BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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In the Matter of Charges and Complaint Against: **MATTHEW OBIM OKEKE, M.D.** **Respondent.**	**Case No. 21-22461-1**

FILED
DEC - 8 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521
(775) 688-2559

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

This case was presented for adjudication and decision before the Nevada State Board of Medical Examiners (Board), during a regularly scheduled Board meeting on December 2, 2022, located at 325 E. Warm Springs Road, Suite 225, Las Vegas, NV 89119 video conferenced to 9600 Gateway Drive, Reno, NV 89521. Matthew Obim Okeke, M.D. (Respondent), was properly served with a notice of the adjudication, including the date, time, and location. Respondent was present with his counsel Liborius Agwara, Esq. The adjudicating members of the Board participating in these Findings of Fact, Conclusions of Law (FOFCOL) and Order were: Nicola (Nick) M. Spirtos, M.D., Ms. Maggie Arias-Petrel, Victor M. Muro, M.D., Ms. Pamela Beal and Carl N. Williams, Jr., M.D., FACS. Sophia Long, Esq., Senior Deputy Attorney General, served as legal counsel to the Board.

The Board, having received and read the Complaint and exhibits admitted at the hearing of this matter, the Hearing Officer's Findings and Recommendations (Synopsis of Record)[1], and the transcript of the hearing, made its decision pursuant to its authority and provisions of the Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), NRS Chapter 622A, and NRS Chapter 233B, as applicable.

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[1] The Hearing Officer's Findings and Recommendations were prepared by Charles Woodman, Esq., who was appointed as Hearing Officer under NRS 630.106 in this matter and presided over the hearing.

The Board, after due consideration of the record, evidence and law, and being fully advised in the premises, makes its FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER in this matter, as follows:

FINDINGS OF FACT

I.

Respondent held a license to practice medicine in the State of Nevada issued by the Board from September 6, 2013, to present.

II.

On October 26, 2021, the Investigative Committee filed its formal Complaint in Case No. 21-22461-1, alleging Respondent violated the Medical Practice Act. Respondent was served with the Complaint on November 8, 2021, at his address of record with the Board. Pursuant to NRS 630.254, each licensee shall maintain a permanent mailing address with the board to which all communications from the Board to the licensee must be sent. A licensee who changes his or her permanent mailing address shall notify the Board in writing of the new permanent mailing address within 30 days after the change.

The Complaint alleges two (2) violations of the Medical Practice Act that constitute grounds for initiating disciplinary action against a licensee, as follows: one (1) violation of NRS 630.301(4) Malpractice and one (1) violation of NRS 630.3062(1)(a) Failure to Maintain Proper Medical Records.

Respondent filed an answer to the allegations set forth in the Complaint on January 11, 2022.

III.

An Early Case Conference was conducted January 21, 2022. Aaron B. Fricke, J.D., General Counsel at the time, (Mr. Fricke) was present on behalf of the Investigative Committee (IC) of the Board, and Liborius Agwara, Esq., appeared telephonically on behalf of Respondent along with Hearing Officer Charles Woodman, Esq. The parties agreed to dates for the prehearing conference, exchange of documents, and the hearing date.

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In compliance with NAC 630.465, a Notice and Order Scheduling Prehearing and Hearing, setting prehearing and hearing was filed on January 31, 2022, setting the prehearing conference for March 25, 2022, at 10:00 a.m., and setting the hearing for April 28 and 29, 2022, at 9:00 a.m., at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521 video conferenced to the Board's Las Vegas Office, located at 325 E. Warm Springs Road, Suite 225, Las Vegas, NV 89119. The Scheduling Order was delivered to Respondent's Counsel via USPS Certified Mail on February 2, 2022.

A second Notice and Order Scheduling Prehearing and Hearing was then filed on June 7, 2022, changing the Prehearing Conference to June 21, 2022, and dates for the formal Hearing to be determined at the Prehearing Conference. A copy of this Order was mailed to Respondent's counsel on June 7, 2022, with courtesy copy by email.

The Prehearing Conference was held telephonically as noticed and ordered, at which time, legal counsel for the IC, Sarah A. Bradley, J.D., Deputy Executive Director, appeared. Liborius Agwara, Esq., appeared telephonically on behalf of Respondent along with Hearing Officer Charles Woodman, Esq. Respondent and his counsel were timely and properly served with the IC's Prehearing Conference Statement, filed June 16, 2022, and the mandated Prehearing Disclosures in accordance with NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and the requirements of due process, by Fed Ex 2-Day Priority Mail, delivered to Respondent's counsel on June 17, 2022.

Following the Prehearing Conference, an Order After Pre-Hearing Conference was filed June 27, 2022, setting the sate for a formal Hearing to be held July 28, 2022, at 9:00 a.m. Respondent and his counsel were mailed a copy of the Order on June 28, 2022, with courtesy copy by email.

A third Notice and Order Scheduling Hearing was filed August 19, 2022, rescheduling the Hearing date for September 12, 2022, at 9:00 a.m. Respondent and his counsel were mailed a copy of the Order on June 28, 2022, with courtesy copy by email.

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IV.

On September 12, 2022, as duly noticed and ordered, a hearing was held before the Hearing Officer to receive evidence and to hear arguments of both parties. Legal counsel for the IC, Ms. Bradley, appeared. Respondent and his counsel appeared in the Las Vegas Board office. Ms. Bradley presented the IC's case, offered documentary evidence and presented witness testimony. Exhibits 1 through 15, were marked and admitted into evidence.

The Hearing Officer provided the Synopsis of Record, filed November 17, 2022. This matter was scheduled for final adjudication on December 2, 2022, at a regularly scheduled Board meeting.

The notice of the adjudication was sent via USPS Certified Mail to Respondent's counsel on October 26, 2022.

A copy of the adjudication materials along with a copy of the Hearing Officer's Synopsis of Record and second notice of the Board meeting were mailed via Fed Ex 2-Day mail to Respondent's counsel and were delivered on Respondent's address of record on November 22, 2022.

V.

Pursuant to NRS 622A.300(5)(a), the Synopsis of Record of the Hearing Officer is hereby approved by the Board with modification, and is hereby specifically incorporated and made part of this Order by reference and attached hereto as **Exhibit 1.** The Board rejects the findings and recommendations made by the Hearing Officer with respect to Count I.

VI.

The Board hereby finds that Count II, as set forth in the Complaint, and as recapitulated in Paragraph II above, has been established by a preponderance of the evidence. The Board hereby finds that Count I, as set forth in the Complaint, and as recapitulated in Paragraph II above, has not been established by a preponderance of the evidence.

VII.

If any of the foregoing Findings of Fact is more properly deemed a Conclusion of Law, it may be so construed.

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CONCLUSIONS OF LAW

I.

The Board has jurisdiction over Respondent and the Complaint, and an adjudication of this matter by the Board members as set forth herein is proper.

II.

Respondent was timely and properly served with the Complaint, and all notices and orders in advance of the hearing and adjudication thereon, in accordance with NRS and NAC Chapters 630, NRS Chapters 241, 622A and 233B, and all legal requirements of due process.

III.

With respect to the allegations of the Complaint, the Board concludes that Respondent has violated the Medical Practice Act, as alleged in the Complaint, as follows: one (1) violation of NRS 630.3062(1)(a) Failure to Maintain Proper Medical Records. Accordingly, Respondent is subject to discipline pursuant to NRS 630.352.

IV.

The Board finds that, pursuant to NRS 622.400, recovery from Respondent of reasonable attorneys' fees and costs incurred by the Board as part of its investigation and disciplinary proceedings against Respondent is appropriate. The Board has reviewed the Investigative Committee's Memorandum of Costs and Disbursements and Attorneys' Fees, and the Board finds them to be the actual fees and costs incurred by the Board as part of its investigative, administrative and disciplinary proceedings against Respondent, and finds them to be reasonable and necessary based on: (1) the abilities, training, education, experience, professional standing and skill demonstrated by Board staff and attorneys; (2) the character of the work done, its difficulty, its intricacy, its importance, the time and skill required, the responsibility imposed and the prominence and character of the parties where, as in this case, they affected the importance of the litigation; (3) the work actually performed by the Board's attorneys and staff, and the skill, time and attention given to that work; and (4) the product of the work and benefits to the Board and the people of Nevada that were derived therefrom.

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V.

If any of the foregoing Conclusions of Law is more properly deemed a Finding of Fact, it may be so construed.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and good cause appearing therefore,

IT IS HEREBY ORDERED that:

1. Respondent has violated the Medical Practice Act, as alleged in the Complaint, as follows: one (1) violation of NRS 630.3062(1)(a) Failure to Maintain Proper Medical Records (Count II).

2. Pursuant to NRS 630.352(4)(e), the Board shall administer a written public reprimand to Respondent.

3. Respondent's license shall be suspended for two (2) years from the date of the Board's order. This suspension shall be stayed, and Respondent's license will be placed on probation for two (2) years from the date of the Board's order. If Respondent fails to comply with the terms and conditions of this Order, including a failure to timely comply with the terms and conditions of this Order, or commits a new violation of the Medical Practice Act during the probationary period, then, after an order to show cause wherein the IC proves by a preponderance of the evidence that the failure to comply or failure to timely comply or violation did occur, the stayed suspension will be immediately lifted and in effect. Matters currently being investigated by the Board and/or pending action by the Board will not be deemed a violation of this Order.

4. The following terms and conditions shall apply during Respondent's probationary period:

a. Respondent must be always accompanied by a chaperone during any and all interactions with female patients. A list of chaperones used by Respondent must be provided to Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board and those chaperones must first be approved by Strategic Management

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Services or other monitoring company approved in the reasonable judgment of the Board before use.

b. Respondent must be monitored by Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board. Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board shall provide quarterly reports to the Board regarding its review of Respondent's charts and patient records. Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board shall review 10% of Respondent's patient charts each quarter, not to exceed fifty (50) charts per quarter and provide a report to the Board. At the end of the first year, Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board shall review fifty patient charts and provide a report to the Board. Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board will be reviewing all aspects of these patient charts, including legibility and completeness of records, verification of the presence of a chaperone for visits with female patients, and compliance with Nevada law regarding prescribing controlled substances, such as proof of regular PMP queries for patients.

c. Respondent shall pay all costs associated with the monitoring of him and/or his practice conducted by Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board.

d. At the end of the first year, after successful completion of monitoring and charter review by Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board, Respondent may come to the Board at a public meeting and request that the Board remove the requirement that he be monitored by Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board from his probation.

e. Even if the Board removes the requirement that Respondent be monitored by Strategic Management Services or other monitoring company approved in the reasonable judgment of the Board as described above in paragraph b, Respondent shall continue to be

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accompanied by a chaperone at all times during any and all interactions with female patients during the remainder of his two (2) year probationary period or until such time as a request is made and the Board removes this requirement.

5. Pursuant to NRS 630.352(4)(h), Respondent is hereby ordered to pay a fine of two thousand five hundred dollars ($2,500.00) to be paid within sixty (60) days from service of this Order.

6. Because the IC prevailed on only one (1) count of the Complaint, the Board reduced the costs assessed against Respondent in this matter from eighteen thousand two hundred twenty-nine dollars forty-four cents ($18,229.44) as shown in the IC's Memorandum of Costs and Disbursements and Attorneys' Fees to ten thousand dollars ($10,000).

7. The Board found that the reasonable, necessary, and actually incurred costs and expenses for the investigation and prosecution of this case in the amount of ten thousand dollars ($10,000), shall be reimbursed by Respondent within ninety (90) days from the service of this Order. The Board, and/or its designee, are granted the authority to collect any and all funds due under this Order.

8. Respondent shall complete eight (8) hours of Continued Medical Education (CME) on record-keeping and documentation and twenty-two (22) hours in the best practices in prescribing in addition to the statutory required CME requirements for licensure. These CME credits must be completed on or before December 31, 2023; and

9. This Order shall be reported to the appropriate entities and parties as required by law, including, but not limited to, the National Practitioner Data Bank.

IT IS SO ORDERED.

DATED this 8th day of December, 2022.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

AURY NAGY, M.D.
President of the Board

OFFICE OF THE GENERAL COUNSEL
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CERTIFICATION

I certify that the foregoing is the full and true original **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** on file in the office of the Board of Medical Examiners in the matter of **MATTHEW OBIM OKEKE, M.D.**, Case No. 21-22461-1.

I further certify that Aury Nagy, M.D., is the President of the Nevada State Board of Medical Examiners and that full force and credit is due to his official acts as such; and that the signature to the foregoing ORDER is the signature of said Aury Nagy, M.D.

IN WITNESS THEREOF, I have hereunto set my hand in my official capacity as Secretary-Treasurer of the Nevada State Board of Medical Examiners.

DATED this 8th day of December, 2022.

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Maggie Arias-Petrel

MAGGIE ARIAS-PETREL
Secretary-Treasurer and Public Member of the Board

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EXHIBIT 1

EXHIBIT 1

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

FILED

NOV 17 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

In the Matter of Charges and Complaint Against MATTHEW OBIM OKEKE, M.D., Respondent.

Case No.: 21-22461-1

SYNOPSIS OF RECORD

Hearing Officer Charles B. Woodman, having heard all formal pre-hearing conferences, as well as the formal Hearing of this matter, hereby presents the Nevada State Board of Medical Examiners with his Analysis of this case. This Analysis is based upon all evidence adduced at the formal Hearing, and this Hearing Officer's findings of facts and conclusions of law, which findings include the credibility of the witnesses who gave evidence.

RELEVANT BACKGROUND

This case came on for hearing on September 12, 2022. Ms. Sarah A. Bradley, Esq., appeared on behalf of the Investigative Committee ("IC") of the Nevada State Board of Medical Examiners. Liborius Agwara, Esq., appeared on behalf of and with Dr. Agwara. Dr. Agwara and his counsel appeared at the Board's Southern Nevada office where the official reporter was also located. Ms. Bradley appeared at the Board's Northern Nevada office where the hearing officer was located. The parties were connected via video teleconference communications.

NRS 233B.123 controls evidence admitted in contested administrative hearings. That code states in pertinent part that "evidence may be admitted, except where precluded

by statute, if it is of a type commonly relied upon by reasonable and prudent persons in the conduct of their affairs."

By conclusion of the formal hearing of this case, Exhibits 1 through 12, as well as Exhibits 14 and 15 offered by the IC and were admitted into evidence. Those admitted Exhibits are attached hereto. Exhibit 13 was excluded from evidence based on the testimony of the IC's main witness Dr. Jayleen Chen, M.D. Dr. Okeke chose not to present a defense case, and accordingly did not offer any exhibits.

It is noteworthy that while certain medical records admitted into evidence are several years old, Dr. Chen acknowledged that she did not review records or testify to facts alleged to have occurred prior to 2017. (See Factual Evidence below.) Dr. Okeke's counsel argued that those records that predate 2017 and were not reviewed by Dr. Chen should thus not be considered. However, all medical records admitted into evidence from years prior to 2017, while not addressed by Dr. Chen, are still in evidence and thus part of the record which can be considered in the determination of this case. Accordingly, paragraphs 2 through 6 of the Complaint on file which allege facts prior to 2017 are not legally barred from consideration.

FACTUAL EVIDENCE

The facts adduced at the formal Hearing of this matter, and which are considered worthy of review by the Board, are as follows from the formal transcript. Except where a quote begins with a "Q" denoting that counsel is asking the witness a question, all testimony presented herein is that of Dr. Chen. A number at the beginning of a line denotes the corresponding line number the on the page of the transcript where the quote is found. All emphasis on the font of the typed testimony (italics and underlines) has been supplied by the undersigned hearing officer for the Board's assistance in pointing out particularly significant testimony.

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Direct Examination of Dr. Chen by Ms. Bradley, Counsel for the IC

Page 47 ("P.47")

12 Q. Dr. Chen, what is your overall opinion regarding Dr. Okeke's care of Patient A?
14 *I felt there were some areas that fell below the standard of care, especially regarding the thoroughness of documentation. When I was reviewing it, I did have some difficulty, kind of, deciphering his medical decision-making.*
19 Q. When you say documentation, what do you mean by that?
21 *Just from looking at the progress notes, it was really hard for me to get a good grasp of her symptomatology. It was difficult to see how severe her symptoms were at what specific time. There were medication changes that I couldn't decipher the justification for. And I just felt those areas were lacking.*

P.48

3 Q. Okay. I think there's some conversation -- well, some use by Dr. Okeke of template material. What is template material?
6 In the electronic medical records, there is a way to kind of expedite your notes because documentation can be rather burdensome. So there are specific templates that you can use that you can kind of set up your notes, so they are similar from patient to patient, visit to visit, and it helps guide you or remember what to put in the note that might be helpful.
13 Q. Did you note Dr. Okeke's use of template material in notes?
15 *There was definitely a template that was used, and my concern was sometimes information from one note to the other wasn't really changed, or it really just remained the same. It didn't provide any updates, in my opinion, how she was doing in the interim from visit to visit.*
21 *Q. So it sounds like what you're saying is there may have been a note made at one visit, but then that note didn't get changed the next time?*
24 Yes. I would say so.
25 Q. So that's a pitfall for electronic records?

P.49

1 For sure.
2 Q. It's trying to help us, but it can fill in the same things?
4 Yes, unfortunately.

Page 53

8. It's not always necessary to write a medication, but usually it's mentioned somewhere in the note.
18. I feel that it could have been helpful to understand why each of these medications were prescribed.

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P. 55

Yes. *It's hard for me to tell upon my first review whether the treatment medications was what she was already on or what she's starting. I imagine it's what she was already on, but I can't tell if there were any additional medications or not.*

P.56

Q. So you're comparing it with NSBME 0050, and that visit is dated September 11, 2017; is that correct?

That's correct.

Q. And you're saying the chief complaint looks like there's a lot of template material copied over, right?

Yes. I think it's the same for the next visit as well.

Q. If we keep going to NSBME 0055, October 9, 2017, you're saying that's the same template?

Yes.

Q. And does that continue like that?

I think it does. On the 11/6 visit, the 12/4 visit as well.

P.57

. . . I'm trying to look back at my previous notes that I had written when I was first reviewing. *There were just a bunch of changes or additions of medications that didn't really have a rationale behind that.*

P.58

I guess if there were complaints that they were still not feeling any efficacy from that dose, I would, of course, gauge what symptoms they're still struggling with and increase or decrease based on their answer.

Q. Would that be documented in your notes for that patient?

It would be.

Q. So you would document a symptom that it's not improving, and that's your reason for change?

Correct.

Q. Did you see in Dr. Okeke's records that the patient's medications were increased at times?

P.59

Yes, I did.

Q. And did you see that they were decreased at times?

Yes, I did.

Q. Did you see that rationale documented in the records?

I don't think always, no.

Q. Sometimes?

Yes, possibly.

Q. But it sounds like not to the level that you would expect?

Right.

Q. *Why is it so important to have this documentation in the records?*

I feel like it is just basic care. I mean, if there's a continuity of care, if they're switching providers or someone needs to read the notes, then it's easy to clearly see what's been going on with the treatment, throughout the treatment.

20 Q. How many patients do you normally see in your practice?
22 Probably 40 patients a week or more.
23 Q. So one of the reasons for good documentation is it helps you remember where the patient is at?
25 For sure, yes.

P.60
1 Q. Because you can't remember every individual one?
3 Yes.
4 Q. Do you have other people who work with you in your practice?
6 I do.
7 Q. So they may also see your patients?
8 Yes.
9 Q. So it would be helpful for them to know what's going on?
11 Right.
12 *Q. So you had concerns, I think you said, regarding the documentation, regarding the changes, increase and decrease. What about changes in medication? How does that work?*
17 *I would prefer seeing that documentation and reasoning why you would switch from one medication to the next just to kind of get a better idea of the thought process that went behind the medication changes.*

P.65
21 Q. So when you have a patient that has a history of substance abuse and needs medication to help them, what does that mean to you as a clinician?
24 It definitely is a little bit of a red flag. I think you have to be a little bit more diligent to make sure there are no diversion or abuse of these medications. We, at my clinic, have a controlled substance agreement where they sign it. There's certain things that we request, like random drug screens or any other lab work. If they want to get their prescription filled, they have to sign our agreement.

P.66
8 Q. You have an agreement. Random drug screens. *Do you also check the PMP --*
12 *Yes. That is mandatory.*
13 *Q. Mandatory?*
14 *Yes.*
15 *Q. When you say mandatory, what does that?*
16 *We must check their PMP when there is initiation of Schedule 2, or unscheduled prescription, and I believe every three months during treatment as well.*
20 *Q. Okay. Every three months. So every three months that you continue to see the patient, you have to check --*
23 *Yes.*

P.67
20 *So in my opinion, I feel like baseline labs are very helpful just to kind of establish what the baseline is, especially when they are taking medications that can have metabolic effects like the anti-psychotics and to rule out any other medical issues that could contribute to symptoms, like a thyroid issue or other hormonal imbalance. So it's just a good practice to get lab work done when you can to establish a baseline.*

P.68

Q. How often would you order lab work?

In my practice, I try to get lab work done during the initial evaluation. If the patient says they've seen a primary care, I'll try to request records, so I have it in my own chart.

Q. Did you see evidence then of Dr. Okeke ordering baseline or routine lab work or conditioning?

I do not recall seeing any lab results in the chart.

Q. *So your opinion, would that be failure to follow the standard of care?*

I would say yes.

Q. *Did you have concern regarding Dr. Okeke's monitoring of the potential medical interactions for these drugs?*

I did, just because of the dosages and how it can be, I guess, cumulative, the effects of sedation and whatnot and some cognitive dulling.

P.69

Q. What is your opinion regarding Dr. Okeke's use of the Nevada Prescription Monitoring Program for Patient A?

I don't think I can remember seeing he checked the PMP or not. Once you check the PMP, it will log your patient request history, and I didn't remember seeing that.

Q. *So based on your recollection, he didn't check the PMP for the patient?*

P.70

I don't think so.

Q. Just so we're clear, I think earlier you said something about a law that requires the PMP to be checked. Do you remember when that law went into effect?

I don't remember.

Q. Would it be helpful if I said it might have been 2017?

Yes.

Q. I think, at least the notes that I read, show the concern maybe wasn't in the initial visits with her, but in 2018, he should have been checking -- So if I help you with remembering the status of the law change, would it be at least part of the treatment? Maybe he didn't have to look at the PMP, but at least at some point during the treatment, if he hasn't, he would have had to have?

Yes.

Q. *As of May 2019, was it required to look at the PMP?*

Yes.

Q. *So he saw the patient through May of 2019. He should have been looking at the PMP at that time frame, at least?*

Yes.

P.76

. . . **And so I feel like this is another fault of the template system**. It seems like the current medications may have been mislabeled, and it's a running history of everything that she had been prescribed before.

Q. If you look at the treatment plan about halfway through, it says -- it appears that perhaps there's an error in the record with regards to the gender of the patient. See where it says, patient was educated on the dangers of alcohol to him, physical health, and his symptoms. Do you see that?

Yes, I see that.

P.78

1 Q. So let's turn to the next visit, August 14, 2017, and if we go to NSBME 0046. *So we have that list of current medications. Is it your understanding those are what she's currently taking, or are you still thinking that's a list of the things she tried?*

7 Yeah. I believe that's the list of things she's tried.

9 Q. Why would you think that?

10 Because Adderall is listed four different times at four different doses. If she was taking it all at the same of the recommended dosaging. There are a few different anti-psychotics. So it wouldn't be the practice to be on four different anti-psychotics, but yeah.

16 Q. Sounds like this isn't an accurate list then?

17 No; not of current medications.

18 Q. So then, if we turn to NSBME 0048, we see treatment medications, and that continues to 0049. Are you thinking those are new medications?

21 I believe those are the current medications.

22 Q. So that's what she's taking today?

23 Yes. If you look above in the treatment plan, if we look, same note, patient was encouraged to stay clean from alcohol. Patient was educated on the dangers of alcohol to him.

2 Does that appear to be the same note from before?

4 Yes.

P.82

7 Q. And I'm asking Dr. Chen if there were changes made to the treatment plan made for the plaintiff based on her complaint that day?

10 *From reviewing my notes, I had questions because Adderall was added to the treatment medications without any discussion as to why.*

19 Q. Okay. You would expect to see discussion about the addition of that?

21 Right.

22 Q. What kind of discussion?

23 Just indicating what it is being used for. Of course it's an ADHD medication. That should be reflected in the updated diagnoses. It also was a little bit of a red flag to me because in that chief complaint section, she had been complaining of anxiety, nervousness. It sounds like -- (Continued inaudible) exacerbate these symptoms if prescribed incorrectly, I guess.

13 Q. Just so I'm clear. Is Adderall given to people that don't have ADHD?

15 There have been some off-label uses to help with mood, I would say, in the elderly or other populations, but there's no actual FDA approval, though.

18 Q. So if it's added, you would want to see a discussion somewhere in this record, why it's being added, and also something added to the assessment that supports the diagnosis for doing that?

22 *Yes. Something like a rule-out, or something to explain why Adderall was added on in light of these symptoms that were reported in the subjective section.*

P.84

9 Q. And if we look at the diagnosis here, what does N-O-S mean?

11 It stands for "not otherwise specified," but that terminology has been replaced with the DSM-5.

13 Q. So here, we see substance abuse more generic and others we've seen alcohol?

15 Right.

16 Q. Do you have any concerns about this report at all?

18 Just the diagnoses, yeah, since they are accepted in the DSM-5, it should be a little bit more specific.

P.86

16 Q. Let's keep going. So if we look at NSBME 0085, this is March 6, 2018, and here she's talking about increasing the dosage of Adderall and stopping the Vivitrol?

20 Yes.

21 Q. *Do you see that the medications were changed based on this conversation?*

23 *I do.*

24 Q. *Do you see a medical reason documented for that change?*

P.87

1 *I don't.*

2 Q. In your practice, if a patient came to you and said, I'd like to increase my medications, what would you do?

5 I would ask why do you feel that's necessary. What symptoms would you like to target. Just those basics.

8 Q. And would you note those in the records?

9 Yes.

10 Q. If they didn't have an answer, what would you do?

12 I probably would take a look at the overall picture and see if it's necessary or not. Try to figure out a reason they're requesting such a change in medications.

16 Q. *Normally, you would say it's not the standard of care to change medications without documenting it, it sounds like?*

19 *Right.*

20 Q. *And there needs to be a justification for the change?*

22 *Correct.*

P.88

13 Q. If we move on to April 3rd, 2018, and this is NSBME 0090. * * * Here, it sounds like she's having some anxiety and other symptoms. Do you see changes of medications for the patient in this visit?

22 The Trazodone was increased back up to 150 milligrams.

24 Q. And that was from 50, it looks like?

25 A hundred.

P.89

1 Q. No. A hundred. Is that a significant increase?

3 Not in my opinion, no.

4 Q. *Would you expect, though, to see that documented, the reason for changing it?*

6 *Yes.*

7 Q. *Do you see that documented here?*

8 *No.*

9 Q. I suppose we see the patient's complaints, but is that enough to document a change, just the patient's?

11 I just don't see it mentioning anything about sleep.

13 Q. And that's what you would expect to see to increase that?

15 Right.

20 Q. What do you see happened with regards to her medication on this visit?

22 Her Valium was increased to 7.5 milligrams twice per day.

24 Q. Okay. 7.5?

25 Yes.

P.90

Q. And is there documentation for the reasons for that?

It did state that she had been taking this same dose at 5 milligrams twice a day for over 10 years.

Q. So it was increased, but it hadn't been that before?

She had been on 5 milligrams twice a day for, it appears, over 10 years, and so now, since she was having more anxiety symptoms, I can only imagine that's why it was increased.

Q. *But you're guessing?*

Yes.

P.91

Q. I don't see a change in the multi-axial on Page 0107. Would that be necessary?

Given her diagnoses, I probably wouldn't have her on an anti-depressant, but I guess we could change her current episode would be depressed instead of manic.

Q. So it sounds like then the medications aren't probably what you would want prescribed?

Correct, but --

Q. But at least there's justification for them?

There is, but *the only thing would be to change the diagnosis since she's not in a current manic episode.*

P.92

Q. Okay. That hasn't been updated. What would you expect it to say?

Bipolar disorder or update it with current episode depressed.

P.93

I think the issue here was that she had a seizure while she was in the hospital, and I feel that should be added to her history because there are certain medications that could decrease the seizure threshold that she has been prescribed later on.

Q. *If we look at NSBME 0130, it says no history of seizures there?*

P.94

Right.

Q. *But that's not accurate anymore?*

Correct.

P.97

Q. I would then look at NSBME 0138. This is a visit dated October 19, 2018. I'm sorry. Can we go back to the previous visit, 0135, and I note on that page, *the neurologic still shows no history of seizures. Do you see that?*

Yes.

Q. So that's still not accurate?

Correct.

P.98

Q. Would you say that might be a use of a template just not being updated?

Yes. Another pitfall of templates.

Q. *Do you see on Page 0140 under neurologic, still has no history of seizures?*

P.99

Correct.

15 Q. *I do note on NSBME 0150 the same error of no seizures is there?*
17 *Correct.*

P.100

6 Q. So the Valium was removed. But I still note NSBME 0155 still shows no history of seizures?
8 Correct.
9 Q. *And the multi-axial says current episode manic, 0156. Would that be right?*
11 *Probably not after a suicide attempt.*
12 Q. So was there any documentation regarding the Valium other than, I guess, the chief complaints?
14 No.
15 Q. Are there any other concerns that you have of this visit?
17 *So the Adderall was changed to 5 milligrams twice a day. I'm not concerned about that, but there's still no diagnosis of ADHD.*
20 Q. *So you were concerned with the continued use of Adderall without medical justification?*
22 *Right.*

P.101

3 . . . Looks like the next visit we have with Dr. Okeke is NSBME 0172, and it's a visit dated January 25th, 2019. What happened with the patient at this visit?
7 She was not doing too well as far as mood goes and struggling with some sleep issues.
9 Q. Sounds like she might also have been anxious or tense?
11 Right. Anxiety.
12 Q. What happened with her treatment plan?
13 Belsomra was started for sleep, and Fanapt was given as samples to see if that would help with psychosis or mood stability.
16 Q. Did you feel like this was adequate justification for those changes?
18 A. For the Balsomra, yes.
19 Q. Did you have other concerns?
20 I didn't see any mention of why the Fanapt was chosen.
22 Q. Did you tell us what Fanapt is used for?
23 Fanapt is an anti-psychotic, but it can have Indication to treat bipolar symptoms.
25 Q. What would you expect to see symptom-wise that would justify it?

P.102

2 I would probably want to treat any mood instability, any mood swings, hypomanic, depression. Just help with mood overall. Because there wasn't mention of mood as much as there was of anxiety.

P.103

3 Q. *And I see a note that says discuss tapering down Valium, but it doesn't look like Valium was prescribed.*
6 *Yeah. It wasn't in the current treatment medication --*

///

///

P.106

11 Q. So then the next visit that we have is NSBME 0200, and *this is dated April 24, 2019. And the presenting problem there says client has been distraught since her marriage divorce. This is the first time that we've seen the patient was married.*

17 *Right.*

18 Q. I think recently it was a boyfriend breakup?

19 Right.

P.107

5 Q. Okay. NSBME 0202 is the same date, April 24, 2019. This is an adult bio-psychosocial assessment. Do you have any concerns regarding this report?

10 No. With the diagnoses again, it's not very clear.

12 Q. That's on 0204?

13 Yes.

14 Q. And you're saying that's not clear the multi-axial assessment?

16 Yes. *It's just with the bipolar disorders kind of contradicting each other.*

18 Q. *Because it says current episode depressed and current episode manic in the same?*

20 *Yes.*

21 Q. You wouldn't write it that way?

22 I would put a mixed episode or just leave it as a Bipolar Disorder Type 1.

P.108

16 Q. The next visit looks like NSBME 0205, and it was a visit dated May 9, 2019?

18 Yes.

19 What happened with the patient on this day?

20 This was just a therapy note, so there wasn't much mention of what was going on.

22 Q. Okay. I do note, though, if you look under vital signs, there's like in the middle of a paragraph, there's symbols that are hard to read. Do you see those?

P.109

1 Yes.

2 Q. So that would be hard to decipher what's going on there?

4 Right.

5 Q. And I see the same assessment for the diagnoses that are conflicting, where it says manic and depressed?

8 Correct.

Cross Examination of Dr. Chen by Mr. Agwara, Counsel for Dr. Okeke

P.115

1 Q. Okay. Now, moving on. *What recommendations would you make to Dr. Okeke going forward based on what you identified as some of the concerns you had? What would you recommend that he do different?*

5 *I guess my main concern was just the documentation and having a clear understanding of the rationale or medical decision-making. I feel it's important if there's another physician looking at your notes, it be a little more clear as to why you made changes to the treatment plan.*

11 Q. That's your major concern. *Any other concerns?*

13 *I guess just dealing with the patient population who do have a history of self-injurious behaviors, suicide attempts, substance abuse, I would really want to see more of a holistic approach -- not holistic, but a whole approach as far as getting therapy on board; looking at AA, NA for relapse prevention. Just trying to cover all the bases and provide as much support as she can maintain for recovery, in addition to stabilize her mental health.*
22 Q. *And that would be a judgment call, correct?*
23 *Yes.*
24 Q. *Now, would you agree with me that if another physician looked at your records that they could disagree with some of how you practice --*

P.116
2 *Yes, for sure. I'm sure they would.*
3 Q. Was there anything that you saw in your review that endangered the patient's life?
5 I guess my main concern is just all the different medications she was taking and maybe not getting a clear history of the medical prescriptions that she was also on. I know there were times in that one drug screen, I do remember, I believe it was positive for opiates, so kind of wondering that whole picture as far as medical treatment and how that plays into her psychiatric care was a concern.
13 Q. I didn't ask about your concern. My question was whether or not you saw something that posed a threat to the patient's life that Dr. Okeke did?
16 To answer that, I guess the combination of medications may have posed a threat.
18 Q. I do recall you stated in your testimony that the list of medications may be a function of the software, and it maybe listed more medications than the patient was taking?
22 Correct.
23 Q. So with that in mind, I'll ask you the question one more time. *Did you see anything that Dr. Okeke did as a physician that endangered this patient's life? Not your concerns.*

P. 117
2 *I'd say no, not from reading the notes, but --*
3 Q. Thank you.
4 *Again, those concerns I've already listed.*
5 Q. Do you know how long Dr. Okeke saw this patient?
7 I believe the first evaluation was back in 2014. So the initial psychiatric evaluation was in October of 2013. And then I think she lost treatment for a while, and popped back up in July 2014, and then off and on since then.
12 Q. Is there a reason why you started or limited your review and your testimony today, starting from 2017?
15 I'm not quite sure.
16 Q. You're not sure of the reason, or you're not sure of what?
18 I'm not sure why everything started after 2017.
20 Q. So that wasn't your decision?
21 No.

P.119
5 Q. You said you see a lot of this with a lot of your colleagues, and you think the people who do this are wrong, or do you think they're making stuff up? What exactly are you trying to say?
9 So I guess what I'm saying is, if there isn't much change from visit to visit, I would say there haven't been any changes. The patient reports to be doing well. No suicidal thoughts, no homicidal thoughts. I guess in his notes, it did list a lot of review of symptoms that, you know, it

could be better summarized there were no changes, patient is doing well, instead of all these different symptoms that I don't know were these questions asked or not.
18 Q. *So your concern is not with the similarity of the notes on the three different dates, but with the questions that may or may not have been asked; is that correct?*
22 *I guess that's correct, yes*.
23 Q. Okay. Thank you. Let me ask you this: *Is there a recognized industry-wide standard for sufficiency of justifications for changing prescriptions or increasing or decreasing dosages?*

P.120
2 *There's not a standard, but I believe it's good practice to spell out your thinking process.*
4 Q. When is that enough? We went through a lot of records with you, and on many of them, you actually agreed with Dr. Okeke, but on some of them, you said, well, you didn't think that the explanations for why a drug was added or removed was sufficient. That's what I'm asking. Is there a standard for what is considered adequate explanation?
12 I would say with maybe lesser medications that are not controlled substances, it may not be as important, but given the patient's history and there wasn't a diagnosis of ADHD, and then Adderall just popped up on her treatment regimen, that was concerning to me.
18 Q. Why was it concerning to you?
19 Just in light of her other diagnoses that were listed without a clear reason to have the Adderall. It could exacerbate her manic symptoms or anxiety, further worsening her mental state.
23 Q. Would you agree that Adderall is used to treat aggression?
25 It can be off-label.

P.121
1 Q. Is it your testimony that you did not see depression as a diagnosis in this patient's -- in the notes that you reviewed?
4 Her main diagnosis was bipolar disorder.
5 Q. I didn't ask about main.
6 A person with bipolar disorder, there is depression, and there are periods of mania or hypomania.
8 Q. So there was depression, correct?
9 But it isn't standard of care to treat bipolar with Adderall.
11 Q. No. I'm just asking. Did this patient suffer from depression or not?
13 Yes.
14 Q. *You already testified that sometimes you can use Adderall to treat depression; is that correct?*
16 *It would be off-label use.*
17 Q. *But acceptable use?*
18 *With good reason.*
19 Q. *Is that a yes?*
20 *With good reason.*

P.122
22 Q. Okay. Now, let me ask you this: Is it your testimony that because the records do not show discussions between Dr. Okeke and the patient that that means there were no such discussions?

P.123
1 No.
2 Q. Okay. You're just saying the records did not reflect some discussions that you would have liked to see; is that correct?
5 Yes.

6 Q. Is it your testimony that Dr. Okeke should have run the patient's PMP on every visit?
8 Not every visit. The standard is upon initiation of controlled substance, and I would say every three months during treatment.
11 Q. And during your review, did you find that that wasn't the case?
13 *I found that wasn't the case just because in that report that, I think Kim Friedman had requested, it didn't look like Dr. Okeke had requested any during the treatment time, but I could be mistaken. I just didn't get that information.*

P.124
8 Q. Okay. *Now, on how many occasions did you note changes without an explanation? I mean, if you don't have that number, that's fine.*
11 *I don't have that number, unfortunately, but I had made notes to myself, but there were definitely, I'd say over 10 times, as a guess.*
14 Q. *10 out of how many? Would you say the majority of times?*
16 *I would say the majority of times where there were changes, there wasn't a rationale.*
18 Q. *Are you sure?*
19 *Yes.*
20 Q. *Okay. Do you want us to review every single one?*
22 *No.*
23 Q. *I'm okay if you don't know if it's a majority or not, but if you're stating it's a majority --*
25 *I don't know. I don't know. I don't know. I know there was enough times that it was confusing for me to understand the process he was using.*

P.125
3 Q. Okay. That's fine. Now, is it your testimony in the chief complaint section that the complaints by the patient are not sufficient explanations for changing prescriptions or reducing the dosage or increasing it?
7 There were definitely some notes which highlighted the symptoms that she was complaining of that did warrant medication changes, but not all of them.

P.127
15 Q. What you're saying is you would not have chosen Adderall to treat the depression?
17 Yes. I would not have.
18 Q. And why is that?
19 Because, of course, bipolar is different than major depression, and with her history of having, I guess, there was an indication there was psychotic symptoms before, the Adderall could exacerbate that, and also could exacerbate her anxiety symptoms.

Closing Argument by counsel for Dr. Okeke

P.139
22 *I will give you this much, that with respect to PMP, my client understands and acknowledges that he probably did not check as often as he should have. He has made a lot of changes in his practice, and he has now made that a frequent practice to check PMPs.*

///

///

P.140

2 *As I pointed out in the beginning, in my opening statement, he has taken quite a few CEUs in terms of recordkeeping and sufficiency of records. And to the extent that some of the records do not have adequate notes in regards to the reasons to changing dosages, those have all -- well, I shouldn't say they have been changed because you can't change them in the past, but going forward, he has adopted new changes, and he's now doing a lot more to explain reasons why he would change the dosage or the prescriptions.*

Beyond the testimonial evidence and exhibits referred to therein, Exhibit 14 is a collection of articles printed off and contributed to the IC's case by Dr. Chen. While the hearing officer discussed those articles with Dr. Chen on the record, (see below), she did not testify substantively about any of those articles. The hearing officer has reviewed them. In general, the articles are not helpful. Had Dr. Chen testified about them, some of the articles may have been quite helpful, especially to a part of this case that is somewhat troubling to the undersigned hearing officer. In particular, the MSDP Standardized Documentation Training Manual's Psychiatry/Medication Progress Note may have been significant to this case. It appears to give a sound example of best practices (and thus possibly an applicable standard of care) for note-taking for psychiatrists. However, like a couple of the other documents[1] included in Exhibit 14, Dr. Chen did not testify as to whether such practices are the standard of care applicable in this case.

FINDINGS AND CONCLUSIONS OF THE HEARING OFFICER

1. Malpractice.

The Complaint on file alleges that Dr. Okeke malpracticed by committing the acts alleged in paragraphs 2-14 thereof. Specifically, the malpractice is alleged to have occurred when Dr. Okeke: failed to justify the use, increase and decrease, and then subsequent increases in dosages of Patient A's medication; prescribed a combination of controlled substances without documenting the medical justification or rationale; failed to

[1] The Flow Chart For The Initial Prescribing Controlled Substances Under AB474 document, and the article entitled Standard-of-Care Testimony: Best Practices or Reasonable Care? both could have been helpful evidence had Dr. Chen testified as to whether those items define the standard of care applicable to Dr. Okeke in light of the allegations in the Complaint.

review the PMP report prior to, during, and after the encounters with Patient A; failed to assess Patient A's concurrent medication interactions; failed to assess Patient A for possible drug abuse, drug diversion or any other non-medical related activity; failed to assess Patient A for possible drug screens on a consistent basis, and; failed to diligently monitor potential medication interactions in Patient A's changing treatment plans.

The legal definition of malpractice generally applicable here is the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances. NAC 630.040. That definition requires evidence proving what a physician using the reasonable care, skill, or knowledge ordinarily used under circumstances similar to those under which Dr. Okeke was treating Patient A would have implemented, thus showing that Dr. Okeke failed to use such reasonable care, skill, or knowledge. Put most simply, the IC's evidence must prove that Dr. Okeke's treatment of Patient A fell below the standard of care. It follows that proving just what the standard of care is must be a necessity in order to show that Dr. Okeke fell below that standard.

"Standard of care" was mentioned five times in Dr. Chen's testimony. Each of those is reviewed here.

The first mention is at page 47 of the transcript. Counsel asked Dr. Chen for her "overall opinion" of Dr. Okeke's treatment of Patient A. Dr. Chen stated that she:

> felt there were some areas that fell below the standard of care, especially regarding the thoroughness of documentation. When I was reviewing it, I did have some difficulty, kind of, deciphering his medical decision-making.

Counsel then asked "When you say documentation, what do you mean by that? Dr. Chen responded that:

> Just from looking at the progress notes, it was really hard for me to get a good grasp of her symptomatology. It was difficult to see how severe her symptoms were at what specific time. There were medication changes that I couldn't decipher the justification for. And I just felt those areas were lacking.

This testimony is helpful and certainly important in determining facts which are critical to this case. Although it does not define the applicable standard of care.

The second mention of standard of care is at page 68 of the transcript. The following is the series of counsel's questions and Dr. Chen's answers at that point in presentation of the evidence, which begins on page 67 of the transcript:

Q. So did you see evidence in your review of the records in this case that Dr. Okeke did the random urine drug screens that you were talking about?

A. I believe there were instances where I did see a urine drug screen, yes.

Q. Was it as frequent as you think it should have been?

A. **That's up to the provider.** I would say once a year at the very least would be sufficient.

Q. Did you see that in this case then?

A. It's hard for me to recall the specifics as far as when they were ordered and how frequent. I know there was at least one that I saw.

Q. At least one?

A. Uh-huh.

Q. What about your opinion regarding his ordering a baseline or routine lab work for the patient?

A. So in my opinion, I feel like baseline labs are very helpful just to kind of establish what the baseline is, especially when they are taking medications that can have metabolic effects like the anti-psychotics and to rule out any other medical issues that could contribute to symptoms, like a thyroid issue or other hormonal imbalance. So it's just a good practice to get lab work done when you can to establish a baseline.

Q. How often would you order lab work?

A. In my practice, I try to get lab work done during the initial evaluation. If the patient says they've seen a primary care, I'll try to request records, so I have it in my own chart.

Q. **Did you see evidence then of Dr. Okeke ordering baseline or routine lab work or conditioning?**

A. **I do not recall seeing any lab results in the chart.**

Q. **So your opinion, would that be failure to follow the standard of care?**

A. **I would say yes.**

Q. I think we've talked about the multiple drugs that the patient was taking. Do those have interactions with each other?

A. They definitely can.

Q. Did you have concern regarding Dr. Okeke's monitoring of the potential medical interactions for these drugs?

A. I did, just because of the dosages and how it can be, I guess, cumulative, the effects of sedation and whatnot and some cognitive dulling.

Q. When you say dosages, what do you mean? High dosages?

A. High dosages and just the different medications that have that same side effects. So it's kind of a synergistic effect, I would say.

Q. You mean two medicines with the same kind of effect, like a sedating effect?

A. True. Yes.

Q. *And you would want to note that?*

A. *Yes. Or at least discuss it with the patient.* It seems like she had a high tolerance to some of these medications, but there might be counteracting others, or you know, causing different effects canceling each other out.

Q. Did you see discussion about that in Dr. Okeke's records regarding this patient?

A. No.

This testimony is critical in that Dr. Chen answers the direct question of whether Dr. Okeke failed to follow the standard of care. However, some of Dr. Chen's surrounding testimony can leave questions as to whether she is testifying as to standard of care, or simply her own opinion of best practices, which can differ in that Dr. Chen's practices may be higher than the standard of care. And again, the standard of care is not set out here.

The third mention of standard of care came up at page 72 of the transcript in a legal argument between counsel about whether hearsay evidence was admissible. This mention of the standard did not address any substantive matter in the case.

The next/fourth mention of the standard occurs at page 73 and arose in the context of Dr. Chen explaining how she compiled the list of documents the IC presented as Exhibit 14. Her testimony was as follows:

> As with my peer-review, obviously, *I kind of have my own opinion, and then I look for things on the internet that could support my opinion. So that's where these came from. There are guidelines as well for my own research as to what other people may be doing as far as standard of care.*
>
> HEARING OFFICER WOODMAN: How does anyone know that what you are relying on here -- if you're doing an internet search, how do we know what you're using and relying on is reliable, is credible, and that it should be a part of the basis of your opinion?
>
> THE WITNESS: I definitely see where you're coming from. *Like I said, I formulate my own opinion first, and then I try to find supporting evidence to put into my review as the Board wants to review materials. So they can see my train of thought and see how others can review these same issues, I guess.*
>
> HEARING OFFICER WOODMAN: In the list, which I see 10 articles listed, correct?
>
> THE WITNESS: There are certain articles that I was able to print out. I guess, for sake of paper, there are these practice guidelines. 2 and 3 are exhaustive --
>
> HEARING OFFICER WOODMAN: I understand that, but there's a list of 10 items that you used for your peer-reviewed materials?
>
> THE WITNESS: Yes.
>
> HEARING OFFICER WOODMAN: As the doctor that your CV tells us that you are, is anything -- are any of these items in 1 through 10, did you have any concerns with the reliability or credibility of anything listed there in 1 through 10 in your professional medical opinion?
>
> THE WITNESS: I mean, *I believe there are some that I would really take with a grain of salt, but I think it's helpful. I didn't really understand the legal process myself, so I thought it was responsible of me to look at how the law and medicine integrate together.*
>
> HEARING OFFICER WOODMAN: So anything in that list, 1 to 10, that you have any concerns with, if any of that was being reviewed by the Board itself, the state Board?

THE WITNESS: I don't think I would have any concerns.

This conversation gives some pause to the hearing officer. As mentioned, while Dr. Chen's CV proves she is a very accomplished medical professional, and her appearance and testimony at the hearing did not detract therefrom, it is not clear whether some of her testimony was based on her own perception of best practices, as opposed to the actual standard of care. And again, from her demeanor at the hearing, this hearing officer would not be surprised in the slightest to discover that Dr. Chen's opinions on best practices may well exceed the standard. In fairness to Dr. Okeke, the standard of care against which he is measured must be clear. And if Dr. Chen is holding Dr. Okeke to her own best practices standards, and those are higher than the actual standard of care due a patient from her physician, then we are using the wrong yardstick to measure.

The fifth and final mention of the standard appears at page 121 of the transcript. This was Dr. Chen's testimony on cross-examination by Dr. Okeke's counsel (beginning at page 119):

> Q. *Okay. Thank you. Let me ask you this: Is there a recognized industry-wide standard for sufficiency of justifications for changing prescriptions or increasing or decreasing dosages?*
>
> **A. There's not a standard, but I believe it's good practice to spell out your thinking process.**
>
> Q. When is that enough? We went through a lot of records with you, and on many of them, you actually agreed with Dr. Okeke, but on some of them, you said, well, you didn't think that the explanations for why a drug was added or removed was sufficient. That's what I'm asking. Is there a standard for what is considered adequate explanation?
>
> A. I would say with maybe lesser medications that are not controlled substances, it may not be as important, but given the patient's history and there wasn't a diagnosis of ADHD, and then Adderall just popped up on her treatment regimen, that was concerning to me.
>
> Q. Why was it concerning to you?

A. Just in light of her other diagnoses that were listed without a clear reason to have the Adderall. It could exacerbate her manic symptoms or anxiety, further worsening her mental state.

Q. Would you agree that Adderall is used to treat aggression?

A. It can be off-label.

Q. Is it your testimony that you did not see depression as a diagnosis in this patient's -- in the notes that you reviewed?

A. Her main diagnosis was bipolar disorder.

Q. I didn't ask about main.

A. A person with bipolar disorder, there is depression, and there are periods of mania or hypomania.

Q. So there was depression, correct?

A. But it isn't standard of care to treat bipolar with Adderall.

Q. No. I'm just asking. Did this patient suffer from depression or not?

A. Yes.

Q. You already testified that sometimes you can use Adderall to treat depression; is that correct?

A. It would be off-label use.

Q. But acceptable use?

A. With good reason.

Q. Is that a yes?

A. With good reason.

Here we have the IC's expert witness testifying that: i) there is no standard of care with regard to "justifications for changing prescriptions or increasing or decreasing dosages" (thus nullifying the allegations in subparagraph "1)" of paragraph 18 of the

Complaint); ii) it is not standard of care to treat bipolar with Adderall, and; iii) with good reason, Adderall could be used to treat depression, off label.

This testimonial exchange highlights the hearing officer's concerns about some of the malpractice allegations in this case. While a generic legal definition of what the standard of care is can be found in the NAC, a psychiatry-specific definition of that standard is not within the record of this case. The hearing officer is left not knowing just what is "the reasonable care, skill, or knowledge ordinarily used under similar circumstances" to those of Dr. Okeke. However, there are other indications that are helpful, as set out below.

We do know from Dr. Chen that: she felt generally that Dr. Okeke fell below the standard of care regarding the thoroughness of documentation; she did not recall seeing any lab results in the chart, nor did she see evidence of Dr. Okeke ordering baseline or routine lab work or conditioning, and accordingly she "would say" that Dr. Okeke fell below the standard in this regard, and; treating bipolar with Adderall is not within the standard of care. But to be clear, according to the record, the hearing officer must either take Dr. Chen at her word on what she said did not meet the standard, or must find that, because the standard was not established, Dr. Okeke cannot be found to have breached it.

All of this confusion aside, and as alluded to above, there is yet another legal hurdle for Dr. Okeke to overcome in the question of whether he committed malpractice. The PMP is mandated to be reviewed regularly. Dr. Okeke's counsel acknowledges that this was not done.[2] Because of its import, and the resulting legal requirement to review it on a continuing basis, the failure to do so *must be* a failure to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances. In this regard, Dr. Okeke did fall below the standard, and thus did commit malpractice. Hence, this hearing officer finds that Count I of the Complaint is proven.

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[2] See Factual Evidence above, where Dr. Okeke's counsel stated that:

I will give you this much, that with respect to PMP, my client understands and acknowledges that he probably did not check as often as he should have. He has made a lot of changes in his practice, and he has now made that a frequent practice to check PMPs.

2. Failure to Maintain Proper Medical Records.

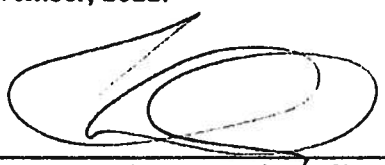
NRS 630.3062(1)(a) states that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment, and care of a patient is grounds for initiating disciplinary action against a licensee. While there are a number of questions in the evidence of this case as to if and how Dr. Okeke malpracticed, the record is quite clear that he did not keep adequate records. His counsel stated:

> As I pointed out in the beginning, in my opening statement, he has taken quite a few CEUs in terms of recordkeeping and sufficiency of records. And to the extent that some of the records do not have adequate notes in regards to the reasons to changing dosages, those have all -- well, I shouldn't say they have been changed because you can't change them in the past, but going forward, he has adopted new changes, and he's now doing a lot more to explain reasons why he would change the dosage or the prescriptions.

Accordingly, it cannot reasonably be challenged that Dr. Okeke failed with regard to his recordkeeping. The fact that he is working to improve his records practice is no doubt an important precipitate of this proceeding. Count II of the Complaint is thus proven.

Finally, with regard to credibility of witnesses, this HO found the IC's two witnesses to be completely credible at all times. While Dr. Chen will – assuming she continues to testify as an expert – learn more about the process of establishing a foundation of and definition for the applicable standard, her presentation left the hearing officer no question as to whether she was credible, and that she had no inappropriate motive in her participation in the case. Accordingly, the hearing officer finds no reason to question the testimony as presented. The IC has thus proven its two Counts alleged in the Complaint.

Respectfully submitted this 16th day of November, 2022.



Charles B. Woodman, Hearing Officer