relates to or in part regulates the practice of medicine, when the licensee or applicant knows or should know that such action is violative of such law, rule, or regulation; or violated a lawful order of the board, previously entered by the board in a disciplinary hearing;

(11) Committed any act or omission which is indicative of bad moral character or untrustworthiness;

(11.1) Failed to attempt to inform a patient, in a timely manner, that the physician has received the results of a laboratory test. The board shall promulgate rules for the implementation of this paragraph no later than January 1, 2002. Any physician who complies with the rules promulgated by the board for informing his or her patient that the results of any laboratory test have been received shall be immune from any civil or criminal liability for such disclosure;...

(b)(1) When the board finds that any person is unqualified to be granted a license or finds that any person should be disciplined pursuant to subsection (a) of this Code section, the board may take any one or more of the following actions:
(E) Revoke any license, or"

O.C.G.A. § 43-34-26 states, in part:

"(a) If any person shall hold himself out to the public as being engaged in the diagnosis or treatment of disease or injuries of human beings, or shall suggest, recommend, or prescribe any form of treatment for the palliation, relief, or cure of any physical or mental ailment of any person, with the intention of receiving therefore, either directly or indirectly, any fee, gift, or compensation whatsoever, or shall maintain an office for the reception, examination, or treatment of diseased or injured human beings,... and shall not in any of these cases then possess a valid license to practice medicine under the laws of this state, he shall be deemed to be practicing medicine without complying with this chapter and shall be deemed in violation of this chapter."

O.C.G.A. § 43-34-46 states, in part:

"(a) Any person who practices medicine without complying with this article or who otherwise violates any provision of this article shall be guilty of a felony and, upon conviction thereof, shall be punished by a fine of not less than $500.00 nor more than $1,000.00 or by imprisonment from two to five years or both."

O.C.G.A. § 16-2-20 states, in part:
"(a) Every person concerned in the commission of a crime is a party thereto and may be charged with and convicted of commission of the crime.

(b) A person is concerned in the commission of a crime only if he:

(3) Intentionally aids or abets in the commission of the crime;"

O.C.G.A. § 16-22-21 states, in part:

"Any party to a crime who did not directly commit the crime may be indicted, tried, convicted, and punished for commission of the crime upon proof that the crime was committed and that he was a party thereto, although the person claimed to have directly committed the crime has not been prosecuted or convicted, has been convicted of a different crime or degree of crime, or is not amenable to justice or has been acquitted."

O.C.G.A. § 16-13-41 states, in part:

"(b) When a registered practitioner writes a prescription to cause the dispensing of a Schedule II substance, he shall include the name and address of the person for whom it is prescribed, the kind and quality of such Schedule II controlled substance, the directions for taking, the signature, and the name, address, and federal registration number of the prescribing practitioner. Such
prescriptions shall be signed and dated by the prescribing practitioner on the date when issued.
(d) (2) When a registered practitioner writes a prescription to cause the dispensing of a Schedule III, IV or V controlled substance, he shall include the name and address of the person for whom it is prescribed, the kind and quantity of such controlled substance, the directions for taking, the signature, and the name, address, and federal registration number of the prescribing practitioner. Such prescriptions shall be signed and dated by the prescribing practitioner on the date when issued.
(e) A controlled substance included in Schedule V shall not be distributed or dispensed other than for a legitimate medical purpose."

Board Rule 360-3-.01 provides:

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

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

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

(5) Prescribing controlled substances (O.C.G.A. T. 16, Ch. 13, Art. 2) and/or dangerous drugs (O.C.G.A. T. 16, Ch. 13, Art. 3) for a patient based solely on a consultation via electronic means with the patient, patient's guardian or patient's agent. This shall not prohibit a licensee who is on-call or covering for another licensee from prescribing up to a 72-hour supply of medications for a patient of such other licensee nor shall it prohibit a licensee from prescribing medications when documented emergency circumstances exist.

(6) Providing treatment and/or consultation recommendations via electronic or other means unless the licensee has performed a history and physical examination of the patient adequate to establish differential diagnoses and identify underlying conditions and/or contraindications to the treatment recommended. This shall not prohibit a licensee who is on call or covering for another
licensee from treating and/or consulting a patient of such other licensee.

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

(a) The patient's name and address;
(b) The date, drug name, drug quantity, and patient's diagnosis necessitating the Schedule II, III, IV, or V controlled substances prescription; and 
(c) Records concerning the patient's history.

(9) Failing to comply with the provisions of O.C.G.A. Section 31-9-6.1 and Chapter 360-14 of the Rules of Composite State Board of Medical Examiners relating to informed consent, which requires that certain information be disclosed and that consent be obtained regarding any surgical procedure performed under general anesthesia, spinal anesthesia, or major regional anesthesia or an amniocentesis procedure or a diagnostic procedure that involves the intravenous injection of a contrast material.

(14) Failing to use such means as history, physical examine, laboratory, or radiographic studies, when applicable, to diagnose a medical problem.
(15) Failing to use medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation, or addiction in the treatment of patients. However, nothing herein shall be interpreted to prohibit investigations conducted under protocols approved by a state medical institution permitted by DHR and with human subject review under the guidelines of the United States Department of Health and Human Services.

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

(a) A physician shall be required to maintain a patient's complete medical record, which may include, but is not limited to, the following: history and physical, progress notes, X-ray reports, photographs, laboratory reports, and other reports as may be required by provision of the law. A physician shall be required to maintain a patient's complete treatment records for a period of no less than ten (10) years from the patient's last office visit.

(17) Failing to attempt to inform a patient of the receipt of laboratory test results within 14 days of the physician receiving the results, unless the standard of case requires a more immediate notification. Dates that laboratory test
results are received and attempts to contact patients shall be documented in the patient record.

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

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

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

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

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

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

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

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

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

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