NEVADA STATE BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF CHARGES AND COMPLAINT AGAINST

MATTHEW OBIM OKEKE, M.D.

ADJUDICATION

Case No: 21-22461-1

Date: December 2, 2022

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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
OCT 26 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Matthew Obim Okeke, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a Medical Doctor holding an active-probation license to practice medicine in the State of Nevada (License No. 14957). Respondent was originally licensed by the Board on September 6, 2013. On September 6, 2019, Respondent's license was placed upon probationary conditions (female supervision for all female patient encounters and maintain a formal monitoring agreement) for two (2) years from the aforementioned date or otherwise ordered by the Board. An Amended Settlement Agreement was approved March 6, 2020 by the Board and filed March 9, 2020 which did not change the above-outlined terms of the agreement.

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Mr. M. Neil Duxbury, Aury Nagy, M.D., Michael C. Edwards, M.D., FACS

2. On December 3, 2013, Patient A[2] was diagnosed by Respondent with bipolar disorder from a psychiatric evaluation based upon Patient A's most recent severe manic episode. Respondent notes such diagnosis of Bipolar disorder in the "chief complaint" section of Patient A's medical record. Respondent did not discuss or document any medication adjustments to address Patient A's "severe" symptoms. Respondent documented "continue present management." Less than thirty (30) days later, Patient A was hospitalized in an acute psychiatric setting for suicidal ideation and paranoia.

3. On September 11, 2014, Patient A requested and Respondent granted an increase in her drug medications, Strattera, Topamax, and Trazodone. Patient A stated her request was based upon her poor sleep and increased drug cravings. The Stattera was increased and another drug was added, Trazodone (a nightly dosage of 300mg). No medical justification or rationale was documented by Respondent into Patient A's medical record for the increased dosage or the added medication. Patient A's medical history and diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) was not documented by Respondent into Patient A's medical record. Respondent did not check Patient A's Prescription Monitoring Program Report (PMP) from the Nevada State Board of Pharmacy to ensure another medical provider had not already prescribed this type of medication to Patient A.

4. On January 20, 2015, Patient A started taking Lithium Carbonate (Lithium) in addition to the Depakote previously prescribed by Respondent. Again, Respondent did not properly monitor or document his monitoring, nor provide medical justification of these aforementioned medications given their respective therapeutic windows and a possibility of drug toxicity due to potential, unintended, side-effects with regard to the Lithium. Respondent did not check Patient A's PMP to ascertain if she was subject to any other prescriptions by other medical providers.

5. On April 13, 2015 and on April 22, 2015, Respondent documented another drastic change in Patient A's "treatment medications" without any indication of a discussion regarding the following: 1) Patient A's non-compliance with Respondent's treatment plan; 2) any possible,

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint and filed under seal.

unintended side-effects of Patient's change in medications; nor, 3) any medical justifications for the medication changes. Respondent did not check Patient A's PMP.

6. On June 27, 2016, Respondent ordered a drug screen for Patient A. The results demonstrated that Patient A was compliant with Respondent's medication regime, but for the positive test results for opiates, which were not indicated or documented in Patient A's medical records. Respondent failed to address the opiate test results with Patient A. Respondent did not check Patient A's PMP.

7. On March 27, 2017, Patient A presented to Respondent and mentioned her having a "schizophrenic episode." Respondent did not document in Patient A's medical record any symptoms she experienced, and if there was any resolution, or a return to the baseline functioning for Patient. Similarly, on September 17, 2018, Patient A presented to Respondent following her most recent acute hospitalization where she suffered seizures and was eventually released on an antiepileptic medication. Here, Respondent did not update Patient A's medical record's sections of "medical history" and "review of systems" to reflect the recent seizures. Respondent did not query or investigate whether Patient A's seizures were potentially medication-withdrawal related. Respondent did not check Patient A's PMP.

8. On January 1, 2018, Respondent failed to review Patient A's PMP prior to his prescribing controlled substances to Patient A. Respondent should have ordered random drug screen tests due to Patient A's medical history of substance and alcohol use. No such tests were ordered and no review of Patient A's current medication (PMP) was documented. Respondent did not check Patient A's PMP.

9. On January 16, 2018, Patient A's complaint of hallucinations was documented in the "chief complaint" section but was not included in the section of the mental status examination. Additionally, Respondent prescribed Adderall (20mg/morning) without any medical justification or rationale documented into Patient A's medical record although Patient A stated her anxiety had worsened and she suffered from psychotic symptoms, both of which could be further exacerbated by a stimulant medication (Adderall). Respondent did not check Patient A's PMP.

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10. On January 25, 2019, Respondent documented Patient A's "treatment medications" were listed as "Fanapt (8mg/night) and Belsoma (20mg/night)." Respondent did not check Patient A's PMP.

11 On February 4, 2019, Patient A stopped taking the aforementioned (Fanapt Belsoma) medications; Respondent updated "treatment medications" and listed "Zoloft (100mg/daily); Geodon (160mg/nightly); Gabapentin (600mg/3x daily)" On February 11, 2019, Patient A stated that she restarted taking Valium (5mg/2x daily) and Belsomra as documented by Respondent in the "treatment medications" of the medical record. Respondent did not either address these recent medications and/or he did not document his medical rationales or justifications for Patient A to continue to take these medications (Valium & Belsomra) in her medical record. Again, Respondent did not check Patient A's PMP. Diazepam (5mg/2x) was the last prescription Respondent wrote for Patient A.

13. On April 24, 2019, Respondent documented "bipolar disorder, current episode manic without psychotic features" and "bipolar disorder, current episode depressed, severe, without psychotic features" in the section label "diagnosis." Here, the entries are inconsistent with each other, e.g., "manic" and "depressed" are the opposite sides of this medical condition. This medical record is inaccurate as to what was the correct type of episode Patient A suffered on this date.

14. On August 22, 2019, Patient A committed suicide at the age of thirty-nine (39) years old. The cause of death was determined by the Clark County Coroner who stated that the manner of death was multiple drug intoxication (bupropion, gabapentin, and diphenhydramine). The autopsy report stated that Patient A had a history of chronic obstructive pulmonary disease; multiple mental illnesses, including bipolar disorder, anxiety and depression; she suffered from addiction since the age of fifteen (15) (chronic alcohol, methamphetamine, and prescription drug abuse). The report further indicated that Patient A's prescription medications were inventoried and too many pills remained in their containers. Thus, indicating non-compliance with taking her prescriptions as ordered.

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COUNT I

NRS 630.301(4) (Malpractice)

15. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

16. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

17. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

18. As demonstrated by, but not limited to, the above-outlined factual allegations, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he provided medical services to Patient A. Respondent's specific acts of malpractice are as follows, but not limited to: 1) failing to justify the use, increase and decrease, and then subsequent increases in dosages of Patient A's medication; 2) prescribing a combination of controlled substances without documenting the medical justification or rationale; 3) failing to review the PMP report prior to, during, and after the encounters with Patient A; 4) failing to assess Patient A's concurrent medication interactions; 5) failing to assess Patient A for possible drug abuse, drug diversion or any other non-medical related activity; 6) failing to assess Patient A for possible drug screens on a consistent basis; and, 7) failing to diligently monitor potential medication interactions in Patient A's changing treatment plans.

19. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

20. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

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21. NRS 630.3062(1)(a) provides 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.

22. As demonstrated by, but not limited to, the above-outlined factual allegations, Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A. The medical records for Patient A were inaccurate and incomplete due to his lack of diligence in documenting the medical justifications and rationales for all of his prescribing of various different medications for Patient A. As well as, the lack of documenting his request and receipt of the PMP reports for Patient A from the Nevada Board of Pharmacy. Further, Respondent failed to document important details regarding Patient A's medication changes, symptomatology, psychiatric history, and medical history.

23. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this matter as outlined in NRS 622.400.

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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6. That the Board take such other and further action as may be just and proper in these premises

DATED this 26th day of October, 2021.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

ROBERT G. KILROY, J.D.
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VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 26th day of October, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

BRET W. FREY, M.D.
Chairman of the Investigative Committee

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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

2 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

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

4 That's correct.

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

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

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

12 *Yes.*

13 *Q. And does that continue like that?*

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

P.57

8 . . . 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

1 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.

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

8 It would be.

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

11 *Correct.*

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

P.59

1 *Yes, I did.*

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

4 *Yes, I did.*

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

7 *I don't think always, no.*

8 *Q. Sometimes?*

9 *Yes, possibly.*

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

12 *Right.*

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

15 *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.
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?*
I guess that's correct, yes.
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
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?
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?
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?
It can be off-label.

P.121
Q. Is it your testimony that you did not see depression as a diagnosis in this patient's -- in the notes that you reviewed?
Her main diagnosis was bipolar disorder.
Q. I didn't ask about main.
A person with bipolar disorder, there is depression, and there are periods of mania or hypomania.
Q. So there was depression, correct?
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?
Yes.
Q. *You already testified that sometimes you can use Adderall to treat depression; is that correct?*
It would be off-label use.
Q. *But acceptable use?*
With good reason.
Q. *Is that a yes?*
With good reason.

P.122
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
No.
Q. Okay. You're just saying the records did not reflect some discussions that you would have liked to see; is that correct?
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.

---

[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.

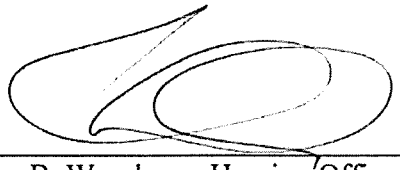
NRS 630.3062(1)(a) states that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment, and care of a patient is grounds for initiating disciplinary action against a licensee. While there are a number of questions in the evidence of this case 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

3

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

In The Matter of Charges and Complaint Against:	)	
MATTHEW OBIM OKEKE, M.D.,	)	CASE NUMBER 21-22461-1
Respondent.	)	

REPORTER'S TRANSCRIPT OF PROCEEDINGS

MONDAY, SEPTEMBER 12, 2022

[APPEARANCES CONTINUE ON THE NEXT PAGE]

REPORTED BY: SHARON CAHN, CCR NO. 985

APPEARANCES OF COUNSEL (CONTINUED):

HEARING OFFICER: CHARLES WOODMAN

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ALSO PRESENT: MATTHEW OBIM OKEKE, M.D.
Respondent

RYAN SWANK, Investigator

GEORGE J. TUIOTI, Investigator

INDEX FOR MONDAY, SEPTEMBER 12, 2022

ADMINISTRATIVE HEARING

INDEX OF WITNESSES

EXHIBITS

MONDAY, SEPTEMBER 12, 2022; 9:00 A.M. - 1:09 P.M.

* * *

HEARING OFFICER WOODMAN: Let's go on the record. This is in the matter of charges and complaint against Matthew Obin Okeke, M.D., Respondent. This is State Medical Board of Examiners Case Number 21-22461-1.

Ms. Bradley is here as counsel for the Investigative Committee of the Board.

Mr. Agwara, are you there with your client?

MR. SWANK: Would you like me to bring them in?

HEARING OFFICER WOODMAN: Yes, please.

Good morning, Mr. Agwara and Dr. Okeke.

Can you both hear me all right?

MR. AGWARA: Yes, we can.

HEARING OFFICER WOODMAN: Good morning. I'm Charles Woodman. I'm the hearing officer assigned to this case. The Court Reporter is actually there with you at the Board of the Southern Nevada office. Present with me in the Northern Nevada office is Ms. Bradley, counsel for the investigative committee of the Board.

We are on the record, and before we get into the IC's case, Mr. Agwara, is that the best way to

pronounce your name?

MR. AGWARA: Yes.

HEARING OFFICER WOODMAN: Are there any housekeeping or other issues that you want to address before we get started?

MR. AGWARA: I was just wondering if you could explain the process for Dr. Okeke. I believe this is his first formal hearing. In other words, what will happen after today, and just procedural.

HEARING OFFICER WOODMAN: I understand. Very good. So Dr. Okeke, what will happen is Ms. Bradley, who is counsel for the Board's Investigative Committee will present her case. She will call witnesses. Your counsel, Dr. Okeke, Mr. Agwara, will have the opportunity to cross-examine those witnesses.

When Ms. Bradley rests her case, your attorney, Mr. Agwara, will have the opportunity to present any evidence that he wants to present. The Board, the IC, has the burden of proof here. So it is not required that any defense case on your behalf, Dr. Okeke, be presented, but that's up to you and your counsel. And after you present any witnesses, of course, Ms. Bradley will have her opportunity to cross-examination just like your attorney can cross-examine her witnesses.

At the end of the presentation of evidence, then the attorneys will have the opportunity, if they choose, to argue what their evidence -- what they think it should mean to me as the hearing officer.

After everyone concludes, I will take the case under submission. We will all get transcripts of the entire proceeding, and then I will make a decision in terms of what I believe the evidence tells me, and I send that decision to the state Board.

Of course, Dr. Okeke, you and your attorney will receive that, and it's essentially a recommendation on my part on what the State Board should decide. Obviously, the IC through their counsel will receive it as well, and then that matter will be brought up at one of the upcoming hearings of the State Medical Board, and at that point, there are opportunities to object to my recommendations, to appeal the Board's decision, et cetera.

Is that helpful?

DR. OKEKE: Yes.

MR. AGWARA: Yes.

HEARING OFFICER WOODMAN: Very good. With that, we will go ahead and proceed.

Ms. Bradley, you have the floor. You may call your first witness.

MS. BRADLEY: Mr. Hearing officer, may I make a brief opening statement?

HEARING OFFICER WOODMAN: You can make an opening statement. Mr. Agwara, since counsel for the IC wants to make an opening statement, you'll have the same opportunity to do so. You can decide to make that opening statement either right after Ms. Bradley makes hers, before she calls her first witness, or you can choose to make an opening statement at the beginning of your evidence if you choose to present any evidence.

All right?

MR. AGWARA: Thank you.

HEARING OFFICER WOODMAN: Ms. Bradley, please.

MS. BRADLEY: So the case we're at here today for is -- the Complaint alleges two counts. The first count is malpractice. The concerns that the Investigative Committee has regarding the treatment of the patient in this case is that Respondent failed to justify the use, increase and decrease, and then subsequent increases of doses of Patient A's medication. That the Respondent prescribed a combination of controlled substances without documenting the medical justification or rationale. Respondent failed to review the PMP report prior to, during, and after the encounter with Patient A. Failed to assess Patient A's concurrent medical

interaction. Failed to assess Patient A for possible drug abuse or diversion or any other non-medical-related activity, particularly knowing that the patient had a history of substance abuse in the past. Failing to assess Patient A for --

THE REPORTER: I'm sorry, Counsel. Can you read slower, and are you saying "Patient A"?

MS. BRADLEY: Yes.

HEARING OFFICER WOODMAN: Ms. Reporter, for confidentiality purposes, the patient or patients in question are referred to as Patient A, as in the letter A. If there were any other patients, they would be B, C, et cetera, and that's how we refer to the subject patient in the case.

THE REPORTER: Thank you.

MS. BRADLEY: And lastly, failing to diligently monitor potential medical interactions in Patient A's changing treatment plan.

The other counts that the Investigative Committee has alleged has to do with records. Specifically, that Respondent failed to maintain medical records that were timely, legible, accurate, and complete. We will hear from Dr. Chen regarding multiple counts, and I do think the medical records here, in her opinion, we're going to hear are more than just slightly

lacking. They're seriously lacking. Throughout her review of this case, she had concerns regarding documentation regarding Patient A's care, and so that is the other allegation that we believe will be proven in this case.

HEARING OFFICER WOODMAN: Very good. Thank you, Ms. Bradley.

Mr. Agwara, do you want to make an opening statement now, or wait until the presentation of any evidence you want to bring today?

MR. AGWARA: Mr. Woodman, I'd rather do it now, but before I do, can -- I don't know the people in the room with us here. I just know the Court Reporter. Can we know the names and the role of all the people in here with us?

HEARING OFFICER WOODMAN: That does not seem to be an unreasonable request. So I've got a limited view. I can only see counsel table there with Mr. Agwara and Dr. Okeke, as well as two people sitting behind them. I believe there are some other representatives of the Board of the IC there helping us out. Am I wrong?

MS. BRADLEY: We do have an investigator in the room. Investigator Ryan Swank is there.

The two witnesses sitting in the back of the room, they are not witnesses, and they are not Board

employees. The hearings are opening to the public, and I believe they're just representatives of one of the participating agencies.

HEARING OFFICER WOODMAN: Are you folks there sitting in the back behind Mr. Agwara and Dr. Okeke, are you folks who are just members of the public who want to hear this hearing?

MS. POLITSOPOULOS: We're here from DEA.

HEARING OFFICER WOODMAN: And ma'am, what is your name, and spell it, please.

MS. POLITSOPOULOS: Investigator Politsopoulos. P-O-L-I-T-S-O-P-O-U-L-O-S.

HEARING OFFICER WOODMAN: So the common spelling. Thank you, Ms. Investigator. And to your left, at least according to the way I see it on the screen, the other gentleman who is there.

MR. LOVELL: Rob Lovell, L-o-v-e-l-l, and I'm a contractor with DEA.

HEARING OFFICER WOODMAN: Okay. Thank you very much. Very good. Who is the other person, the other investigator there?

MS. BRADLEY: I believe Investigator Swank is in the room.

INVESTIGATOR SWANK: That's me.

HEARING OFFICER WOODMAN: Anybody else there?

INVESTIGATOR SWANK: No, sir.

HEARING OFFICER WOODMAN: All right.

Mr. Agwara, if you want to make your opening statement, please.

MR. AGWARA: Thank you, Mr. Woodman.

Dr. Okeke is not here today to fight with the Board or the IC. To the extent that evidence shows mistakes, he will acknowledge those mistakes. To the extent that there's a difference between the State's expert and Dr. Okeke regarding judgments made as a physician, we intend to point those out. And for whatever mistakes that may be evidenced at this hearing, he has taken steps to correct those, and will be -- he has made a lot of changes in his practice.

And as the hearing proceeds, I believe the Hearing Officer will be hearing from Dr. Okeke regarding those changes. He's also taken over 30 hours of continuing medical education courses in areas regarding detecting substance abuse, and in other areas, and I will give, toward the end of the hearing, I will give a list of those courses that he has taken as a way to make sure that any mistakes that were made will not be repeated in the future.

I just wanted to put that on the record that this is not as adversarial as it may look. We're here

with the hope that going forward, mistakes that were made will be corrected or have been corrected and so these mistakes won't happen again.

HEARING OFFICER WOODMAN: Thank you, Mr. Agwara.

One other item that we just discussed between me and the Court Reporter, who is there with you, before you came into the room, is that our Court Reporter has a hard break today at 1:00 o'clock. She is done at 1:00.

Ms. Bradley let me know that there's a backup reporter, if we need a backup reporter. So depending where counsel is in the presentation of the evidence, it's possible that we may go through the lunch hour, if that works for everyone, to try to wrap up by 1:00 o'clock. If that doesn't look realistic, we'll take a break at the lunch hour and come back with the backup Court Reporter, and put the rest of the case on.

It doesn't matter to me. I just want to make sure everybody has ample time to present their evidence, and again, we'll check on that going into the lunch hour to see where we are.

So with that, Ms. Bradley, you may call your first witness.

MS. BRADLEY: I will call Ernesto Diaz.

HEARING OFFICER WOODMAN: Mr. Diaz is here in the Northern Nevada office.

Ms. Reporter, I know that you can't see him, or you might be able to see him, I'm not sure, but will you please swear in Mr. Diaz.

ERNESTO DIAZ,

having been duly administered the oath

was examined and testified as follows:

HEARING OFFICER WOODMAN: Very good. All right. Ms. Bradley.

DIRECT EXAMINATION

BY MS. BRADLEY:

Q. Mr. Diaz, will you please state your name and spell your last name for the record?

A. My name is Ernesto Diaz. My last name is D-i-a-z.

Q. And who is your employer?

A. I'm employed by the Nevada State Board of Medical Examiners.

Q. What is your job title?

A. My position is Chief of Investigations.

Q. How long have you had that position?

A. Approximately two and a half years.

Q. Do you have any other investigation experience?

A. I do.

Q. Could you tell us about that?

A. I was a special agent with the Department of Justice, Bureau of Alcohol, Tobacco, Farms, and Explosives. I was a Border Control Agent under then-Immigration and Naturalization Service for approximately 25 years.

Q. As the Chief of Investigations for the Nevada State Board of Medical Examiners, what are your duties?

A. As the Chief of Investigations, I review all complaints that come to the Board. I review them for jurisdiction. If they're within our jurisdiction and the individual is a licensee of the Board, I will open up the investigation and assign it to investigators. I also do reporting for disciplinary actions.

Q. Do you supervise the investigators?

A. I do.

Q. And the investigation is done that they are conducting?

A. Yes.

Q. And when a complaint comes in, what happens?

A. I review the complaint. If we have jurisdiction, we open up a new investigation, assign it to an investigator, and then go through our investigative process.

Q. Part of that process would be creating a file for that case?

A. That's correct; a case file.

Q. Are you familiar with the case file in this case? And just for the record, it's 19-19202?

A. I am.

Q. Who was the original investigator on this case?

A. Kim Friedman.

Q. Is Ms. Friedman still employed with the Board?

A. No, she's not.

Q. Did you take over this case then?

A. I did.

Q. As the Chief of Investigations, are you familiar with the procedure that the Board uses when investigating cases?

A. Yes, I am.

Q. Have you reviewed the file for this case?

A. I have.

Q. Based on your review, does this case appear to be similar to other investigations conducted by the Board?

A. Yes, it does.

Q. For the record, let's go ahead and look at the exhibits in this case. I believe there are copies of

exhibits there on the table in a binder, and I think there's also a copy for the Court Reporter, most likely.

Just for the record, we have pre-marked exhibits 1 through 15. I'm hoping that we can agree to the admission of 1, 2, 3, 4, and 5. Because those are all documents that have been sent to Dr. Okeke, and his attorney, and then his responses.

So I'm asking if Mr. Agwara will stipulate to the addition of 1 through 5. 1 is the formal complaint. 2 is Dr. Okeke's answer to the formal complaint. 3 --

MR. AGWARA: There's no need to read. We can stipulate. That's fine. As a matter of fact, we can include 6 also.

MS. BRADLEY: Okay. We'll stipulate to the admission to the Exhibits 1 through 6 then.

MR. AGWARA: Yes.

HEARING OFFICER WOODMAN: IC's Exhibits 1 through 6 are admitted.

MS. BRADLEY: Thank you.

MR. AGWARA: Going forward, just to make this time efficient, if there are factual things that counsel would like to ask if I agree or not, the chances are that we are going to agree more today than we are going to disagree. So if you want to do like what you just did now, that will save us time.

MS. BRADLEY: Okay. If I could, just for the record, I want to put into the record what 1 through 6 are.

So 1 is the filed formal complaint. It was filed October 26, 2021, by the Investigative Committee.

Exhibit 2 is the Respondent's answer to the formal complaint, and that was filed on January 11, 2022.

Exhibit 3 is the Board's allegation letter that was sent to Respondent dated December 19, 2019.

Exhibit 4 is the Board's allegation letter to Respondent and second request; that was dated January 13, 2020.

And then No. 5 is the Respondent's response to the Board's allegation letter. Now, it's dated January 14, 2019. I believe that's a typo, though. I believe it's actually 2020. We all know that sometimes when we get into January, we don't always switch over as quickly as we should to the new year, so I think it's a typo, and it should be 2020.

We've also agreed to Exhibit 6, which is an order to produce health care records, and that was dated December 19, 2019.

Q. Okay. So let's turn to Exhibit 7 in the Board's exhibits, Mr. Diaz.

Do you recognize Exhibit 7?

A. I do.

Q. Okay. What is it?

A. It's a Subpoena Duces Tecum to the Las Vegas Metropolitan Police Department.

Q. Is this a true copy of the Subpoena Duces Tecum that's in the Board's file for this case?

A. Yes, it is.

Q. What's the date on that?

A. December 31st, 2019.

MS. BRADLEY: I would ask that Exhibit 7 be admitted.

HEARING OFFICER WOODMAN: Any objection, Mr. Agwara.

MR. AGWARA: I would like to know the relevance.

MS. BRADLEY: Mr. Diaz just testified that this was something that was prepared, and it's in the Board's file for this case. I think that's the relevance. In a sense, it's part of this investigation.

HEARING OFFICER WOODMAN: So Mr. Agwara, any reply to the fact that it's relevant because it's a key -- I think it would appear to be a key discovery item for this case?

MR. AGWARA: Let me see. I'll keep my objection, and of course, you can overrule it. I just don't see

how it's related to the disciplinary complaints in the actual complaint.

HEARING OFFICER WOODMAN: I'm going to admit it, essentially based on my history and experience with these hearings. I have a feeling, I could be wrong, but I know where Ms. Bradley is going with this. So I will admit I had provisionally, and holding onto the objection that if for whatever reason I find it's not relevant, I will clarify that for the record.

MR. AGWARA: Thank you.

BY MS. BRADLEY:

Q. So let's turn to Exhibit 8 then, Mr. Diaz.

Do you recognize this document?

A. I do.

Q. What is it?

A. It's a report of a psychological assessment of Patient A.

Q. Who was this prepared by?

A. These would be records that we obtained from Dr. Matthew Okeke and Brian Baudiun.

Q. If we go to the last page of the document, it appears that it was prepared by Dr. Okeke and Brian --

A. That's correct.

Q. Is this a true and correct copy of what the Board received?

A. It is.

MS. BRADLEY: I would ask for admission on Exhibit 8?

HEARING OFFICER WOODMAN: Any objection, Mr. Agwara?

MR. AGWARA: No objection.

HEARING OFFICER WOODMAN: 8 is admitted.

MS. BRADLEY: Can we turn to Exhibit 9, Mr. Diaz.

Q. Do you recognize this document?

A. I do.

Q. What is it?

A. It is a Clark County Coroner's Autopsy Report on Patient A.

Q. What's the date on this report?

A. August 23rd, 2019.

Q. How did the Board receive this document?

A. We sent an order, a Subpoena Duces Tecum to request a copy of the Autopsy Report of Patient A.

Q. Is this a true and correct copy of what the Board received?

A. That's correct.

MS. BRADLEY: Based on Mr. Diaz's testimony, I would ask that Exhibit 9 be admitted.

HEARING OFFICER WOODMAN: Mr. Agwara, any

objection to 9?

MR. AGWARA: Yes. Same objection, relevance. And also, to the extent that the chief investigator is testifying, is he testifying to the authenticity of this document, or is he testifying as a custodian of records? I don't understand. Did he author this document? Or is he the one that received it?

MS. BRADLEY: Mr. Diaz has testified as to the authenticity of the records that are in the Board's file for this investigation.

He's testifying that this is a true and correct copy of what the Board received in response to a request as part of the investigation. As far as relevance goes, it was alleged in the complaint that Patient A did pass away. Page 4 of the complaint, Factual Allegation 14. So this exhibit just goes to support the fact that she did pass away, and the Clark County Coroner made some determinations regarding that, as alleged in the complaint.

We're not saying that Mr. Diaz authored this, but that the Board received it as part of this investigation.

HEARING OFFICER WOODMAN: Mr. Diaz, is that accurate, as part of the IC's investigation, this Coroner's Report was received by the IC's Court Ordered

Investigation Group?

THE WITNESS: That's correct. It was received December 30th, 2019.

HEARING OFFICER WOODMAN: So here's what I'm going to do, because of the allegation in the complaint, I'm going to admit 9 provisionally, also, along with 7, which has been admitted provisionally. Based on the evidence that I hear going forward, I'll either determine that 9 is definitely part of the record, or we'll re-address it depending on what I hear.

MR. AGWARA: Just to be clear. Mr. Diaz is also testifying as a custodian of records?

MS. BRADLEY: He's testifying as a staff member of the Board. The investigator who originally handled this case is no longer employed by the Board. Mr. Diaz testified that he supervises the investigators and that he took over this matter. However, I would say it was completed in its investigation stage. He's taken over it for the purposes of reviewing the file, testifying here today, and authenticating what is in the Board's file in the case.

MR. AGWARA: Ms. Bradley, I'm not arguing with you. I just want it for the record. If he's not testifying as a custodian of records, can we put that on the record that he's not?

MS. BRADLEY: Okay. I think the only person that's a custodian of records for the Board is the Executive Director, who is upstairs. So yeah, we can put that on the record that he is not a custodian of records.

MR. AGWARA: Thank you.

MS. BRADLEY: But I think he can testify to what's in the Board's file for an investigation that he took over after an employee left.

HEARING OFFICER WOODMAN: I believe Mr. Woodman has ruled on the admission anyway.

HEARING OFFICER WOODMAN: That's correct. I appreciate your point, and I'm not sure, again, the evidence that I hear going forward will help me make a determination as to whether Mr. Diaz's testimony comes in, in part, as a custodian of records. To a certain extent, there is that element; whether that's going to make a difference or not, I have to see what I hear.

MS. BRADLEY: Mr. Diaz, will you turn to Exhibit 10.

Q. And do you recognize this document?

A. I do.

Q. And what is this?

A. This is a Prescription Monitoring Program query of Patient A and the types of narcotics that

Patient A was prescribed.

Q. For the record, are you familiar with the PMP?

A. I am.

Q. That's the acronym that we use for Prescription Monitoring Program?

A. That's correct.

Q. What is the PMP?

A. PMP is a Nevada State Board Pharmacy database that is utilized for health care providers that can prescribe narcotics. Basically, it was enacted to monitor and ensure the prescribing is done within the law and safely. It's also used by licensees to self-query themselves to make sure their prescription pad is installing, for example, and it's also used for querying patients to see what kind of medications they are receiving and if they are receiving from other providers as well.

Q. Do Board investigators have access to the PMP?

A. Yes.

Q. Why would a Board investigator review a PMP Report in an investigation?

A. To determine the types and frequency of narcotics that a patient has been prescribed. A lot of times, that can help in diversion investigations with prescriptions as well.

Q. How does the Board receive what's been pre-marked as the Board Exhibit 10?

A. Investigator Friedman utilized her access to the PMP program, and queried Patient A's prescriptions for that period of time.

Q. Is this a true and correct copy of the report that was generated by Investigator Friedman?

A. Yes, it is.

Q. And that is what's in the Board's investigation file?

A. Yes, it is.

MS. BRADLEY: Based on Mr. Diaz's testimony, I ask that Exhibit 10 be admitted.

HEARING OFFICER WOODMAN: Mr. Agwara, any objection to Exhibit 10?

MR. AGWARA: Yes. I want to object to 10 on the same grounds, and this time more strenuously. If he is not testifying at the custodian of records, he cannot authenticate this document, and he seems to be doing it.

HEARING OFFICER WOODMAN: Ms. Bradley.

MS. BRADLEY: I guess I would say, early on, Mr. Diaz testified that he supervises the investigators. Investigator Friedman left the Board's employment, and he's taken over her file. He can testify that he reviewed her file. He's familiar with the contents in

the investigative file. He's familiar with the processes used and the things that investigators would do to investigate cases, and so, I will agree. He did not do this investigation, but he's the boss of the person who did, and he has taken over that file, and he's going through the documents contained in that file, you know, for the purposes of this hearing. I don't have any other response to that.

HEARING OFFICER WOODMAN: Isn't it true that under these circumstances where he did not do the investigation, but oversees the person who did, to the extent he's testifying as to, at least some of these exhibits, as a custodian of records because he knows the process by which they are acquired and kept and preserved, correct?

MR. AGWARA: Mr. Woodman, I object to the statement that you just made. Please let Ms. Bradley defend her case. She put it on the record a few minutes ago that Mr. Diaz is not testifying as a custodian of records.

HEARING OFFICER WOODMAN: Your objection is noted, but I already stated that because of what I just articulated a little more in depth, to a certain extent, I see Mr. Diaz, in part here today, as effectively a custodian of records. And because of that, as I

understand the process whereby, again, he supervises investigators. He knows the drill. He knows how these things are put together.

And I will ask this question: Mr. Diaz, from everything that you have seen in this case, have you noted any irregularity in the preservation of the investigation file that previously belonged to your reporting investigator, and from the time that she was handling the investigation -- I think it was a she, correct?

THE WITNESS: Correct.

HEARING OFFICER WOODMAN: -- until today, as the investigation has come back in your full direction, is there anything irregular or anything at all we should discuss about the receipt and/or preservation of these records?

THE WITNESS: No.

MR. AGWARA: Objection, again.

THE WITNESS: Our investigations have a process. Investigator Friedman conducted that process exactly as we do in all our investigations. She documented everything that she did, from sending out requests for records, to receiving documents. Everything was very detailed. I double-checked in our investigative database. I double-checked in the case file. And this

investigation is common and regularly done as all the other ones were. There are no irregularities.

HEARING OFFICER WOODMAN: All right. Based on that then, Mr. Agwara, your objections are noted. Same thing. I'm going to provisionally admit 10 based on what I know about the allegations in the complaint, and I haven't looked at Exhibit 10 substantively at all. So depending on the evidence that I hear going forward, I'll make a decision, yes, it's absolutely admitted, or I'll pull back that provisional admission that I'm making at this time.

MR. AGWARA: I was going to point that out. You can overrule my objection. That's fine. What I'm also objecting to is asking the witness questions that tend to point to whether or not you want to authenticate him as a custodian of records. And the reason I object to that is because his own lawyer, Ms. Bradley, has stated on the record that he's not testifying as a custodian of records. I just want to make that clear.

HEARING OFFICER WOODMAN: That is clear. It's just that she's calling him, I believe, as a substantive witness. We'll see that going forward. I'm just stating my own personal opinion, which I think has legal validity to it, which is to a certain extent because he was not the investigator who did this, but he does

oversee that investigator. I find him in a situation to an extent, he is the custodian of records.

So I can disagree with Ms. Bradley on that point, and I don't think it makes a significant difference. In any event, I made the ruling that I made. Ms. Bradley, you can continue.

MS. BRADLEY: Mr. Diaz, will you please turn to Exhibit 11.

Q. Do you recognize these documents?

A. I do.

Q. And what are they?

A. These are medical records that we received at the request of an order Investigator Friedman sent out.

Q. Where are they from?

A. Grand Desert Psychiatric Services.

Q. Do these documents appear to be true and correct copies of the records that were received by the Board and contained in the Board's investigative file?

A. Yes, they do.

Q. And were these received from Dr. Okeke?

A. Yes.

MS. BRADLEY: Based on Mr. Diaz's testimony, I would ask Exhibit 11 be admitted.

HEARING OFFICER WOODMAN: Mr. Agwara, objections to 11?

MR. AGWARA: No.

HEARING OFFICER WOODMAN: All right. 11 is admitted.

MS. BRADLEY: Mr. Diaz, please turn to Exhibit 12.

Q. Do you recognize these documents?

A. I do.

Q. What are they?

A. These are Patient A's medical records from Montevista Hospital.

Q. How did the Board receive these records?

A. Investigator Friedman sent an order to receive health care records on December 31st, 2019. The Board subsequently received them on January 9, 2020.

Q. Do these documents appear to be true and correct copies of the records that were received in this investigation as requested by Investigator Friedman?

A. Yes.

MS. BRADLEY: Based on Mr. Diaz's testimony, I ask that Exhibit 12 be admitted.

HEARING OFFICER WOODMAN: Mr. Agwara?

MR. AGWARA: I'll object on the grounds of relevance.

HEARING OFFICER WOODMAN: So on 12, from what I'm hearing, I'm going to hold off until we get some

foundation, some substance, and I'll rule on 12.

MS. BRADLEY: Okay. Exhibit 13.

Q. Mr. Diaz, will you please turn to that.

A. Okay.

Q. Do you recognize Exhibit 13?

A. I do.

Q. What is Exhibit 13?

A. Exhibit 13 is a request for records that we sent to Sunrise Hospital, and it includes the records that they provided for Patient A.

Q. Do these documents appear to be a true and correct copy of the records that were received by Ms. Friedman as part of the investigation?

A. Yes, they are.

MS. BRADLEY: Based on Mr. Diaz's testimony, I ask that Exhibit 13 be admitted.

HEARING OFFICER WOODMAN: Mr. Agwara?

MR. AGWARA: Same objection; relevance.

HEARING OFFICER WOODMAN: All right.

MS. BRADLEY: I would say that 12 and 13 are relevant in that they were documents received regarding Patient A as part of the investigation. They show Patient A's history, as alleged in the Complaint. She had a complicated mental health and other history, and she did subsequently pass away. And I believe some of

these records are regarding that as well.

HEARING OFFICER WOODMAN: I'm going to make the same statement with 13 as I did with 12. Once I hear some substantive testimony -- the reality is, I anticipate that the IC is able to show that they're relevant, but I'm going to hold off on ruling until I hear some substance to make sure they are relevant.

MS. BRADLEY: Mr. Diaz, will you turn to Exhibit 14, please.

Q. Do you recognize Exhibit 14?

A. I do.

Q. What is Exhibit 14?

A. Exhibit 14 are the Peer Review materials references that a peer review is in writing, their Peer Review report, when the Board requests a peer review be conducted.

Q. How does the Board receive Exhibit 14?

A. Peer Review materials and reference materials are included with a peer-review report. It is written by a peer reviewer.

Q. So these were sent by Dr. Chen?

A. Yes.

Q. Do these appear to be a true and correct copy of the items Dr. Chen sent to the Board after she reviewed them?

A. Yes.

MS. BRADLEY: If you would turn to Exhibit 15.

Q. Do you recognize Exhibit 15?

A. I do.

Q. What is Exhibit 15?

A. Exhibit 15 is a Curriculum Vitae of Dr. Chen, and it is also provided as part of the Peer Review Report.

Q. We also have a list of peer reviewers that the Board uses with their CV?

A. Yes. When we first obtain someone that's going to do a Peer Review for the Medical Board, we ask they provide a CV that states their training, experience, and qualifications.

Q. Does this appear to be a true and correct copy of the Curriculum Vitae that the Board has on file for Dr. Chen?

A. Yes.

MS. BRADLEY: Thank you. I have no further questions for Mr. Diaz at this time.

HEARING OFFICER WOODMAN: Thank you, Ms. Bradley. Mr. Agwara, questions of Mr. Diaz?

MR. AGWARA: First of all, I didn't hear Ms. Bradley request that either Exhibit 14 or 15 be admitted. So I'm assuming that she's not offering them

as evidence.

MS. BRADLEY: I'm not offering them as evidence at this time. I intend to have a subsequent witness authenticate them further so they could be admitted.

MR. AGWARA: Okay. Thank you.

CROSS-EXAMINATION

BY MR. AGWARA:

Q. Mr. Diaz, can you explain what it is your job entails?

MS. BRADLEY: I'm going to object. I think that's been asked and answered. He's already talked about his job duties with regard to his position on the Board.

HEARING OFFICER WOODMAN: I'm going to overrule it and let him explore it a little bit.

Go ahead, Mr. Agwara.

MR. AGWARA: Thank you.

THE WITNESS: Sure. As Chief of Investigations, I oversee two deputy chiefs and seven investigators. We had an office in Las Vegas with a deputy chief and three investigators. My primary role of chief investigations is to oversee the Investigations Division of the Medical Board. That also includes reviewing complaints that are filed with the Medical Board. Determining if there's jurisdiction to open an investigation. Open an investigation. Assign those to investigators. In

addition, I also assign cases to myself, and I work investigations as a chief.

BY MR. AGWARA:

Q. Thank you. Would you say that your deputy investigators or deputy chief investigators, would you say that they are more familiar with individual cases that are being investigated than yourself?

A. If it's their investigation, they are the first-line investigator. I, as a supervisor, am the second-level reviewer. I review investigations; that's part of my duties as well, to make sure they're following the investigative process. I also approve certain things in an investigation, such as payments for records, payments for peer reviewers, et cetera. All those things I independently review in cases that require a second-level review.

Q. Was this case assigned to one of your deputies?

A. It was assigned to a senior investigator.

(Speaking simultaneously.)

BY MR. AGWARA:

Q. Was this case reviewed by one of your deputies?

A. No. It was reviewed by myself.

Q. Okay. Were you the one that actually received

any one of these documents that you testified to?

A. No.

Q. Did your office request that Ms. Friedman testify to that?

A. No.

Q. Is there a reason why?

A. I'm capable of testifying as a supervisor of investigations.

Q. That's the only reason you didn't ask Ms. Friedman?

A. No.

Q. What other reasons?

A. There was no reason to ask Ms. Friedman to testify in this case.

Q. Even though she was the investigator that requested all these documents?

A. That's correct. She's no longer with the Board.

Q. But she's still in Nevada?

A. I believe so. I haven't spoken to her since she left.

MR. AGWARA: Okay. No further questions.

HEARING OFFICER WOODMAN: Redirect?

MS. BRADLEY: No, thank you. I have none.

HEARING OFFICER WOODMAN: May Mr. Diaz be excused,

subject to recall?

MS. BRADLEY: I do not need Mr. Diaz anymore for my case in chief. I may need him for rebuttal, if I were to need a rebuttal case.

HEARING OFFICER WOODMAN: Okay. Mr. Diaz, I imagine you will make yourself available for rebuttal.

THE WITNESS: Yes.

HEARING OFFICER WOODMAN: Thank you, sir.

THE WITNESS: Thank you.

MR. AGWARA: Mr. Woodman, I drank a lot of water before we started. Can I get a quick bathroom break?

HEARING OFFICER WOODMAN: Yes. We'll go off the record for a few minutes and take a break.

(Recess taken: 9:48 a.m. to 9:53 a.m.)

HEARING OFFICER WOODMAN: Back on the record in the matter of the complaint against Matthew Okeke, M.D., Respondent.

We concluded with Mr. Diaz, the first witness for the IC.

Ms. Bradley, call your next witness.

MS. BRADLEY: I would call Dr. Jayleen Chen.

HEARING OFFICER WOODMAN: Can we adjust the camera, so Dr. Chen, who is here in the Northern Board, can see our Reporter in the Southern Board.

(Technical difficulties.)

JAYLEEN CHEN, M.D.,
having been duly administered the oath
was examined and testified as follows:

HEARING OFFICER WOODMAN: Thank you, Ms. Reporter. Ms. Bradley, you can go ahead.

DIRECT EXAMINATION

BY MS. BRADLEY:

Q. Dr. Chen, will you please state your name and spell your last name for the record?

A. Jayleen Chen, C-h-e-n.

Q. Are you licensed as a medical doctor in the State of Nevada?

A. Yes, I am.

Q. Okay. How long have you been licensed?

A. I had a limited license in --

THE REPORTER: I'm sorry, I can't hear her.

HEARING OFFICER WOODMAN: That's why I interrupted. I was going to check with you, Ms. Reporter, to see if you can hear her.

(Technical difficulties, and a discussion was held off the record.)

HEARING OFFICER WOODMAN: Ms. Bradley has moved the microphone and put it right in front of Dr. Chen.

Dr. Chen, do your best to be loud and proud so that our reporter can get you. And Ms. Reporter, I can see you now, so if you have a hard time hearing, just raise a hand, give me a sign, and we'll interrupt.

BY MS. BRADLEY:

Q. Dr. Chen, please state your name and spell your last name for the record?

A. Jayleen Chen, C-h-e-n.

Q. Are you licensed as a medical doctor in the State of Nevada?

A. Yes, I am.

Q. And how long have you been licensed?

A. I've been fully licensed since 2015.

Q. I think you said earlier that you had a limited license in Nevada?

A. Yes, when I was in my residency and fellowship, and that was 2010 to 2015.

Q. Are you certified by the American Board of Medical Specialties?

A. Yes, I am.

Q. What is your specialty?

A. I am Board-Certified in general psychiatry and child and adolescent psychiatry.

Q. What type of medicine do you practice in?

A. I practice psychiatry.

Q. And based on, I think, your Board specialty is with both adults and adolescents and children?

A. I prefer children and adolescents, but I do see adults as well.

Q. Let's look at first Exhibit 15, which we had Mr. Diaz testify that the Board received. I'm hoping that you have seen Exhibit 15 before.

A. Yes, I have.

Q. What is Exhibit 15?

A. That is my Curriculum Vitae.

Q. Is that something that you provided to the Board?

A. Yes, it is.

Q. Does it appear to be a true and correct copy of your Curriculum Vitae that you provided?

A. It is.

MS. BRADLEY: Based on Dr. Chen's testimony, I would ask that Exhibit 15 be admitted.

HEARING OFFICER WOODMAN: Mr. Agwara, any objection to Dr. Chen's CV?

MR. AGWARA: No.

HEARING OFFICER WOODMAN: Very good. Then, 15 is admitted.

BY MS. BRADLEY:

Q. Have you served as a peer reviewer for the

Board before?

A. I have.

Q. How many cases do you think you have reviewed for the Board?

A. I believe five different cases.

Q. How long have you been on the Board's peer review list?

A. I believe I started back in 2017.

Q. Are you familiar with Investigation 19-19202 regarding Dr. Matthew Okeke?

A. Yes, I am.

Q. Have you seen the Board's Exhibits 3 through 5, and I believe those are already admitted?

A. Yes, I have.

Q. You've seen those before?

A. Yes.

Q. And what about Exhibits 8 through 13? Those --

A. Yes, I've seen them all.

Q. Did you review Exhibits 8 through 13 when you did your review of this case?

A. Yes, I did.

Q. So based on -- and so part of your review was looking at these documents?

A. Yes. Correct.

Q. So that would include Exhibits 9 and 10, which were provisionally admitted, as well as 12 and 13, which were provisionally admitted; you did look at those?

A. Yes. Not as in-depth as Exhibit 12 and 13 because they were not information that I needed to review.

Q. So 12 and 13 were not as necessary for your review?

A. Yes.

Q. But you did review them?

A. Yes.

Q. I think that's helpful.

MR. AGWARA: Counsel, can you slow down. You guys are going too fast.

HEARING OFFICER WOODMAN: Ms. Reporter, can you hear Ms. Bradley? Ms. Bradley is a fast talker, and Dr. Chen is a soft talker, so we'll try to moderate that a little bit.

THE REPORTER: Thank you. Thank you, Counsel.

BY MS. BRADLEY:

Q. I wanted to just say then, Mr. Hearing Officer, I don't know if Dr. Chen's testimony changes your provisional admission of 12 and 13. She testified that she did review them, although maybe did not rely on them extensively in her review. So I wanted to bring

that up in case that changes the admission.

HEARING OFFICER WOODMAN: Are you going to get into any substance with Dr. Chen on 12 and 13?

MS. BRADLEY: No. I don't believe so. Primarily we're concerned with Exhibit 11, as well as Exhibit 8.

THE WITNESS: Can I add something? Exhibit 12, I did read the history, that was helpful. 13 was when she was in ICU, so kind of repetitive and not very helpful. So I think 12 was more important than 13.

MS. BRADLEY: I don't know if you heard that.

Dr. Chen is saying Exhibit 12 is helpful to her with the patient history more than Exhibit 13, but she did say that 12 helped her with understanding the history of the patient, and then 13 was repetitive for her, but she did look at it as well.

We're not going to rely overly on 12 and 13, but they are documents regarding Patient A that were reviewed in the case, so part of the reason we were trying to admit them is to ensure that everything that Dr. Chen relied on was in the record. That was my goal.

HEARING OFFICER WOODMAN: Before I give Mr. Agwara the opportunity to object. Dr. Chen, looking -- with reference to Exhibit 12 that you said was helpful to you, was there anything that you recall in Exhibit 12 that seemed -- I guess, I would say, where you read

something or saw something that made you question the validity of the record that you saw in Exhibit 12?

Is there anything that seemed out of the norm?

THE WITNESS: It's hard to recall everything that I read, but just glancing at it, I feel like it did provide a pretty thorough and comprehensive past history for her, the medications that were given to her in the past, and diagnosis. That was helpful for me.

HEARING OFFICER WOODMAN: I'm inclined to admit 12 for now.

Mr. Agwara, do you have any position on the admission of 12?

MR. AGWARA: If the test for admission is whatever it was helpful, then a lot of things would get admitted. If counsel doesn't intend to get into that exhibit for substance, like you initially asked, what's the point of admitting it?

MS. BRADLEY: I would respond to that by under 233(B) allows anything that is helpful. I can cite to the statute if you like, but it's a pretty relaxed standard for admission in administrative hearings, and it's generally something that's relevant and not unduly repetitive.

Again, if 13 isn't admitted, I don't know how much I care. I provided it because Dr. Chen reviewed

all these documents, and I was trying to make sure the record was complete out of fairness to Dr. Okeke because I think everything that was peer-reviewed and relied on and review should be in the record. That was my goal. I was trying not to hide evidence rather than provide too much. I will find the statute. Give me a second.

HEARING OFFICER WOODMAN: I know the statute that you're referring to.

MR. AGWARA: I don't disagree about what the statute says. All I'm saying is that the initial question that the Hearing Officer asked should determine whether or not it comes in. If you don't intend to ask any questions regarding that -- Mr. Woodman, I'll leave it up to you.

HEARING OFFICER WOODMAN: Thank you. I want to clarify the record. On 12 and 13 earlier, I actually did not provisionally admit those. I withheld my decision.

MS. BRADLEY: I apologize.

HEARING OFFICER WOODMAN: That's all right. I know you weren't trying to mislead me. I'll provisionally admit 12, but it's still subject to what I hear in the rest of the hearing.

Based on Mr. Diaz's testimony, and again, my own history with how things work in the IC's

investigations, I feel safe, especially under the relaxed evidentiary rules that we have in administrative hearing, 12 is admitted provisionally. I'll see ultimately whether that stays in or goes out, and I'm still holding back any decision on 13 at this point.

MS. BRADLEY: Thank you. Okay.

Q. So Dr. Chen, I think if we look at Exhibit 8, we can see some records from Dr. Okeke regarding Patient A. So my question for you would be, what was Dr. Okeke's diagnosis of Patient A?

A. It appears that the diagnosis from this assessment were Bipolar Disorder Type 1, Borderline Personality Disorder --

Q. If you could read a little slower. You're reading really fast.

A. Got you. So from the assessment, which was performed by the psychometrist, he agreed with the diagnosis of Bipolar Disorder Type 1 with Psychosis. Methamphetamine abuse. Alcohol dependency. And Borderline Personality Disorder.

MR. AGWARA: Was she reading from a particular page because this is Bates stamped?

MS. BRADLEY: We were looking at Exhibit 8. I'm not sure what page.

THE WITNESS: 32.

MS. BRADLEY: Page 32.

MR. AGWARA: That helps.

MS. BRADLEY: She was looking at Page 32 and talking about the diagnosis of Patient A.

HEARING OFFICER WOODMAN: And Dr. Chen, when you're reading, we tend to read fast, especially doctors do, and keep in mind, our reporter is trying to write down everything that you say, so you have to help her out.

THE WITNESS: I will. Sorry about that.

BY MS. BRADLEY:

Q. Dr. Chen, what is your overall opinion regarding Dr. Okeke's care of Patient A?

A. 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.

Q. When you say documentation, what do you mean by that?

A. 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.

Q. Okay. I think there's some conversation -- well, some use by Dr. Okeke of template material.

What is template material?

A. 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.

Q. Did you note Dr. Okeke's use of template material in notes?

A. 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.

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?

A. Yes. I would say so.

Q. So that's a pitfall for electronic records?

A. For sure.

Q. It's trying to help us, but it can fill in the same things?

A. Yes, unfortunately.

Q. So let's look at Exhibit 11. I believe these are the records from Dr. Okeke regarding Patient A, and I'm sure you have reviewed these records before.

A. Yes, I have.

Q. So this top visit, the first visit here, do you see the date on this page?

A. Yes. It is July 17th, 2017.

Q. Okay. If we go to the back, I think we'll go to the last visit probably. So if we go to NSBME 0242. Do you see that page?

A. Yes. That is dated August 19, 2019.

Q. Do you see who saw the patient on that day?

A. Yes. It was Deborah Perkins.

Q. So it doesn't look like Dr. Okeke saw her?

A. No.

Q. Let's go back to NSBME 0236?

A. That's still Deborah Perkins.

Q. Okay. Then if we go to NSBME 0229.

A. That was the psychologist.

Q. Vanessa Parker?

A. Yes.

Q. And then NSBME 0223?

A. Again psychologist.

Q. And again, I think it's the psychologist on NSBME 0217?

A. Correct.

Q. Okay. But if I go to NSBME 0215, was that Dr. Okeke?

A. Yes.

Q. What date is that visit?

A. May 30th, 2019.

Q. So then it looks like, if we look at the records starting from the beginning, it was July 17, 2017, that the patient saw Dr. Okeke, maybe all the way through May 30, 2019.

Does that sound right to you?

A. Yes.

MR. AGWARA: Objection. That doesn't reflect the record accurately. The last visit was 4/16/2019, not May.

MS. BRADLEY: Okay. Well, we're looking at a record that is NSBME 0215 on this exhibit. It says visit date 05/30/2019, attending physician, Dr. Okeke. Are you saying that's not an accurate record?

MR. AGWARA: Just a minute.

HEARING OFFICER WOODMAN: The objection will be

overruled because this document is admitted into evidence, and the record states what it states, but on cross-examination, Mr. Agwara, if you can challenge the credibility of that record, that's certainly going to be noted.

MR. AGWARA: That's fine. Go ahead.

BY MS. BRADLEY:

Q. So what is your opinion regarding Dr. Okeke's prescribing patterns for the patient in this case?

A. My opinion was that the prescribing was a little, I guess, sloppy. Again, there were rare occasions where I didn't really figure out why he was prescribing what he was prescribing, and what symptoms he was trying to target. And so upon reflection, I do remember that there were instances where the patient, kind of, stopped medications on her own or wanted to re-start, and I don't think there was a discussion how dangerous these behaviors could be. I also remember that there were times when she had requested certain medications, and it seemed like Dr. Okeke was willing to prescribe it without further exploration, or at least it was documented in the note.

Q. You prescribe medicine for your patients?

A. Yes, I do.

Q. When you talk about documentation, what would

you have expected to see documented regarding prescribing?

A. I would like to review whatever symptoms are relevant to the patient at that time. Insomnia, increased agitation, instability, poor focus; those are symptoms that I try to target with my medication and regimen. That would help guide me into what medication they choose, what doses I choose, and switching of any medication, I would put that in my note.

Q. You would note the symptoms the patient has?

A. Right.

Q. What medicines might treat that?

A. Right. I always have a list of current medications, and I walk through my treatment plan for decreasing or switching to a different medication than what I had put in my subjective history.

Q. In Dr. Okeke's care of Patient A, were medications changed in this nearly two-year period?

A. There were lots of changes in medications, and there's a running list of all the different medications that she'd been tried on in each of the notes.

Q. Let's look at maybe the first visit. Are you looking at the July visit?

A. Yes.

Q. This sounds like the first visit. Do you see

any discussion regarding prescribing in this visit?

A. In the treatment plan, it does mention medication management, and he discussed side effects and alternatives it looks like, but in the treatment medications --

MR. AGWARA: What page?

MS. BRADLEY: We are looking at NSBME 0043.

THE WITNESS: It's not always necessary to write a medication, but usually it's mentioned somewhere in the note.

BY MS. BRADLEY:

Q. Okay. Just so we're clear. You're looking at the treatment plan, and in the treatment plan part, he talks about medications?

A. Yes.

Q. And is there something that you think is lacking in this spot here?

A. I feel that it could have been helpful to understand why each of these medications were prescribed.

Q. Okay. If we look at treatment medications, are those things that she's going to start taking, or are those new ones, or how do we know?

A. That is why I was confused when I was reading the notes because of -- I don't know if --

THE REPORTER: I'm sorry to keep interrupting, but it's hard on this end when the mic is right by where you're flipping papers, and that's all we hear.

(Technical difficulties.)

MR. AGWARA: I haven't done a lot of depositions. This is advisory on my part. It may look like you're having a conversation with counsel, but actually, remember it's more important that we hear you. She can hear you sitting right next to you, but it's not a conversation that you're having.

HEARING OFFICER WOODMAN: And again, by nature, I can tell you're soft spoken, which is fine, but especially for our Court Reporter who is in Clark County, and obviously, Dr. Okeke and his attorney have to hear you. Try to avoid speaking when you're turning pages because that microphone is right there, and that comes across as very loud.

MS. BRADLEY: I'm sorry. I'm asking her to look at pages.

HEARING OFFICER WOODMAN: Right. So if she asks you to flip to a page, go ahead and do it before you start talking.

MS. BRADLEY: Okay.

Q. I think we were talking about NSBME 0043, the treatment plan and the treatment medications, and you

said you had some confusion.

A. 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.

Q. Let's go ahead and look at the next visit. So that's NSBME 0045?

A. Yes.

Q. So looking at this visit, do you have concerns regarding the documentation here?

A. So I guess this is where I can recall my train of thought. If you compared this note to the next note, it looks like maybe the copy/pasting may have taken effect as the body of the chief complaint is similar, if not verbatim, of the visit before.

Q. I'm looking at August 14, 2017, and you're saying it's the same as the previous one or the one that comes next?

A. The next one.

Q. I'm trying to make sure the record is clear. NSBME 0045 is August 14, 2017, and you mentioned the chief complaint?

A. Yes. Of course, the medication was injected in a different spot, but the rest of the body of the

chief complaint is similar.

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

A. That's correct.

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

A. 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?

A. Yes.

Q. And does that continue like that?

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

Q. So 11/6, just for the record, is NSBME 0060, and 12/4/2017 is NSBME 0065. Okay.

So, and I guess, I would want to compare that with what would you expect to see in a visit note?

A. Maybe just some minor differences. I'm sure not everything was touched upon that it could have been. Just something different.

Q. So it sounds like then, at least in your practice, it would be uncommon to have the chief complaint listed the same way in each visit?

A. Right.

Q. Okay. I think we were talking about prescribing patterns, and you testified that there was lack of documentation, and I was hoping that we could find examples in the records where you would like to have seen more documentation?

A. Unfortunately, it's been a while since I was able to review these notes, but 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.

Q. So if a patient is on a certain medication, right? Let's use an example of one that the patient was taking here.

What was one that she was taking?

A. Just from my notes, I don't know if there's a note from 10/8/2014.

Q. 10/8/2014?

A. Right.

Q. I don't think she started seeing him until 2017. That might have been Exhibit 12. I mean, we can talk about it in general then.

If a patient is on certain medications, what would you do to increase the medication?

A. 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?

A. It would be.

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

A. Correct.

Q. How does it work for decreasing?

A. I guess, for example, if I saw that there were more side effects with an increased dose and the patient felt better at a lower dose or did get some efficacy, I might try decreasing the dose, or if there was a need to cross-taper off a medication and start another medication, I would decrease the dose for a certain amount of time while concurrently to trying a different medication to see if that could be more helpful with symptoms.

Q. Would that be documented in the notes?

A. Yes.

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

A. Yes, I did.

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

A. Yes, I did.

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

A. I don't think always, no.

Q. Sometimes?

A. Yes, possibly.

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

A. Right.

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

A. 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.

Q. How many patients do you normally see in your practice?

A. Probably 40 patients a week or more.

Q. So one of the reasons for good documentation is it helps you remember where the patient is at?

A. For sure, yes.

Q. Because you can't remember every individual one?

A. Yes.

Q. Do you have other people who work with you in your practice?

A. I do.

Q. So they may also see your patients?

A. Yes.

Q. So it would be helpful for them to know what's going on?

A. Right.

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?

A. 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.

Q. You mentioned cross-tapering earlier?

A. Yes.

Q. What does that mean?

A. If there is an instance where a patient is not responding well to one medication, it could be

beneficial to switch to a different class or a different medication within the same class. Cross-tapering would be a practice where you were decreasing the medication that was inefficacious and starting a new medication that could be tried to see if they help with the symptoms that they are still complaining at the same time.

Q. Okay. And we're talking about medications. What kind of medications are we talking about? Antibiotics?

A. No. Anti-depressants, anti-psychotics, mood stabilizers.

Q. Are they controlled substances?

A. No, they are not. But controlled substances would be like a benzodiazepine medication.

Q. Did the patient receive some of those medications as well?

A. Yes, she did.

Q. She received anti-depressants, it sounds like?

A. Yes.

Q. What category are those?

A. There could be atypical anti-depressants. Serotonin reuptake inhibitors and serotonin norepinephrine.

Q. But those aren't controlled -- I guess what

I'm getting at is like, what kind of medications make you have to check the PMP, that prescription --

A. So the stimulants, a lot of ADHD medications are stimulant based, and then it depends on the benzodiazepines that have been used to treat acute anxiety.

Q. Those would be controlled substances, right?

A. Yes.

Q. So we're clear --

(Simultaneously speaking.)

THE REPORTER: Excuse me. Can I just ask you to slow down because you're both speaking at the same time.

HEARING OFFICER WOODMAN: So conversationally, we do this all the time, but wait for Ms. Bradley to finish her question before you answer. It's trying to undo what we do in our conversations every day.

MS. BRADLEY: Okay. Excuse me?

MR. AGWARA: I just made a joke. I'm sorry.

MS. BRADLEY: Okay.

Q. So controlled substances, you said, have a heightened prescribing requirement; is that fair?

A. Yes. I would say so.

Q. So based on your review of the records, what kind of medications was the patient taking in this case?

A. She was prescribed different ADHD medications.

I can see Adderall was -- the dosage was changed with the Adderall. She was also taking Valium, which is a Benzodiazepine, and there was a history of Klonopin as well.

Q. What is Klonopin?

A. Klonopin is a different Benzodiazepine.

HEARING OFFICER WOODMAN: What do you say?

THE WITNESS: A different Benzodiazepine. There's different properties to different benzodiazepines, I guess.

BY MS. BRADLEY:

Q. So those three, the ADHD med, the Valium, and the Klonopin, are those all controlled substances?

A. Yes, they are.

Q. What other kinds of medicines was she taking?

A. She was taking anti-psychotics, mood stabilizers, and sleep aids, anti-depressants.

MR. AGWARA: Is she reading from a page?

MS. BRADLEY: No.

MR. AGWARA: She appeared to be reading from something.

MS. BRADLEY: She has some notes regarding her review that she's looking at.

THE WITNESS: I have notes that I took from a couple of years ago when I was doing the review.

MS. BRADLEY: I'm sorry. Just to try to understand the different medicines.

Q. So anti-psychotics, are those controlled substances?

A. No, they are not.

Q. What about mood stabilizers?

A. Mood stabilizers can be helpful in treating bipolar disorder. It seems like she was on -- she had been on Gabapentin, and that could be used in seizure disorders or mood instability or anxiety.

Q. Are those controlled substances?

A. No.

Q. And anti-depressants, I think you said are not controlled substances?

A. No.

Q. And what about sleep aids? Are those controlled substances?

A. Some can be. She was on, I think, Anorexin (ph.), Belsomra that is like a Schedule 4 medication. Trazodone, which is a terrible anti-depressant, but it has been used for sleep, and is not a controlled substance.

Q. When you say Schedule 4, can you tell us for the record the different schedules? I know there's --

A. Schedule 1, I believe, are all the illegal

drugs. The illicit drugs. Schedule 2 are the next level down, which is still pretty addictive and has potential for abuse, and those are the stimulants.

Q. Like the ADHD meds?

A. Yes.

Q. And then you said Schedule 4 was maybe the Trazodone --

A. I believe Schedule 4 is probably -- Benzodiazepines fall in that category as well.

Q. I think when we looked at the first visit, if we go to NSBME 0040, you mentioned it says that she -- something about a history of Methamphetamine use, I think you said.

A. That was in the report from the psychometrist.

Q. Okay. That's Exhibit 8. I apologize.

Exhibit 8, when we look at her diagnosis, it says NSBME 0029, it talks about addiction to methamphetamines.

A. Yes. The actual diagnosis is on 0032.

Q. 0032 says Methamphetamine abuse.

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?

A. 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.

Q. You have an agreement. Random drug screens. Do you also --

A. Yes.

Q. -- check the PMP --

A. Yes. That is mandatory.

Q. Mandatory?

A. Yes.

Q. When you say mandatory, what does that?

A. 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.

Q. Okay. Every three months.

So every three months that you continue to see the patient, you have to check --

A. Yes.

(Simultaneously speaking.)

(Reporter clarification.)

HEARING OFFICER WOODMAN: Let's continue.

BY MS. BRADLEY:

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.

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

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?

A. 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?

A. I don't remember.

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

A. 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 --

MR. AGWARA: Objection as to --

MS. BRADLEY: I'll rephrase.

Q. 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?

A. Yes.

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

A. 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?

A. Yes.

Q. I think we talked about Exhibit 14, but let's talk about that briefly.

Exhibit 14, I think you've seen these before, but we didn't admit them.

What is Exhibit 14?

A. So these are the materials that I used to help substantiate my peer review.

Q. So these are documents that you provided to the Board?

A. Yes.

Q. Do these look to be true and correct copies of what you provided to the Board?

A. Yes.

MS. BRADLEY: Based on Dr. Chen's testimony, I would ask that Exhibit 14 be admitted.

HEARING OFFICER WOODMAN: Mr. Agwara, any objection to Exhibit 14?

MR. AGWARA: For what purpose?

MS. BRADLEY: She just testified that these are what she relied on as part of her peer review, so I think it's relevant.

MR. AGWARA: It is being offered for the truth of

whatever is in it?

MS. BRADLEY: No. It's being offered to show what Dr. Chen relied on. That's what I said. Hearsay is admissible in administrative hearings, so the Board could look at these and decide that he violated the standard of care. They would just have to have other evidence available to them.

MR. AGWARA: I have a problem letting it come in as evidence of anything.

MS. BRADLEY: I understand that you have that problem. I would submit that these are relevant because these are what Dr. Chen relied on, and this is what she provided to the Board after she finished reviewing this case, and it helps substantiate her opinion.

MR. AGWARA: Are they results of peer-reviewed studies, or are these opinions?

MS. BRADLEY: You could look at them. We gave them to you ahead of time. So I think you can decide if you think they're opinion. My understanding is that they're documentation that physicians relied on. That's why Dr. Chen provided them.

MR. AGWARA: She also relied on her notes, and I don't see those here, and those are probably more relevant.

MS. BRADLEY: Her notes were taken for her own

purposes. No, I didn't admit them. I don't even have them.

MR. AGWARA: I would defer to Mr. Woodman.

HEARING OFFICER WOODMAN: Dr. Chen, would you describe for me, and more importantly for the record because, I believe, again, from my past history, my experience in these cases for the IC and the Board, I think I know how this works pretty well, but for the record, will you describe where you get this information that you relied on in Exhibit 14, and what it does to help you in doing the work that you've been called on to do in this case?

THE WITNESS: Sure. 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.

HEARING OFFICER WOODMAN: All right. So then 14 will be admitted.

You may continue, Ms. Bradley.

MS. BRADLEY: Thank you.

Can I take a couple-minute break.

HEARING OFFICER WOODMAN: I think that would be good timing. We are 10 to 11:00, approximately. So let's take 10 minutes, and we'll come back just a couple of minutes before 11:00 o'clock. Give our reporter a chance to rest and let everyone use the facilities. Let's try to be back two minutes to the hour.

(Recess taken: 10:48 a.m. to 10:58 a.m.)

HEARING OFFICER WOODMAN: We're back on the record, and Ms. Bradley, you may continue with your examination of Dr. Chen in the matter of the Complaint against Matthew Obin Okeke, M.D.

BY MS. BRADLEY:

Q. Dr. Chen, I think you testified earlier that

you do a contract with patients in your office?

A. When they're prescribed certain medications, yes, we do. We have a control substance agreement.

Q. Would you say that that's part of the standard of care you would expect?

A. I would say it's probably better for the doctor to have for liability issues.

Q. Do you see evidence of a contract like that with Patient A?

A. I don't believe I saw one, but I could be mistaken.

Q. Let's look back at that first visit that we had on July 17, 2017, and if we go to NSBME 0040 is the first page, and it ends on 0044. I think we talked about the treatment medications, and I think you said there was some confusion.

I do see a list on 0040, current medications.

A. Right. 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?

A. Yes, I see that.

HEARING OFFICER WOODMAN: Which page are you on?

MS. BRADLEY: 0043.

Q. Was that something related to the template?

A. That may be another pitfall of the template, I guess, function.

HEARING OFFICER WOODMAN: Are you folks getting some feedback?

THE REPORTER: Yes.

HEARING OFFICER WOODMAN: It's gone away up here, but if it interrupts, let me know.

MR. AGWARA: We will.

HEARING OFFICER WOODMAN: Go ahead.

MS. BRADLEY: Okay.

Q. NSBME 0043, if you look under multi-axial assessment, it says alcohol dependence?

A. Yes.

Q. But then when we go back to the diagnosis on Exhibit 8, does it refer to alcohol dependence?

A. It does.

Q. But it also says Methamphetamine use?

A. Correct.

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?

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

Q. Why would you think that?

A. 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.

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

A. No; not of current medications.

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?

A. I believe those are the current medications.

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

A. 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.

Does that appear to be the same note from before?

A. Yes.

Q. Would you expect to see the treatment plan staying the same every time?

A. Some cases, when the patient is stable, it could be the same.

HEARING OFFICER WOODMAN: Hold on a second. Is there an objection?

MR. AGWARA: I was going to object to "every time." I don't think the doctor had actually testified to that.

MS. BRADLEY: I apologize. I misspoke. I meant from the previous visit to this visit, we have the same note in the treatment plan with the same error referring to the patient as a male, and I was asking her if she thought the treatment plan would change, or if you had the same note every time for the treatment plan.

MR. AGWARA: Thanks for the clarification.

HEARING OFFICER WOODMAN: Dr. Chen, your response to that question was?

THE WITNESS: So in my opinion, if a patient is stable, there could be minor changes to the treatment plan.

But it could be reasonable to have that same treatment plan if they're doing well on their current medication regimen.

BY MS. BRADLEY:

Q. Let's go ahead and go on to the next visit, which is September 11, 2017. NSBME 0050.

I guess my question to you would be, if you look at the list of current medicines, which we think she's tried and not what she's actually taking, and it sounds like, and it sounds like the things in the treatment medications is what she is taking. How would we know if the medications changed?

A. I would say medication changes could be mentioned in the subjective or the chief complaint section and/or the treatment plan section.

Q. Okay. I don't see that in that visit. I guess we'll go forward a little more until we see that.

Could I ask you, though, it looks like at least for these visits, she's getting Vivitrol, 350 milligrams. What is that?

A. That is a medication to help with, I guess --

(Technical difficulties.)

(Reporter clarification.)

THE WITNESS: First, it was approved for opioid dependency to help a person get off of opiates. It's

used nowadays to help with any drug cravings, as well as there are indications for younger kids who have self-harm behaviors to decrease those urges.

BY MS. BRADLEY:

Q. I do note, for example, I'm looking at 0061, this is for a visit on November 6, 2017, and it says medication reconciliation performed.

What does that mean?

A. It means that you're making sure that the medications that they're taking are consistent with what you have in your notes.

Q. How do you make sure?

A. I guess you would have these medications that are listed; you would go through them and see what the patient is currently still taking.

Q. It's a conversation with the patient?

A. Yeah. It could be.

Q. Okay. I think we'll keep going with the records. I don't see any changes quite yet in 2017.

So if we go to NSBME 0070. That is a visit dated January 16, 2018.

Do you see that?

A. Yes.

Q. I think if we look at the chief complaint there, the second paragraph, it looks like the patient

is not doing maybe as well this day?

A. Yes.

Q. So does it look like there were any changes made or what happened on that day?

MR. AGWARA: What day?

MS. BRADLEY: 0070 and ends on 0074.

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?

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

Q. Okay. I see. So if we look at NSBME 0074, Adderall 20 milligrams --

A. Correct.

Q. -- is right there, and it wasn't in the previous?

A. I don't believe it was.

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

A. Right.

Q. What kind of discussion?

A. 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.

Q. You said you would expect to see something updated in the diagnoses.

Where is diagnoses listed?

A. On my multi-axial assessment on 0073.

Q. What would you expect to see added there?

A. Maybe a mention of ADHD or an indication for a stimulant to be added on; some sort of diagnoses.

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

A. 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.

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?

A. 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.

Q. Okay. And if we go on to 0075, it appears

this is a report of psychological assessment that is different with what we have with a different date.

How often would you expect to see a report like this for a patient?

A. It just depends on the patient's history, I would say. If they needed an updated psychological evaluation, I guess that would be helpful from year to year.

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

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

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

A. Right.

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

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

Q. When were they replaced in the DSM-5? Was it as of the date of this report?

A. Prior to this date, I believe.

Q. It looks like the report was dated January 27, 2018. I'm sorry. That's the date of the assessment,

and then January 18, 2018, was the report. But prior to that?

A. Right.

Q. So then it sounds like maybe an outdated version of the DSM was used or something?

A. It appears so.

Q. So if we look at the next visit, NSBME 0080, and this is February 27, 2018. Now, if we look at 0083 bipolar disorder, current episode manic without psychotic features. I guess we have seen that before.

Were there any changes in medications on this day?

A. I believe the Trazodone was decreased.

Q. Is there any discussion on that?

A. Well, it had mentioned -- or the Trazodone was changed. It did mention that she had stopped taking the prazosin, and she would like to increase the Trazodone.

Q. Okay. But there's no -- is there a medical reason? I mean, this is what the patient is asking for.

I'm just wondering, how would you expect to see a conversation with your doctor regarding a change in medication like this?

A. I'm trying to double back to the one previously.

Q. I think it's on 0074.

A. It doesn't look like there's a change here, though, if you're comparing the two notes and the medication list.

Q. Oh, she stopped taking them?

A. She stopped the prazosin.

Q. Looks like Valium was added on this day. 0084; do you see that?

A. I think ketamine was on there. The only inconsistency would be the Valium is on there. No. It was on the prior note as well. Sorry.

Q. I can't see it on 0073 and 0074. It has Valium, oh, it does, on the top?

A. Yes.

Q. Okay. So there's no change there?

A. No.

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?

A. Yes.

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

A. I do.

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

A. I don't.

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

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

Q. And would you note those in the records?

A. Yes.

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

A. 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.

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

A. Right.

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

A. Correct.

Q. I think this is the first time that we're seeing the patient is smoking marijuana. Would that be a concern to you?

A. Yes, of course. You would want to counsel them on drug use and how it could affect mood or other symptoms.

Q. If you're taking a substance like that, it could affect how other medications are working?

A. It could, but usually not, but it would put an earmark to do more drug screens more frequently.

Q. I think you testified before that you saw one drug screen done in the time that Dr. Okeke saw the patient?

A. One that I can remember, but there could have been more. I just don't remember.

Q. If we move on to April 3rd, 2018, and this is NSBME 0090. Here, it looks like the patient says she relapsed and wants to get the injection of Vivitrol, which I thought she was about getting every time. Oh, I see. She stopped it the previous one. Okay. Here, it sounds like she's having some anxiety and other symptoms.

Do you see changes of medications for the patient in this visit?

A. The Trazodone was increased back up to 150 milligrams.

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

A. A hundred.

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

A. Not in my opinion, no.

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

A. Yes.

Q. Do you see that documented here?

A. No.

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

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

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

A. Right.

Q. All right. Let's go ahead and move on to NSBME 0095. This is the visit of May 3, 2018.

It sounds like the patient was also having some difficulty on this day.

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

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

Q. Okay. 7.5?

A. Yes.

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

A. 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?

A. 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?

A. Yes.

Q. If we go to NSBME 0100, this is a bio-psychosocial assessment. Doesn't look like this was Dr. Okeke's. So I think we can skip this one.

So I think the next visit with Dr. Okeke is NSBME 0104.

What happened at this visit with regard to the patient, symptoms of that patient?

A. I think the Adderall was just decreased to 20 milligrams again, and then --

Q. Looks like maybe Zoloft was added. Is that accurate?

A. Yeah. Zoloft was added.

Q. Do you see documentation that supports the

changes in her medicine?

A. He did mention that she was feeling more depressed.

Q. Okay.

A. And there are some other neurovegetative symptoms that speak to the depression.

Q. So looking at the chief complaint, that makes sense to you why there was the change?

A. I guess I would have to extrapolate, but yeah.

Q. What would you consider better documentation?

A. Actually, I take that back. He does list the symptoms that she had reported. It may still be a template kind of documentation style, but it does mention some depression and hopelessness and lack of motivation, lack of energy.

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

A. 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?

A. Correct, but --

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

A. There is, but the only thing would be to

change the diagnosis since she's not in a current manic episode.

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

A. Bipolar disorder or update it with current episode depressed.

Q. Okay. If we go to NSBME 0109, it looks like we have a different physician here as well, so we'll skip that until something we see with Dr. Okeke again. Looks like the next visit that Dr. Okeke had with her is NSBME 0123, and this is August 3rd, 2018.

So what happened at this visit?

A. There was just more complaints of anxiety symptoms.

Q. And did that change her medications or treatment plan?

A. It did not.

Q. Okay. Would you expect it to?

A. Not necessarily. If the symptoms were not debilitating, I guess.

Q. Okay. NSBME 0128, and this is a visit on September 17, 2018, and this looks like this is a visit after she had a suicide attempt?

A. Yes.

Q. And also seizures?

A. Yes.

Q. So what happened at that visit?

A. Patient A was following up after being released from the hospital for a suicide attempt.

Q. Looks like she has new medications listed under that chief complaint section?

A. Yes.

Q. Would you say those are probably current meds?

A. Yes.

Q. I don't see medication listed again other than the list of the past ones that we've been seeing that say current?

A. Right. So that would lead me to assume these are the medications that she's taking currently.

Q. Okay. And if we look at the multi-axial assessment, it still says current episode manic. Would that match recovering from a suicide attempt?

A. No. But I wouldn't say that's too important. 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?

A. Right.

Q. But that's not accurate anymore?

A. Correct.

HEARING OFFICER WOODMAN: Which page were you referring to there.

MS. BRADLEY: NSBME 0130.

Q. If we now go to NSBME 0134, and that's a visit dated September 25th, 2018.

So what happened at this visit with this patient?

A. It appears that she was thinking the Zyprexa was causing her an opposite effect and exacerbating her psychotic symptoms, so that was discontinued, and Geodon was started.

Q. How would a patient know if the medicine was starting a symptom?

A. It's all subjective --

MR. AGWARA: Objection.

MS. BRADLEY: Excuse me?

MR. AGWARA: I objected to your question.

HEARING OFFICE WOODMAN: What's the basis for your objection?

MR. AGWARA: Calls for hearsay.

MS. BRADLEY: Calls for what?

MR. AGWARA: Hearsay. Asking the doctor how the

patient would know that a medicine was working.

MS. BRADLEY: I'll respond that hearsay is admissible in an administrative hearing, and it can't be the sole determiner of a person's -- No. 1, if you're saying hearsay, it's admissible --

THE REPORTER: I'm sorry, Counsel. You're breaking up, and your screen is frozen.

(Technical difficulties.)

HEARING OFFICER WOODMAN: Ms. Bradley, why don't you restate your response.

MS. BRADLEY: I heard that the objection was hearsay, which is not a valid objection in an administrative hearing. Hearsay is admissible as the Nevada Supreme Court has decided. It just can't be the only thing the finder of fact relies on in making a finding.

Secondly, I'm not asking her to tell me hearsay. And perhaps I misstated the question, but my intent was to ask, how would the patient know what the results -- you know, what a medication may or may not do given, generally, that patients aren't experts in medications.

MR. AGWARA: You're asking the doctor to guess how one particular patient would respond.

MS. BRADLEY: I heard you say hearsay. I didn't

hear you say that guessing -- I'll rephrase the question.

MR. AGWARA: Thank you.

BY MS. BRADLEY:

Q. Dr. Chen, in your experience, how would a patient know what the effect of a medication might be on their symptoms?

MR. AGWARA: Same objection.

MS. BRADLEY: Well, I'm going to respond that she's a licensed physician. She works with lots of patients. I'm asking in her experience how would a patient come to this conclusion. It says in the records that she believes that this medication is causing a problem. I think she can testify in her experience how patients come to these conclusions.

HEARING OFFICER WOODMAN: If you have a response to that, you can answer.

THE WITNESS: Okay.

HEARING OFFICER WOODMAN: And if you want the question clarified so that it's very clear what question she's asking, that's fair too.

THE WITNESS: Got you. So when patients approach me with complaints that they feel symptoms may be related with a medication, there's a certain timeline that coincides, like with the start of the medication,

with the start of new symptoms they're not experiencing before. There should be conversation about the risk, the side effects, and the benefits. Maybe this is her medication related and having these side effects that's another way, and of course, the patients have the internet where they can search and see what common side effects and uncommon side effects might be present with the medication, and they can hone on in on what they want to hone in on, I think.

BY MS. BRADLEY:

Q. So it looks like there was a change here from Zyprexa to Geodon?

A. Yes.

Q. Based on that conversation?

A. Yes.

Q. Did anything else happen at this visit?

A. No.

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?

A. Yes.

Q. So that's still not accurate?

A. Correct.

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

A. Yes. Another pitfall of templates.

Q. NSBME 0138 is a visit dated October 19, 2018, and sounds like the patient is doing better on this day. Did anything change with the patient?

A. She had found her old prescription of Adderall and started taking it on her own accord.

Q. Is that something that would be a concern for you as a physician?

A. I guess patients can do this quite often, but I would have that discussion of just having, you know, a clear transparent conversation with me before we would continue it further. Just to kind of troubleshoot any symptoms that she could potentially have given her diagnoses.

Q. Was she now prescribed the Adderall moving forward?

A. Yes.

Q. Okay. Do you see Dr. Okeke talking with her or at least noting that he was concerned that she found an old prescription and was using it?

A. I guess he did mention that she was aware that the Adderall could exacerbate her mania.

Q. Do you see on Page 0140 under neurologic,

still has no history of seizures?

A. Correct.

Q. Okay. The next visit is November 16, 2018, and it's NSBME 0143. Looks like the patient was doing well on this day.

Were there any changes to her treatment plan?

A. No.

Q. The next visit, NSBME 0148, December 18, 2018. It also sounds like this was a relatively good day for the patient.

Do you see any changes on this day here?

A. No changes.

Q. Did you have any concerns?

A. No.

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

A. Correct.

Q. All right. So the next visit, NSBME 0153. This was January 21, 2019.

What happened with the patient on this day?

A. So she had reported that she apparently tried to overdose for the third time.

Q. And so what happened with regard to her treatment plan?

A. She had mentioned as well that the Vivitrol

may be causing some suicidal thoughts, and due to her own history and acknowledgment of her alcohol dependence, she did not want to be on Valium anymore. So the changes I see that the Valium had been taken off of her regimen.

Q. So the Valium was removed. But I still note NSBME 0155 still shows no history of seizures?

A. Correct.

Q. And the multi-axial says current episode manic, 0156. Would that be right?

A. Probably not after a suicide attempt.

Q. So was there any documentation regarding the Valium other than, I guess, the chief complaints?

A. No.

Q. Are there any other concerns that you have of this visit?

A. 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.

Q. So you were concerned with the continued use of Adderall without medical justification?

A. Right.

Q. If we go to NSBME 0158, looks like this is another psychological assessment.

Do you have any concerns about this report?

A. No.

Q. Move on. Then, I think we have some paperwork from the office. 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?

A. She was not doing too well as far as mood goes and struggling with some sleep issues.

Q. Sounds like she might also have been anxious or tense?

A. Right. Anxiety.

Q. What happened with her treatment plan?

A. Belsomra was started for sleep, and Fanapt was given as samples to see if that would help with psychosis or mood stability.

Q. Did you feel like this was adequate justification for those changes?

A. For the Balsomra, yes.

Q. Did you have other concerns?

A. I didn't see any mention of why the Fanapt was chosen.

Q. Did you tell us what Fanapt is used for?

A. Fanapt is an anti-psychotic, but it can have indication to treat bipolar symptoms.

Q. What would you expect to see symptom-wise that

would justify it?

A. 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.

Q. And then if we go to NSBME 0177, that's with a different provider, so we'll skip that one.

The next visit with Dr. Okeke, looks like NSBME 0180, and it's dated February 4, 2019.

What happened with the patient on this day?

A. So she came in complaining of anxiety after a breakup. She had mentioned that she stopped the Balsomra and Fanapt herself, as she was not feeling good after taking these medications.

Q. That's what D slash C --

A. Yes. Discontinued.

Q. Okay. Are you concerned about a patient who stops medications on their own?

A. Yes. Unfortunately, that happens a lot, though, but just having that discussions with them is important as well just to remind them that medication compliance is important because certain medications may have nasty withdrawal symptoms.

Q. Okay. What happened with the patient's treatment plan?

A. It looks like Geodon was restarted. Gabapentin was added on. Zoloft was restarted.

Q. And I see a note that says discuss tapering down Valium, but it doesn't look like Valium was prescribed.

A. Yeah. It wasn't in the current treatment medication --

Q. Okay.

A. -- section.

Q. Do you have other concerns regarding this visit?

A. No.

Q. Okay. The next visit is NSBME 0185, and this is February 11, 2019.

How was the patient doing on this day?

A. Seems like she is doing better, but it appears that she had restarted the Valium on her own accord again.

Q. And was her treatment plan changed?

A. Yes. The Valium was added back on, and so was the Balsomra, which she had self-discontinued a couple of visits before.

Q. Did she seem to need the Balsomra? Do you see anything supporting that?

A. No.

Q. So what would you expect to see to justify the Balsomra?

A. Complaints of insomnia.

Q. Are there any other concerns about this visit?

MR. AGWARA: You're still breaking up.

HEARING OFFICER WOODMAN: How about now? Are we coming through all right? I'm seeing glitches in the screen. Try it again, Ms. Bradley.

BY MS. BRADLEY:

Q. My question was, did you have any other concerns about this visit?

A. I do not.

Q. The next visit is NSBME 0190. The visit is dated March 19, 2019.

What happened with the patient at this visit?

A. So she did admit to using Methamphetamine two days prior to the visit. She also complained of more anxiety, guilt, and shame.

Q. Was her treatment plan changed at that visit?

A. No. It was not.

Q. All right. Is there anything that concerns you about this visit?

A. Just the relapse.

Q. Okay. Concerns of the patient, but is there anything that Dr. Okeke should have done that you think

on this one?

A. I'm trying to see if there was a discussion about a relapse prevention thing would have been helpful.

MS. BRADLEY: Did you hear that, Madam Court Reporter?

THE REPORTER: I believe so.

MS. BRADLEY: I just felt like she was mumbled.

All right. The next visit is NSBME 0195, and this is a visit dated on April 16, 2019.

Q. What happened with the patient on this visit?

A. So she was requesting to having the Vivitrol injections again due to increasing alcohol cravings. She had been sober for the last two months from the Methamphetamine, but that was inconsistent with the last note. Those are the highlights that I have.

Q. It says two months sober, but previously we know as of March 19, she reported using that. So there's an error there?

A. Yes.

Q. Okay. Was there a change in her treatment plan on this day?

A. Yes. Naltrexone was started, which is the oral form of the Vivitrol.

Q. Okay. I note, too, now, in the multi-axial

assessment, there's additional bipolar disorder diagnosis that was added that says current episode depressed?

A. Yes.

Q. Which we hadn't seen before, I don't think. Yeah. I think this is the first time we see that. Okay.

Is there anything else about this visit that you'd like to talk about?

A. No.

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.

A. Right.

Q. I think recently it was a boyfriend breakup?

A. Right.

Q. Okay. What happened at that visit?

A. So it was decided upon that she engage in dialectical behavior therapy, and that was to start at the end of the month.

Q. No changes to her medications?

A. No.

Q. Do we even see her medications on this visit?

A. No, but I guess it's just a recommendation for therapy, so it may not be important.

Q. It looks like it's a different version of the reports that we have. 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?

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

Q. That's on 0204?

A. Yes.

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

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

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

A. Yes.

Q. You wouldn't write it that way?

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

Q. Okay.

MR. AGWARA: I'd like to point out that that visit

was only 8 days after the previous visit.

MS. BRADLEY: What?

MR. AGWARA: I said the visit you're discussing occurred only 8 days after the previous visit.

MS. BRADLEY: No. We were talking about an assessment that was done on April 24, 2019, and there was also a visit on April 24, 2019.

MR. AGWARA: I know. I was just pointing out that that visit on that day was only 8 days after the previous one.

MS. BRADLEY: Okay. You'll have a chance to present that when you present your case.

HEARING OFFICER WOODMAN: And in cross-examination, you can address it.

BY MS. BRADLEY:

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

A. Yes.

Q. What happened with the patient on this day?

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

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?

A. Yes.

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

A. Right.

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

A. Correct.

Q. Okay. If we go to NSBME 0208, this is a visit dated May 14, 2019?

A. That's a different practitioner.

Q. Yeah. Let's skip forward. I apologize. The next with Dr. Okeke is NSBME 0213, and that's May 23rd, 2019.

What happened with the patient on this day?

A. This appears to be another therapy note. She had missed a couple of weeks, but stated that she was not using medicine, and she was drinking every day.

Q. Okay. And I think we have also something in the middle of that paragraph under vital signs that's hard to read?

A. Right.

Q. Do you have any concerns about this note?

A. Not really, since therapy notes are pretty basic.

Q. And we don't see anything regarding medications on this?

A. No.

Q. And then the next -- excuse me?

HEARING OFFICER WOODMAN: Looks like they're talking to each other.

BY MS. BRADLEY:

Q. The next NSBME 0215, this is a visit May 30th, 2019.

What happened with the patient on this day?

A. So there's been complaints of anxiety and depression, but absent from alcohol and drugs for about a week. And also, just looking back -- sorry.

Q. Okay.

A. It appears these notes were written by David Buob, and Dr. Okeke co-signed them.

Q. Do you have any concerns about that?

A. No. Just to mention.

Q. That's why they're therapy notes then rather than --

A. Right.

Q. -- And not a doctor visit?

A. Right.

Q. And then I note, too, it's still has the symbol that's hard to read in the middle of that

paragraph.

Do you see that?

A. Yes.

Q. Is there anything else about this note that you have concerns about?

A. No.

HEARING OFFICER WOODMAN: My notes indicate this is the end of the exhibits as far as Dr. Okeke is concerned.

MS. BRADLEY: It is.

MR. AGWARA: Mr. Woodman, I'm going to need a three-minute break to run to the restroom and run back.

HEARING OFFICER WOODMAN: Let's go off the record, Ms. Reporter, for housekeeping.

(Discussion was held off the record.)

(Recess was taken: 12:01 p.m. - 12:10 p.m.)

HEARING OFFICER WOODMAN: Let's go back on the record.

Dr. Chen is still on the witness stand.

Back on the record in the matter of charges and complaint against Matthew Obin Okeke, M.D.

Dr. Okeke and Mr. Agwara are in the Southern Nevada office with the reporter, and the rest of us are in the Northern Nevada office.

Ms. Bradley, you can go ahead and conclude

your examination questions on direct with Dr. Chen.

BY MS. BRADLEY:

Q. Dr. Chen, you testified that you did look at Exhibit 12, and I believe that has been admitted now. Is 12 admitted or provisionally admitted?

HEARING OFFICER WOODMAN: It's provisionally admitted.

MS. BRADLEY: Okay.

Q. Is there anything in Exhibit 12 that you found particularly helpful or that you want to put on record for the Board?

A. I guess what I found most helpful in Exhibit 12 were the psychiatric evaluations and the discharge summaries. It does provide good history and some other medication trials that she had been on in the past.

Q. And then as far as Exhibit 13, I think that one was less relevant to you, but you did testify that you also reviewed that.

Is there anything in Exhibit 13 that you would like to put on the record regarding your review?

A. Yeah. It seems like a lot of it was from maybe an ICU stay that I didn't find too helpful except for the diagnoses that they found, other diagnoses to get a full picture of her health.

Q. So there were other medical conditions going

on in addition to the --

A. Right.

Q. -- psychiatric concerns? All right.

I think you probably reviewed the Clark County Coroner's Autopsy Report, which is Exhibit 9?

A. Yes.

Q. Can you tell us what your thoughts are about this report?

A. So it seems pretty standard that it was an overdose, and it was ruled a suicide.

Q. And I know that the patient had struggled with some suicide ideation in the past.

Were some of the drugs used for this overdose, drugs that had been prescribed to her?

A. Yes.

Q. And some of those were prescribed by Dr. Okeke?

A. Yes.

Q. Is there anything you want to put on the record for the Board regarding this report?

A. Yes. Just to mention the toxicity levels found with Patient A, and they also did note that she had been taking the diazepam or the Valium and Zoloft. So she was taking those at the time as far as they were able to detect.

Q. I know it's an unfortunate incident, but is part of the concern of not monitoring medications carefully that they can result in an overdose?

A. True, but this is a very complex patient who has a history of being on numerous medications. It's hard to say, you're not taking this, throw it away. They often tend to stockpile or keep medications around, unfortunately.

MS. BRADLEY: Okay. I have no further questions for Dr. Chen.

HEARING OFFICER WOODMAN: Very good. Mr. Agwara, you can begin your cross-examination of Dr. Chen.

CROSS-EXAMINATION

BY MR. AGWARA:

Q. Doctor, let me start where Ms. Bradley ended; the autopsy report.

What is the relevance of this report to your testimony today?

A. The relevance is it is an overdose that they had ruled a suicide, and the medications that they found to be at toxic levels were psychiatric medications.

Q. Based on your review of the records and your experience, did you find any evidence that Dr. Okeke had anything to do with this woman's suicide?

A. There's no direct correlation, I would say.

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?

A. 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.

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

A. 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.

Q. And that would be a judgment call, correct?

A. Yes.

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 --

A. Yes, for sure. I'm sure they would.

Q. Was there anything that you saw in your review that endangered the patient's life?

A. 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.

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?

A. To answer that, I guess the combination of medications may have posed a threat.

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?

A. Correct.

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.

A. I'd say no, not from reading the notes, but --

Q. Thank you.

A. Again, those concerns I've already listed.

Q. Do you know how long Dr. Okeke saw this patient?

A. 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.

Q. Is there a reason why you started or limited your review and your testimony today, starting from 2017?

A. I'm not quite sure.

Q. You're not sure of the reason, or you're not sure of what?

A. I'm not sure why everything started after 2017.

Q. So that wasn't your decision?

A. No.

Q. Okay. Did you review the records for the first time Dr. Okeke saw this patient?

A. I did.

Q. And is it still your testimony that there was

no patient consent form signed?

A. I don't think I ever said there was no patient consent form signed.

Q. I apologize. Did you find one, or don't you recall?

A. I can't recall. I'm trying to look at my previous notes, but it's hard to decipher. It's been so long ago.

Q. That's okay. Now, let me get more specific with your testimony.

Is it your opinion that on three visits, if you have similar notes in the records, that somehow that is evidence of practice below the standard?

A. I would say similar notes, I see it all the time with colleagues. I just feel there has to be some change to comment on instead of commenting on nothing.

Q. So if a patient came to see you on Day 1, Day 3, and Day 7, and nothing has changed, and they were doing fine, why would you change something in your note?

A. I don't see why there would be a need to see them that frequently if they were stable.

Q. Let's say two weeks or every 30 days. If they were doing fine and being compliant with your instructions, why would you change anything for the sake of changing something?

A. Well, I guess my main concern was in the body of the note, it listed lots of different symptoms, and I kind of questioned, did you really ask these questions if you see no changes.

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?

A. 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.

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?

A. I guess that's correct, yes.

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.

Q. That's a yes with good reason. Okay.

Are you familiar with the software P-B-O-M-D?

A. What was that again? I'm sorry. I missed it.

Q. The software that physicians use called P-B-O-M-D.

HEARING OFFICER WOODMAN: Is that P-D-O-M-D?

MR. AGWARA: P-B-O-M-D.

HEARING OFFICER WOODMAN: P-B-O-M-D. Okay.

THE WITNESS: I'm not familiar with it.

BY MR. AGWARA:

Q. Well, I'll represent to you that that's the software that Dr. Okeke uses, and you already testified that, and this was without even knowing what software he was using, that it's not unusual for the software to repeat previous prescriptions as if the patient is currently taking them. So you do know that that happens?

A. I could say it happens, but you could fix that. Right? You could change the headings, easily.

Q. Okay. Well, I don't know, but when you were testifying on your direct, you stated that you knew that the patient was not actively taking those prescriptions, those medications because of your experience as a doctor, that was not possible, and you did state that could be a problem with the software; is that correct?

A. That's correct.

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?

A. No.

Q. Okay. You're just saying the records did not reflect some discussions that you would have liked to see; is that correct?

A. Yes.

Q. Is it your testimony that Dr. Okeke should have run the patient's PMP on every visit?

A. Not every visit. The standard is upon initiation of controlled substance, and I would say every three months during treatment.

Q. And during your review, did you find that that wasn't the case?

A. 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.

Q. Did you have any concerns about Dr. Okeke's order or orders regarding the patient's psych assessments?

A. Can you clarify that question? I don't know that I understand.

Q. During the review on your direct, we saw three, maybe four psych assessments that were done.

Would you agree with the frequency of those

assessments; that's basically what I'm asking?

A. So those assessments were done by a psychologist to kind of update information. I believe there was only one psychiatric evaluation, and that's all you really need.

Q. So you didn't have any problems with that?

A. Not really.

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.

A. 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.

Q. 10 out of how many? Would you say the majority of times?

A. I would say the majority of times where there were changes, there wasn't a rationale.

Q. Are you sure?

A. Yes.

Q. Okay. Do you want us to review every single one?

A. No.

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 --

A. 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.

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?

A. There were definitely some notes which highlighted the symptoms that she was complaining of that did warrant medication changes, but not all of them.

Q. Wasn't that a judgment call?

A. I guess. I don't know what that means.

Q. You don't know what "judgment" means or --

A. I mean, you're saying it was my judgment that there should have been more in the body of the chief complaint?

Q. No. What I'm saying is that you're second-guessing a fellow physician in terms of sufficiency of explanation. That's what it is. It's a difference in judgment?

A. Yes.

Q. Is that a yes?

A. I can agree with that, but I think where I get hung up is if I were to take over her care, I'd have a lot of unanswered questions as to why he was doing some

of these things.

Q. And some of these things, you're talking about increasing dosage, reducing them?

A. Or just adding on specific medications for what symptomatology, I guess. The big one for me would be Adderall, without any mention of how or when the ADHD was diagnosed.

Q. Can you look at your notes and see if you can specify when the Adderall was first added, so we can go and review and see whether there were reasons for it?

A. I will take a look. I know she was on Zotero (ph.) before, so that makes me believe there was some suspicion for ADHD rather than using Adderall as an adjunct to help with depression.

January 2018, maybe.

MS. BRADLEY: January 16, 2018, is what I'm seeing if that's helpful.

MR. AGWARA: What's the page number?

MS. BRADLEY: 0074. Has it at the top of the page, and that's the first time I see it in treatment medications in Exhibit 11.

BY MR. AGWARA:

Q. Dr. Chen, are you saying in the chief complaint section you didn't see any justification for the Adderall?

A. Yeah. Or yes. There is trouble concentrating, but in this context, he's referring to anxiety symptoms.

Q. So trouble concentrating, feeling tense, and jumpy. Feelings of --

A. Those are anxiety symptoms, which is supported by her diagnosis of generalized anxiety disorder.

Q. When was the first time you saw depression as a chief complaint or as a diagnosis?

A. I guess bipolar disorder has that depressive component, and in those patients, they suffer through those depressive episodes far more than those hypomanic or manic episodes, so just having bipolar disorder, I don't think she has depression.

Q. What you're saying is you would not have chosen Adderall to treat the depression?

A. Yes. I would not have.

Q. And why is that?

A. 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.

Q. Was that the case in this patient?

A. I don't recall which note it was, but I do

think there was something that said that she had acknowledged these medications worsening her mood or psychosis.

Q. Are you sure that Adderall was one of those that she stopped using as a result of exacerbating her conditions?

A. Let me review. I think it's June 6th. No. It's --

MS. BRADLEY: June 6, 2018. 0104.

MR. AGWARA: Okay.

Q. I'm trying to find where the patient stated that she stopped Adderall because it made her condition worse?

A. I remember something, but I guess just putting this note in context, it seems like she must have decreased the dosages because it was causing some sort of untoward side effect.

Q. Did you read that somewhere, or is that a guess on your part?

A. (No audible response).

Q. Ma'am, did you hear my question?

A. I'm sorry. I did not.

Q. What you stated, was that a guess, or did you see that in the records somewhere?

A. I believe I saw something in the record. I

just can't recall where it was. But this note, I guess there wasn't an explanation of why she did those things, so one could obviously imagine she decreased the dosage because she thought that many of them were worsening her symptoms.

Q. And she started it after three days, correct?

MS. BRADLEY: What did you say?

BY MR. AGWARA:

Q. She started taking the Adderall again after three days?

A. Correct.

Q. And you're still guessing from that that the Adderall was making her condition worse?

A. I guess I don't know because there's no reasoning outlined in the note.

Q. Dr. Chen, was today the first time of reviewing some of his notes?

A. No. Re-reviewing, yes. It's been a while that I've seen these.

Q. Yes, but I'm assuming you took notes the first time you reviewed these records?

A. Yes. I took extensive notes.

Q. So it didn't jump out at you if the patient had complaints that Adderall was making her worse; I'm sure you would have noted the visit, the date, the page?

A. I just noted from this visit that there was a change that she decreased the Adderall and the Valium herself.

Q. All right. Let's move on. That's fine.

Now, Exhibit 14, can you point me to exactly -- can I continue now?

HEARING OFFICER WOODMAN: Go ahead.

BY MR. AGWARA:

Q. Doctor, can you point me to exactly where and what exactly you relied on from that exhibit?

A. I had gone through each of the listed sites and used information from all of them.

Q. Can you give me an example of one information that you used from that exhibit?

A. So No. 10. I don't think it had been printed out, but that is the guidelines for the Prescription Monitoring Program, and how it should be used. I don't think it's printed out.

Q. Okay. So what we have printed out, can you point to a particular section that you used or relied on?

A. I wouldn't say I relied on any of these. I would say I formulated my peer-review based on my practices and colleagues around me, and then I tried to find supplemental evidence to show what we're doing is

supported.

Q. Okay. Thank you.

Now, did you review the formal complaint that was filed in this case?

A. Yes.

Q. Would you agree --

A. What was the question? I'm sorry.

Q. I'm waiting for you to finish the paper shuffling because it's preventing us from hearing.

HEARING OFFICER WOODMAN: It's difficult because in order to have the microphone close enough to hear her, we realize it's noisy. We appreciate you working with us on that. But she has the complaint in front of her now.

MR. AGWARA: Okay.

Q. Dr. Chen, would you agree with me that the allegations in the complaint that are based on records prior to 2017, they would not be applicable since you didn't testify regarding those?

A. Yes.

MR. AGWARA: Thank you. I'll pass the witness, or I have no further questions.

HEARING OFFICER WOODMAN: Thank you. Redirect?

MS. BRADLEY: I don't have anything.

HEARING OFFICER WOODMAN: All right. Do you have

any other witnesses, Ms. Bradley?

MS. BRADLEY: No.

HEARING OFFICER WOODMAN: So we are 10 minutes before we lose our reporter. Mr. Agwara, Ms. Bradley, on behalf of the IC, has rested her case.

What is your intention as far as putting on any type of a defense case?

MR. AGWARA: None.

HEARING OFFICER WOODMAN: So you're not going to put on any evidence?

MR. AGWARA: We don't see any need to.

HEARING OFFICER WOODMAN: All right. So Madam Reporter, do you need to literally be out the door at 1:00 o'clock?

(Discussion was held off the record.)

HEARING OFFICER WOODMAN: We'll first hear from Ms. Bradley.

MS. BRADLEY: So today we heard testimony from two witnesses. Mr. Diaz primarily spoke about the Board's investigation and the documents that were received by the Board, and those have been, I believe, all of them were admitted, with a couple that were provisionally admitted. 1 through 15.

And the Investigative Committee alleged two violations in the Complaint. The first one has to do

with malpractice. We heard Dr. Chen testify about that. Particularly her concerns regarding about him failing to justify the use of certain medications, increases and decreases of medicines, and maybe a subsequent increase again. She felt like the rationale wasn't explained well enough. I think what she said there toward the end was that she said if she were to have taken over the care of the patient, she would have been confused and not sure of what was going on with the patient, you know, what the reasons were for some of these medications.

And as we know, documentation is really important. It's important to patient care because it helps subsequent providers know what's going on with the patient, history, other things like that.

We also heard testimony that there were medications prescribed together that potentially would have bad impacts together or even exacerbated effects. So more than one medicine that would have a sedative effect, and that was done without really documenting that that could occur, and maybe the reason for doing it, even though that was a possibility.

We also heard Dr. Chen testify that Dr. Okeke did not review the PMP Report, and I think Mr. Agwara was just talking about the time frame, and we absolutely

can see that when he first started seeing the patient, the PMP review was not required to be as it is now, which is at the initiation of a controlled substance and then every 90 days. Dr. Chen didn't see that done, and that would violate the law in failing to do that.

Also, failing to assess concurrent medication interaction. We heard testimony about different medications, not all of them are psychotropic or psychiatric medicine. Some of them were other medicines. And again, just so I think a lack of documentation. But the level that we believe the lack of documentation arises to malpractice is not just a failure to clearly document.

Other concerns that Dr. Chen talked about was the history of Patient A. We know that Patient A had a history of alcohol use, Methamphetamine use, and other substances, and that would make the patient at more of a risk for diversion or other potential things. Even maybe misusing medications. Which would mean also, the second part, or sorry, next part, would have to do with the drug screens. She saw evidence of one drug screen being done. That one she recalls having opiates included, and that wasn't done consistently, those drug screens, which would be more important for a patient that has substance abuse history.

And then failing to diligently monitor potential medication interactions and changing plans because the plans would change, maybe without sufficient documentation, and that could have affected the patient. We saw some up and down movement with the patient.

Obviously, the patient was complex, and Dr. Chen testified to that, and the records show that. The patient had multiple things going on, and I know that it's difficult to treat a patient with multiple things going on, but at the same time, maybe better documentation and better use of the tools that are there to help make the prescribing less sloppy, and I think that's what Dr. Chen said early on. She described it as sloppy prescribing.

She also said the patient was in a vulnerable population with having multiple psychiatric issues going on, and kind of a complicated history. I think it's more important to be very precise and accurate with regard to prescribing documentation. In Count 2 of the complaint was failure to maintain timely, legible, accurate, and complete medical records regarding the diagnosis, treatment, and care of the patient.

I feel like there's no question. There was multiple, multiple instances where we found errors in the records; things were not updated. We have the

history of seizures that it was noted one time in a follow-up visit after a hospital stay, but the records were never updated to reflect that. There was confusing list of current medications with the treatment medications, and Dr. Chen responded to on cross that that can be fixed.

Yes, maybe electronic medical records programs have maybe some risks, maybe something that might make them harder to use. They're trying to help us, but I think as most technology things go, there's pitfalls there, but just because the program filled in something doesn't mean the practitioner is alleviated from his or her responsibility for making sure the record is accurate.

The template or the other things the program inserts are definitely there to help, but the provider still needs to make sure it's accurate, and updated, and it's not wrong. Certainly, an error or two may not deviate, but there were multiple, repeated. Again, these were templates where things were cut and pasted.

I think the neurological symptoms showing no history of seizures is a perfect example. It wasn't updated, and every record after that symptom was known was incorrect.

So again, just really a lack of ensuring that

the records are timely, legible, accurate, and complete. And it's important.

The IC is not saying that Dr. Okeke caused what ended up happening to the patient, but I think what ended up happening to the patient highlights the fact that it's important that we're accurate and clear in our documentation, and really ensure that the records are clear because the patient did have incidents where she had to go to the emergency room or other places due to suicide attempts and other things that happened during the course of treatment. So it highlights the fact that other people may look at these records, and they need them to be accurate so they can help treat that patient moving forward.

We would submit that both of the counts as contained in the Complaint have been proven based on the exhibits that have been admitted, as well as Dr. Chen's testimony and that of Mr. Diaz, and so we would ask that the Hearing Officer find that those counts have been proven and I make the recommendation that those counts have been proven so the Board can take appropriate action at its next Board meeting.

HEARING OFFICER WOODMAN: Thank you very much, Ms. Bradley. Give me one second here, Mr. Agwara, and I'll be right with you.

MR. AGWARA: Sure.

HEARING OFFICER WOODMAN: Okay. Mr. Agwara, your argument, please.

MR. AGWARA: Thank you, Mr. Woodman.

I'm looking at the formal complaint, the factual allegations that form the basis of the IC's Count 1 and 2, I would like to note for the record that allegation or Factual Allegations No. 2, 3, 4, 5, and 6 were prior to 2017. And because Dr. Chen rendered no opinion as to those factual allegations, I would request that the Hearing Officer not consider those allegations in your decision.

Now, looking at the allegations that Dr. Chen actually testified about, she did conclude her major concern was that there was not sufficient explanation for changes in dosages and prescriptions. She did not say there were not any explanations. She just said they were not sufficient. I asked her if this would amount to a difference in judgment; she agreed.

I asked her if another physician were to look at her own records, would she agree that they would find things that they would do differently. She actually answered yes.

I asked her if she thought Dr. Okeke's care had something to do with the unfortunate suicide of this

patient. She said no.

Now, Ms. Bradley made the statement regarding what she understood to be Dr. Chen's concern also, which is that if another provider were to take over the care of this patient, that that provider would be confused and wouldn't know where to start.

Well, let me remind Ms. Bradley that two other providers did take over the care of this patient from the last time that Dr. Okeke saw her.

HEARING OFFICER WOODMAN: Hold on for one second. There's a phone ringing in here that we're taking care of. I apologize for the interruption, Mr. Agwara. I don't want to miss anything else you're saying here.

MR. AGWARA: That's okay.

HEARING OFFICER WOODMAN: Go ahead, Mr. Agwara. I think we'll be okay.

MR. AGWARA: So what I was saying, that there were two providers that saw this patient after Dr. Okeke stopped seeing her, and they didn't seem to be confused. And I don't know to what extent a change what Dr. Okeke had been doing since 2013.

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.

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.

So what I would do, I would urge the Hearing Officer to look at the transcript, and pay close attention to Dr. Chen's testimony instead of what the lawyers are saying. What we have here, I mean, two physicians, they're different. There are one or two areas where my client, like I said, has acknowledged that he could do better, and he's doing better in those areas.

Does that rise to a level of malpractice? No. Even Dr. Chen stated most of our colleagues do that. So I hope we're not selectively trying to discipline Dr. Okeke if a lot of doctors are doing what he did.

So I don't really see that anything that was covered today rises to a level of malpractice.

Now, with respect to maintaining proper medical records, perhaps Dr. Chen was expecting to see a separate section that had justifications for changing prescriptions or reducing or increasing the dosage. However, if you look at the chief complaints, at least in my opinion, they seem to have sufficient information to justify the treatment courses that Dr. Okeke followed and recommended.

And also, in the few areas where it may not have been sufficient, it did not mean that he did not have that conversation with the patient.

So with that, I would submit.

HEARING OFFICER WOODMAN: Thank you very much, Mr. Agwara.

MR. AGWARA: Thank you.

HEARING OFFICER WOODMAN: Were you finished?

MR. AGWARA: Yes.

HEARING OFFICER WOODMAN: All right. In the interests of getting our Court Reporter released so she can get on to her next engagement, I'll just let everyone know as soon as I have transcripts, I will set aside a day to go through everything and finish up. Compare my notes with the transcript, write up my synopsis, and when that goes to the Board office, everyone will get immediately a copy of that, and it

will be scheduled for our Board hearing.

MR. AGWARA: I believe there may have been a couple of exhibits that you wanted to rule on after hearing the evidence. I think 13 is one of them. I don't think Dr. Chen testified to anything about that.

HEARING OFFICER WOODMAN: I thought Exhibit 13 --

MS. BRADLEY: I thought it was provisionally admitted.

MR. AGWARA: No. 12 and 13.

HEARING OFFICER WOODMAN: No. 12 and 13 were originally withheld. I provisionally admitted 12. Everything that is provisionally admitted is going to be admitted. I never did admit 13, so it's probably too late to do it now, and from everything that I heard from Dr. Chen, I'm not sure I really need that as part of my deliberation. All right.

Mr. Agwara, Dr. Okeke, thank you for your time today. Ms. Reporter, thank you very much. And of course, Dr. Chen, very much appreciated. And my appreciation to both counsel for doing a good job, presenting this well. Sorry about the technological issues. Appreciate you putting up with that, Ms. Reporter. We'll cut you loose now and go off the record.

(Whereupon, at 1:09 p.m. the proceedings concluded.)

CERTIFICATE
OF
CERTIFIED COURT REPORTER

The undersigned Certified Court Reporter of the State of Nevada does hereby certify:

That the foregoing proceeding was taken before me at the time and place therein set forth, at which time, the witnesses were duly sworn by me to testify to the truth;

That the testimony of the witnesses and all objections made at the time of the examination were recorded stenographically by me and was thereafter transcribed; said transcript being a complete, true, and accurate transcription of my shorthand notes thereof.

I further certify that I am not a relative, employee, or independent contractor of counsel, or of any of the parties involved in the proceeding; nor a person financially interested in the proceeding; nor do I have any other relationship that may reasonably cause my impartiality to be questioned.

IN WITNESS HEREOF, I have set my hand in my office in the County of Clark, State of Nevada, this 28th day of September, 2022.

SHARON CAHN, CCR NO. 985

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IC’S EXHBITS

IC’S EXHBITS

EXHIBIT 1

EXHIBIT 1

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

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

FILED
OCT 26 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert G. Kilroy, Esq., Senior Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Matthew Obim Okeke, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a Medical Doctor holding an active-probation license to practice medicine in the State of Nevada (License No. 14957). Respondent was originally licensed by the Board on September 6, 2013. On September 6, 2019, Respondent's license was placed upon probationary conditions (female supervision for all female patient encounters and maintain a formal monitoring agreement) for two (2) years from the aforementioned date or otherwise ordered by the Board. An Amended Settlement Agreement was approved March 6, 2020 by the Board and filed March 9, 2020 which did not change the above-outlined terms of the agreement.

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[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Mr. M. Neil Duxbury, Aury Nagy, M.D., Michael C. Edwards, M.D., FACS

2. On December 3, 2013, Patient A[2] was diagnosed by Respondent with bipolar disorder from a psychiatric evaluation based upon Patient A's most recent severe manic episode. Respondent notes such diagnosis of Bipolar disorder in the "chief complaint" section of Patient A's medical record. Respondent did not discuss or document any medication adjustments to address Patient A's "severe" symptoms. Respondent documented "continue present management." Less than thirty (30) days later, Patient A was hospitalized in an acute psychiatric setting for suicidal ideation and paranoia.

3. On September 11, 2014, Patient A requested and Respondent granted an increase in her drug medications, Strattera, Topamax, and Trazodone. Patient A stated her request was based upon her poor sleep and increased drug cravings. The Stattera was increased and another drug was added, Trazodone (a nightly dosage of 300mg). No medical justification or rationale was documented by Respondent into Patient A's medical record for the increased dosage or the added medication. Patient A's medical history and diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) was not documented by Respondent into Patient A's medical record. Respondent did not check Patient A's Prescription Monitoring Program Report (PMP) from the Nevada State Board of Pharmacy to ensure another medical provider had not already prescribed this type of medication to Patient A.

4. On January 20, 2015, Patient A started taking Lithium Carbonate (Lithium) in addition to the Depakote previously prescribed by Respondent. Again, Respondent did not properly monitor or document his monitoring, nor provide medical justification of these aforementioned medications given their respective therapeutic windows and a possibility of drug toxicity due to potential, unintended, side-effects with regard to the Lithium. Respondent did not check Patient A's PMP to ascertain if she was subject to any other prescriptions by other medical providers.

5. On April 13, 2015 and on April 22, 2015, Respondent documented another drastic change in Patient A's "treatment medications" without any indication of a discussion regarding the following: 1) Patient A's non-compliance with Respondent's treatment plan; 2) any possible,

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint and filed under seal.

unintended side-effects of Patient's change in medications; nor, 3) any medical justifications for the medication changes. Respondent did not check Patient A's PMP.

6. On June 27, 2016, Respondent ordered a drug screen for Patient A. The results demonstrated that Patient A was compliant with Respondent's medication regime, but for the positive test results for opiates, which were not indicated or documented in Patient A's medical records. Respondent failed to address the opiate test results with Patient A. Respondent did not check Patient A's PMP.

7. On March 27, 2017, Patient A presented to Respondent and mentioned her having a "schizophrenic episode." Respondent did not document in Patient A's medical record any symptoms she experienced, and if there was any resolution, or a return to the baseline functioning for Patient. Similarly, on September 17, 2018, Patient A presented to Respondent following her most recent acute hospitalization where she suffered seizures and was eventually released on an antiepileptic medication. Here, Respondent did not update Patient A's medical record's sections of "medical history" and "review of systems" to reflect the recent seizures. Respondent did not query or investigate whether Patient A's seizures were potentially medication-withdrawal related. Respondent did not check Patient A's PMP.

8. On January 1, 2018, Respondent failed to review Patient A's PMP prior to his prescribing controlled substances to Patient A. Respondent should have ordered random drug screen tests due to Patient A's medical history of substance and alcohol use. No such tests were ordered and no review of Patient A's current medication (PMP) was documented. Respondent did not check Patient A's PMP.

9. On January 16, 2018, Patient A's complaint of hallucinations was documented in the "chief complaint" section but was not included in the section of the mental status examination. Additionally, Respondent prescribed Adderall (20mg/morning) without any medical justification or rationale documented into Patient A's medical record although Patient A stated her anxiety had worsened and she suffered from psychotic symptoms, both of which could be further exacerbated by a stimulant medication (Adderall). Respondent did not check Patient A's PMP.

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10. On January 25, 2019, Respondent documented Patient A's "treatment medications" were listed as "Fanapt (8mg/night) and Belsoma (20mg/night)." Respondent did not check Patient A's PMP.

11 On February 4, 2019, Patient A stopped taking the aforementioned (Fanapt Belsoma) medications; Respondent updated "treatment medications" and listed "Zoloft (100mg/daily); Geodon (160mg/nightly); Gabapentin (600mg/3x daily)" On February 11, 2019, Patient A stated that she restarted taking Valium (5mg/2x daily) and Belsomra as documented by Respondent in the "treatment medications" of the medical record. Respondent did not either address these recent medications and/or he did not document his medical rationales or justifications for Patient A to continue to take these medications (Valium & Belsomra) in her medical record. Again, Respondent did not check Patient A's PMP. Diazepam (5mg/2x) was the last prescription Respondent wrote for Patient A.

13. On April 24, 2019, Respondent documented "bipolar disorder, current episode manic without psychotic features" and "bipolar disorder, current episode depressed, severe, without psychotic features" in the section label "diagnosis." Here, the entries are inconsistent with each other, e.g., "manic" and "depressed" are the opposite sides of this medical condition. This medical record is inaccurate as to what was the correct type of episode Patient A suffered on this date.

14. On August 22, 2019, Patient A committed suicide at the age of thirty-nine (39) years old. The cause of death was determined by the Clark County Coroner who stated that the manner of death was multiple drug intoxication (bupropion, gabapentin, and diphenhydramine). The autopsy report stated that Patient A had a history of chronic obstructive pulmonary disease; multiple mental illnesses, including bipolar disorder, anxiety and depression; she suffered from addiction since the age of fifteen (15) (chronic alcohol, methamphetamine, and prescription drug abuse). The report further indicated that Patient A's prescription medications were inventoried and too many pills remained in their containers. Thus, indicating non-compliance with taking her prescriptions as ordered.

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COUNT I

NRS 630.301(4) (Malpractice)

15. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

16. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

17. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

18. As demonstrated by, but not limited to, the above-outlined factual allegations, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he provided medical services to Patient A. Respondent's specific acts of malpractice are as follows, but not limited to: 1) failing to justify the use, increase and decrease, and then subsequent increases in dosages of Patient A's medication; 2) prescribing a combination of controlled substances without documenting the medical justification or rationale; 3) failing to review the PMP report prior to, during, and after the encounters with Patient A; 4) failing to assess Patient A's concurrent medication interactions; 5) failing to assess Patient A for possible drug abuse, drug diversion or any other non-medical related activity; 6) failing to assess Patient A for possible drug screens on a consistent basis; and, 7) failing to diligently monitor potential medication interactions in Patient A's changing treatment plans.

19. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.3062(1)(a) (Failure to Maintain Proper Medical Records)

20. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

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21. NRS 630.3062(1)(a) provides 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.

22. As demonstrated by, but not limited to, the above-outlined factual allegations, Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A. The medical records for Patient A were inaccurate and incomplete due to his lack of diligence in documenting the medical justifications and rationales for all of his prescribing of various different medications for Patient A. As well as, the lack of documenting his request and receipt of the PMP reports for Patient A from the Nevada Board of Pharmacy. Further, Respondent failed to document important details regarding Patient A's medication changes, symptomatology, psychiatric history, and medical history.

23. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this matter as outlined in NRS 622.400.

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

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6. That the Board take such other and further action as may be just and proper in these premises

DATED this 26th day of October, 2021.

INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____

ROBERT G. KILROY, J.D.
Senior Deputy General Counsel
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: rkilroy@medboard.nv.gov
Attorney for the Investigative Committee

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 20th day of October, 2021.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
BRET W. FREY, M.D.
Chairman of the Investigative Committee

EXHIBIT 2

EXHIBIT 2

ANSWER

LAW OFFICES OF LIBO AGWARA, LTD
LIBORIUS AGWARA, ESQ.
Nevada Bar No. 7576
2785 E. Desert Inn Rd., Suite 280
Las Vegas, NV 89121
Tel:(702) 385-4800 Phone
libolaw@yahoo.com
Attorney for Respondent

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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

RESPONDENT'S ANSWER TO NEVADA BOARD OF MEDICAL EXAMINERS' COMPLAINT

Respondent, MATTHEW OBIM OKEKE, MD., by and through counsel, LIBORIUS AGWARA, ESQ., of the Law Offices of Libo Agwara, Ltd., hereby files his Answer to the Nevada Board of Medical Examiners' ("Board") Complaint and states as follows:

1. Answering paragraph 1 of the Board's complaint, Respondent agrees with the allegations contained therein.

2. Answering paragraphs 2, 3, 4, 5, 6, 7, 9, 10, 11 and 12, Respondent denies that he did not discuss, document, address or justify the diagnoses and/or medications allegedly given to the patient.

3. Answering paragraph 8 of the Board's complaint, Respondent states that the date alleged in said paragraph (January 1, 2019) was New Year's Day and

LAW OFFICES OF LIBO AGWARA, LTD.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
702-385-4800 Phone

he did not see any patients on said day; therefore, Respondent denies the allegations contained therein.

4. Answering paragraph 13 of the Board's complaint, Respondent states that he did not see the subject patient on April 24, 2019, and a result, denies the allegations contained therein.

5. Answering paragraphs 14, 15, 16, 17, 20, 21, and of the Board's complaint, Respondent states that he is without sufficient knowledge or information as to the truth or falsity of the allegations contained therein, and as a result, denies said allegations.

6. Answering paragraphs 18 and 22 of the Board's complaint, Respondent denies any and all allegations contained therein.

7. Answering paragraphs 19 and 23 of the Board's complaint, Respondent denies that he is subject to discipline as a result of the factual allegations contained in the Board's complaint.

WHEREFORE, Respondent prays that the Board find, and therefore order, that Respondent has not violated the Medical Practice Act. Respondent further requests for such other and additional relief as the Board may find just and proper under these circumstances.

Dated this 10TH day of January, 2022.

LAW OFFICES OF LIBO AGWARA, LTD

LIBORIUS AGWARA, ESQ.
Nevada Bar No.: 7576
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
Tel: (702) 385-4800 Phone
Libolaw@yahoo.com
Attorney for Respondent

LAW OFFICES OF LIBO AGWARA, LTD.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
702-385-4800 Phone

EXHIBIT 3

EXHIBIT 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS

6010 S. Rainbow Blvd., Bldg. A, Ste. 2
Las Vegas, NV 89118

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

December 19, 2019

Matthew Okeke, M.D.
[redacted]

RE: BME CASE [redacted]
PATIENT: [redacted]

Dear Dr. Okeke:

We have received information and a complaint regarding your medical treatment of the above named patient. The complaint alleges your care and treatment of the above named patient may have fallen below the standard of care.

It is alleged:

1. You may be excessively and inappropriately prescribing controlled substances to the above named patient which may have resulted in the patient's demise.

2. The patient informed you, and your staff, of her paranoid and suicidal ideations which she felt was being caused by the medications you were prescribing to her.

3. Instead of admitting the patient for treatment, the patient was sent home with instructions to "take more valium."

4. On or around August 22, 2019, the patient overdosed.

It is further alleged:

5. You may be in violation of a regulation adopted by the State Board of Pharmacy for failing to monitor the patient's Prescription Monitoring Profile.

According to these allegations, you may have violated the Nevada Medical Practice Act, Nevada Revised Statutes, Chapters 629 and 630, and Nevada Administrative Code, Chapters 629 and 630 (NMPA).

In order to determine whether or not there has been a violation of the NMPA, **please provide a written response to each allegation noted above, as well as complete health care records for the aforesaid patient[s]. Include copies of any imaging, x-ray or other films that were produced during treatment of this patient.** Please include any further information you believe would be useful for the Board to make a determination in this matter. **Please reply to this request within 21 calendar days.**

Please return the health care records with the signed Custodian of Records Affidavit, enclosed herewith. If you are not a custodian of the patient records, please indicate where the health care records can be obtained.

✓1/6/2020 Records
✓1/21/2020 Resp

The Nevada State Board of Medical Examiners investigates all information received concerning possible violations of the NMPA. We make no determination as to whether or not there has been a violation of the NMPA until a thorough investigation is completed. As a physician under investigation by the Board, you are required by the NMPA to provide the requested information, and your cooperation is not subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Please be advised that if the particular allegations referenced above did occur, and depending on the facts and circumstances, then you may have violated the NMPA, specifically including but not limited to: NRS 630.304(4), NAC 630.040, NRS 630.306(1)(b), (3).

Respectfully,

Kim Friedman, CMBI
Sr. Investigator
Las Vegas Office

EXHIBIT 4

EXHIBIT 4

NEVADA STATE BOARD OF MEDICAL EXAMINERS
6010 S. Rainbow Blvd., Bldg. A, Ste. 2
Las Vegas, NV 89118

Rachakonda D. Prabhu, M.D.
Board President

Edward O. Cousineau, J.D.
Executive Director

Second Request

January 13, 2020

Matthew Okeke, M.D.
[redacted]

RE: BME CASE NUMBER: [redacted]
PATIENT: [redacted]

Dear Dr. Okeke:

This is the **second request** for your reply regarding the patient associated with this case. Please provide the requested reply to the allegations. **Please reply to this request within 15 days.**

Providing the requested information is deemed a professional obligation of any physician under investigation by the Board and shall not be deemed to be cooperation subject to the whistle-blower protections provided to physicians in NRS 630.364(3).

Enclosed is a copy of the original letter sent to you on December 19, 2019.

Should you have any questions you may contact me at (702) 486-3339.

Respectfully,

Kim Friedman, CMBI
Sr. Investigator
Las Vegas Office

EXHIBIT 5

EXHIBIT 5

Grand Desert Psychiatric Services

A Life Changing Experience

1-14-19

Re: BME Case [redacted]

Patient: [redacted]

Responses to allegations.

1) I did not over prescribe any controlled substance to this patient. Patient is on Diazepam 5mg twice a day and Belsomra 20 mg at night. She later saw another practitioner who reduced the dose of Diazepam to 5mg daily on 7-29-19. She was also given Amphetamine 5mg daily. At no time was this patient given a high dose of any controlled substance in my office.
2) Patient has never told me she was suicidal when I last saw her in April 2019.
3) I never saw any reason to admit the patient to the hospital when I last saw her in April 2019.
4) Patient saw Deborah Perkins a NP in my office and she did not mention that she was suicidal.
5) The PMP did not show that this patient was on any high dose controlled substances. She was not getting medication from any other practice. She saw other practitioners in my office.

Thank you for your understanding.

Sincerely,

Matthew Okeke M.D.

Board Certified Psychiatrist

Matthew Okeke M.D.
2021 S Jones Blvd Las Vegas NV, 89146
Phone: 702-202-0099 Fax: 702-778-7632

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

EXHIBIT 6

EXHIBIT 6

The Investigative Committee of the Board of Medical Examiners of the State of Nevada

* * * * *

In the Matter of the Investigation of: **Matthew Okeke, M.D.** License No. 14957	Case No. 19-19202

ORDER TO PRODUCE HEALTH CARE RECORDS

The Investigative Committee (IC) of the Board of Medical Examiners of the State of Nevada sends greetings to:

Matthew Okeke, M.D.
[redacted]

Pursuant to the authority of Nevada Revised Statute (NRS) 630.311(1), the IC directs you to produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Order:

1. Properly authenticated and complete copies of any and all health care records of [redacted]
2. The name and contact information for any entity, facility, or person that you believe may possess the health care records of [redacted]

Said records shall be provided to an investigator of the Nevada State Board of Medical Examiners **within 21 days of service** of this Order (Investigation Division, Attn. Kim Friedman, Sr. Investigator, Nevada State Board of Medical Examiners, 6010 S. Rainbow Blvd., Bld. A, Suite 2 Las Vegas, NV 89118). Failure to comply and produce said records in the aforesaid manner may subject you to potential disciplinary action, to include a violation of NRS 630.3065(2)(a) and NRS 630.3062(4); further, the Investigative Committee may seek administrative sanctions as set forth in NRS 630.352.

Additionally, compliance with this order is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

Dated this 19th day of December, 2019.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

M. Neil Duxbury

M. Neil Duxbury, Chairman
Nevada State Board of Medical Examiners
Investigative Committee

EXHIBIT 7

EXHIBIT 7

Before the Board of Medical Examiners of the State of Nevada
Investigative Committee

* * * * *

In the Matter of the Investigation of:	)	
	)	
	)	**Case No. 19-19202**
Matthew Okeke, M.D.	)	
	)	
License No. 14957	)	
	)	

SUBPOENA DUCES TECUM

The Investigative Committee of the Board of Medical Examiners of the State of Nevada sends greetings to:

Manager, Criminal History/Custodian of Records
Las Vegas Metropolitan Police Department
400 S. Martin L. King Boulevard
Las Vegas, NV 89106

Pursuant to the authority of NRS 630.140(1) ,**WE COMMAND YOU,** that all singular, business and excuses being set aside; you shall produce and deliver to the Nevada State Board of Medical Examiners, the materials as set forth in this Subpoena Duces Tecum:

1. Properly authenticated and complete copies of any and all records for, [redacted] to include any and all photo evidence obtained.

Said records shall be forwarded to the Investigation Division, Nevada State Board of Medical Examiners, 6010 S. Rainbow Blvd. Bldg. A, Suite 2 Las Vegas, NV 89118 **within ten (10) days from the date of service** of this subpoena. Failure to comply and produce said records at the aforesaid time and place may subject you to possible disciplinary action, to include NRS 630.3065(2)(a); further the Investigative Committee may seek relief as provided in NRS 630.140(3).

Additionally, compliance with this subpoena is deemed compulsory and shall not be deemed to be cooperation subject to the protections provided to a physician pursuant to NRS 630.364(3).

1/10/2020

Dated this 31st day of December, 2019.

NEVADA STATE BOARD OF MEDICAL EXAMINERS
INVESTIGATIVE COMMITTEE

M. Neil Duxbury

M. Neil Duxbury, Chairman
Nevada State Board of Medical Examiners
Investigative Committee

Transmission Report

Date/Time 12-31-2019 08:25:37 a.m.
Local ID 1 702
Transmit Header Text
Local Name 1 NV BOARD OF MEDICAL EXAMINERS

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Nevada State Board of Medical Examiners
INVESTIGATIONS DIVISION
6010 S. Rainbow Blvd. Bldg. A Suite 2
Las Vegas, NV 89118
Phone: (702)486-3339
Fax: (702) 486-3301

CONFIDENTIAL

FAX TRANSMISSION

Page 1 of 3

Date: December 31, 2019

To: Las Vegas Metropolitan Police Department

ATTN: Records

From: Kim Friedman

Fax # (702) 828-1551

COMMENTS: Please contact me at the number above if you have any questions.

Thank You,
Kim Friedman, CMBI
Sr. Investigator

kfriedman@medboard.nv.gov

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Abbreviations:
HS: Host send
HR: Host receive
WS: Waiting send
PL: Polled local
PR: Polled remote
MS: Mailbox save
MP: Mailbox print
RP: Report
FF: Fax Forward
CP: Completed
FA: Fail
TU: Terminated by user
TS: Terminated by system
G3: Group 3
EC: Error Correct

Nevada State Board of Medical Examiners
INVESTIGATIONS DIVISION
6010 S. Rainbow Blvd. Bldg. A Suite 2
Las Vegas, NV 89118
Phone: (702)486-3339
Fax: (702) 486-3301

CONFIDENTIAL

FAX TRANSMISSION

Date: December 31, 2019

To: Las Vegas Metropolitan Police Department

ATTN: Records

From: Kim Friedman

Fax # (702) 828-1551

COMMENTS: Please contact me at the number above if you have any questions.

Thank You,
Kim Friedman, CMBI
Sr. Investigator

kfriedman@medboard.nv.gov

EXHIBIT 8

EXHIBIT 8

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

EXHIBIT 9

EXHIBIT 9

Clark County Coroner
1704 Pinto Lane
Las Vegas, NV 89106
(702) 455-3210

AUTOPSY REPORT

Case Number: 19-04240

August 23, 2019

AUTOPSY REPORT

PATHOLOGICAL EXAMINATION ON THE BODY OF

[redacted]

FINAL ANATOMIC DIAGNOSES

I. Multiple drug intoxication (bupropion, gabapentin, diphenhydramine).
II. Chronic obstructive pulmonary disease.
III. Cholelithiasis.
IV. Uterine leiomyoma.
V. Right parietal scalp contusion with multiple extremity contusions.

SUMMARY AND INTERPRETATION

This 39-year-old female, [redacted] died of multiple drug intoxication (bupropion, gabapentin, diphenhydramine). Toxicology results on the decedent's blood showed lethal levels of bupropion (11,000 ng/mL). The normal therapeutic dose for this drug ranges from 50-100 ng/mL. Levels greater than 4000 ng/mL are within a lethal range. Toxic effects include cardiac dysrhythmias (abnormal cardiac rhythms). Additionally, results showed toxic levels of gabapentin (160 mcg/mL). The normal dose of this drug ranges from 2-15 mcg/mL. Toxic levels of this drug result in profound sedation. Diphenhydramine was also detected within a toxic level (970 ng/mL). The normal dose of this drug ranges from 4-250 ng/mL. Toxic effects of this drug also include sedation. Additionally, diazepam and sertraline were also detected at therapeutic levels. The presence of these drugs would have additive sedative effects.

Clark County Coroner
1704 Pinto Lane
Las Vegas, NV 89106
(702) 455-3210

AUTOPSY REPORT

Case Number: 19-04240

Other significant findings at autopsy include multiple intact capsules of bupropion within the stomach. Additionally, the lungs showed marked airway expansion consistent with chronic obstructive pulmonary disease. The contusion on the right parietal scalp is not associated with underlying injuries to the skull or brain. With the information available to me at this time, the manner of death, in my opinion, is Suicide.

CAUSE OF DEATH: Multiple drug intoxication (bupropion, gabapentin, diphenhydramine).

MANNER OF DEATH: SUICIDE.

CIRCUMSTANCES OF DEATH: As per investigative report, the decedent's mother became concerned when she did not reach her daughter and drove to her residence on August 22, 2019. When she arrived, she used her key to make entrance into the locked and secured residence where she discovered the decedent unresponsive on her bedroom floor. She called emergency personnel, and the paramedics arrived to find her beyond resuscitation.

As per the mother, the decedent had a history of chronic obstructive pulmonary disease, and multiple mental illnesses, including bipolar disorder, anxiety and depression. She has suffered from addiction since the age of 15 (chronic alcohol, methamphetamine, and prescription drug abuse). The decedent has had multiple prescription drug overdoses in the past, the last one being approximately six months ago. Her mother confirmed that the past overdoses were suicide attempts. The decedent frequently verbalizes suicidal ideation. The decedent's prescription medications were inventoried and too many remained indicating noncompliance.

Clark County Coroner
1704 Pinto Lane
Las Vegas, NV 89106
(702) 455-3210

AUTOPSY REPORT

Case Number: 19-04240

It appears that the decedent was last known alive on August 19, 2019 at approximately 1900 hours when she spoke with her mother via text. The decedent left behind multiple writings indicating suicidal ideations and intention.

Medical records from previous hospital admissions are received and reviewed. The decedent was admitted to Monte Vista Hospital September 2014 for complications of bipolar disorder. There had been five previous admissions to this institution for the same diagnosis. The decedent was admitted to Sunrise Hospital on August 19, 2019 for overdosage of prescription medications in a suicidal attempt.

Jerry J. Hodge, D.O.
JH/kra/amu

DATE: 10 Oct 2019

EXHIBIT 10

EXHIBIT 10

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

EXHIBIT 11

EXHIBIT 11

MEDICAL RECORDS

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EXHIBIT 12

EXHIBIT 12

MEDICAL RECORDS

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EXHIBIT 13

EXHIBIT 13

MEDICAL RECORDS

This exhibit contains person medical information, records of a patient or other personal identifying information that is confidential and otherwise protected from disclosure to the public pursuant to NRS 622.310

EXHIBIT 14

EXHIBIT 14

Peer Review Materials:

1. Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition
https://psychiatryonline.org/doi/full/10.1176/appi.books.9780890426760.pe02

2. PRACTICE GUIDELINE FOR THE Treatment of Patients With Bipolar Disorder
https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf

3. PRACTICE GUIDELINE FOR THE Treatment of Patients With Substance Use Disorders
https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf

4. Malpractice Law and Psychiatry: An Overview
https://focus.psychiatryonline.org/doi/10.1176/appi.focus.20190017

5. Addressing Risk Management Issues and Concerns in the Field of Psychiatry: Documentation
https://www.prms.com/media/1662/rx_for_risk_v25_issue2_digital.pdf

6. Prudent prescribing: Intelligent use of lab tests and other diagnostics
https://www.mdedge.com/psychiatry/article/59834/prudent-prescribing-intelligent-use-lab-tests-and-other-diagnostics?sso=true

7. Use of the Clinical Laboratory in Psychiatric Practice
https://www.bluthbio.com/uploads/2/0/2/5/20250081/lab_med_in_psychiatry.pdf

8. AB474 Toolkit – Your resource for prescribing controlled substances under new Nevada law.
https://nvdoctors.org/practice-resources/prescribing-opioids/

9. Appropriate Use of Drug Testing in Clinical Addiction Medicine
https://www.asam.org/docs/default-source/quality-science/appropriate_use_of_drug_testing_in_clinical-1-(7).pdf?sfvrsn=2

10. Prescription Drug Monitoring Programs: A Guide for Healthcare Providers
https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4997.pdf

Prudent prescribing: Intelligent use of lab tests and other diagnos

Current Psychiatry. 2004 October;3(10):25-39

Evidence that atypical antipsychotics can increase risk of diabetes and heart disease is changing psychiatry's approach to lat for careful psychotropic prescribing—with intelligent use of diagnostic testing—has been emphasized by:

- four medical associations recommending that physicians screen and monitor patients taking atypical antipsychotics.
- FDA requiring antipsychotic labeling to describe increased risk of hyperglycemia and diabetes
- medical malpractice lawyers using television and Internet ads to seek clients who might have developed diabetes while

This article offers information you need to detect emerging metabolic problems in patients taking atypical antipsychotics. We clinical situations where laboratory testing can help you:

- rule out organic illness
- perform therapeutic drug monitoring
- protect the heart when prescribing
- watch for clozapine's side effects
- monitor for substance abuse.

Table 1

Lab testing with atypical antipsychotics*

Expand table

Obtain baseline values before or as soon as possible after starting the antipsychotic:

- Weight, height, body mass index (BMI)
- Waist circumference (at umbilicus)
- Fasting plasma glucose and/or hemoglobin (Hb) A_{1c}
- Fasting lipids (total cholesterol, LDL, HDL, triglycerides)
- Blood pressure

Abnormal values (eg, fasting blood glucose >110 mg/dL or Hb A_{1c} >6.1%) suggest need for medical consultation

Also note patient/family histories of obesity, diabetes, hypertension, hyperlipidemia, heart disease[†]

Repeat diabetes monitoring with fasting blood glucose and/or Hb A_{1c} after 3 months of treatment, then at least annually. I monitoring (quarterly or monthly) may be indicated for patients with:

- baseline diabetes risk factors
- clinical course factors (dramatic weight gain, development of diabetes symptoms such as polyuria or polydipsia)
- random blood glucose >200 mg/dL

Consider switching to a medication with less weight-gain liability[‡] for patients:

- at risk of developing diabetes
- who show diabetes symptoms (polyuria, polydipsia, fatigue, blurry vision) while taking an antipsychotic associated with for weight gain

Identify patients with metabolic syndrome,[§] and ensure that they are carefully monitored by a primary care clinician. Ch monthly for all patients for the first 6 months, then every 3 months thereafter

Repeat fasting lipid profile after 3 months, then every 2 years if serum lipids are normal or every 6 months in consultation clinician if LDL >130 mg/dL

[*] Individualize to particular patients' needs.

[†] Patients with schizophrenia are at increased risk of coronary heart disease.

[‡] Weight gain liability = clozapine, olanzapine > risperidone, quetiapine > aripiprazole, ziprasidone

§ Metabolic syndrome: A proinflammatory, prothrombotic state described by a cluster of abnormalities including abdominal o hypertriglyceridemia, insulin resistance, hypertension, and low HDL cholesterol. Can be exacerbated by atypical antipsychoti

Source: Adapted from reference 3.

DIABETES RISK

New monitoring standards. The American Psychiatric Association set a new standard of care by collaborating with the Americ and others in recommending how to manage the potential for increased risk of obesity, diabetes, and lipid disorders when us antipsychotics.[2] The February 2004 APA/ADA report cites olanzapine and clozapine as the atypicals most likely to cause met increase heart disease risk. It also notes, however, that atypicals' potential benefits to certain patients outweigh the risks.

Because of this report, psychiatrists who prescribe atypicals are now obligated to document baseline lab values and monitor effects (*Table 1*).[1] We recommend that you also note patient race, as certain ethnic populations (such as African-American, His Asian, Pacific Islander) are at elevated risk for diabetes.

Determining BMI. When starting patients on atypical antipsychotics, calculate baseline body mass index (BMI) with the simple using BMI tables (see *Related resources*).[4] Determine BMI before starting a new atypical antipsychotic, at every visit for the fir quarterly when the dosage is stable.

A BMI increase of 1 unit warrants medical intervention, including increased weight monitoring and placing the patient in a wei

program and switching to another antipsychotic.[3]

Table 2 An easy formula to calculate body mass index (BMI)

The increasing incidence of diabetes in the U.S. population makes it difficult to assess the relationship between atypical antipsychotic use and blood glucose abnormalities. Moreover, the risk of diabetes may be elevated in patients with schizophrenia, whether or not they are receiving medications. Diabetes and disturbed carbohydrate metabolism may be an integral component of schizophrenia itself.[4]

RULING OUT ORGANIC ILLNESS

A classic role of laboratory and diagnostic testing in psychiatry is to exclude organic illness that may be causing or exacerbat For a patient presenting with serious psychiatric symptoms, most sources recommend a standard battery of screening tests (

Of course, the DSM-IV-TR "mental disorder due to a general medical condition" should be included in the differential diagnos presentation. DSM-IV-TR also calls for disease-specific tests, such as polysomnography in certain sleep disorders, CT for enla schizophrenia, and electrolyte analysis in patients with anorexia nervosa.[5] Order other tests as indicated, depending on patie

THERAPEUTIC DRUG MONITORING

Therapeutic drug monitoring (TDM) is used to optimize treatment with medications for which therapeutic blood levels for psy been described.[6] These include lithium, valproate, carbamazepine, clozapine, and tricyclic antidepressants.

Keep in mind that "therapeutic" blood levels have been determined in "usual" patients in controlled clinical trials and may not "unusual" patients who metabolize drugs differently because of genetic variation, age, and concomitant diseases, diet, or me

Lithium. A therapeutic blood level is typically 0.6 to 1.2 mEq/L, and—although the dosage must be individualized—900 to 1,20 usually maintains this blood level. Lower levels between 0.4 mEq/L and 0.8 mEq/L have been described for the elderly.[8]

In uncomplicated cases, monitor lithium levels at least every 2 months during maintenance therapy. Draw blood immediately —such as 8 to 12 hours after the previous dose—when lithium concentrations are relatively stable.

Consider both clinical signs and serum levels when dosing, as patients unusually sensitive to lithium may exhibit toxic signs a patients often respond to reduced dosages and may exhibit signs of toxicity—such as gastric upset and confusion—at serum patients can tolerate.

Valproate. For seizure and bipolar disorders, the therapeutic blood level is 50 to 100 mcg/mL. Potential hematologic complica thrombocytopenia; indigestion and nausea are common side effects. Typical practice is to obtain levels weekly for the first fe quarterly thereafter.

Carbamazepine. Plasma carbamazepine concentrations have not been correlated with response in bipolar disorder but are n identify toxicity. Dosages of 600 to 1,200 mg/d usually produce nontoxic levels of 4 to 12 mcg/mL. Carbamazepine interacts w affect or are affected by hepatic metabolism. Blood dyscrasias including aplastic anemia are rare side effects.

Clozapine. Consensus is lacking on the optimal clozapine plasma level needed to achieve a therapeutic response. For some 350 ng/mL, which usually corresponds to 200 to 400 mg/d. Dosing must be individualized, however, because clozapine leve among patients taking the same dosage.[9] Other studies[10] and at least one recent textbook[11] have reported therapeutic respo clozapine levels >350 ng/mL, although adverse effects may be more likely at this higher dosage.

PROTECTING THE HEART

Before you prescribe any psychotropic with potential cardiotoxic effects, we recommend a baseline ECG for patients with car including:

- history of heart disease or ECG abnormalities
- history of syncope
- family history of sudden death before age 40, especially if both parents had sudden death
- history of prolonged QTc interval, such as congenital long QT syndrome.

Cardiotoxic effects such as QTc interval prolongation and torsades de pointes have been associated with thioridazine, mesor ECG, a QTc interval >500 msec suggests an increased risk of potentially fatal arrhythmias. Do not prescribe medications asso prolongation to patients with this ECG finding.

Table 3

Screening tests most sources recommend for psychiatric practice

Expand table

Blood
Complete blood count (CBC)
Serum chemistry panel ("CHEM-20," including liver function tests)
Lipid panels
Thyroid function tests (TFTs, TSH)
Screening tests for HIV, hepatitis C, syphilis
Serum B_{12}
Pregnancy tests in women of childbearing age and potential
Blood alcohol level in alcohol-intoxicated patient
Urine
Urine drug toxicology screen for substance abuse

Urinalysis

Cardiac

ECG

Imaging

Brain CT or MRI (preferred) if clinically indicated*

Chest radiography

Others

Serum medication levels†

Erythrocyte sedimentation rate or urine heavy metal screen, as indicated by medical history

Erythrocyte uroporphyrinogen-1-synthase

Urine uroporphyrins

EEG

Skull radiography

* Such as patient with disorientation, confusion, or abnormal neurologic exam

† When therapeutic/toxic blood levels are available for patient's medications, such as theophylline, tricyclics, digoxin

ECG is also indicated in patients who experience symptoms associated with a prolonged QT interval—such as dizziness or sy antipsychotics. If ziprasidone is prescribed for patients with any of the risk factors described above, we recommend a baselin begins, with a follow-up ECG if the patient experiences dizziness or syncope.[4]

Table 4

Screening tests for a patient beginning substance abuse treatment

Expand table

- Complete blood count (CBC) for anemia, mean corpuscular hemoglobin (MCH), mean corpuscular volume (MCV) >95, li
  measures of liver function such as bilirubin, gamma-glutamyltransferase (GGT), and serum glutamic oxaloacetic transam
- Amylase and lipase
- Chemistry, lipid profile, triglycerides
- HIV and TB testing
- Hepatitis panel A, B, and C
- Chest radiography
- ECG

WHEN USING CLOZAPINE

Clozapine is the only antipsychotic shown to improve neuroleptic-resistant symptoms[12] and reduce suicidality[13] in patients wi
Unfortunately, clozapine's potential side effects—including potentially life-threatening agranulocytosis—are legion, but carefu
necessary lab testing can allow its benefits to outweigh the risks.

Agranulocytosis. Obtain white blood cell (WBC) count and differential at baseline, during treatment, and for 4 weeks after dis
following the distribution program's required schedule. Advise patients to immediately report flu-like complaints or signs that
such as lethargy, weakness, fever, sore throat, malaise, or mucous membrane ulceration.

Eosinophilia. In clinical trials, 1% of patients developed eosinophilia, which can be substantial in rare cases. If a differential co
eosinophil count >4,000/mm^3, stop clozapine therapy until the eosinophil count falls below 3,000/mm^3.

Myocarditis. Clozapine-treated patients are at much greater risk for developing myocarditis and of dying from it—especially d
therapy—than is the general population.[3] Tachycardia can be a presenting sign.

Abnormal laboratory findings associated with clozapine-induced myocarditis may include increased WBC count, eosinophilia,
sedimentation rate, and increased cardiac enzyme levels and plasma troponin. Because the mortality rate of clozapine-induc
approaches 40%, stop clozapine and refer the patient for medical evaluation as soon as possible when you suspect myocard

Endocrine and hepatic effects. Severe hyperglycemia, sometimes leading to ketoacidosis, can occur during clozapine treatm
history of hyperglycemia. Ketoacidosis symptoms include rapid breathing, nausea, vomiting, clouding of sensorium (even con
polydipsia, and dehydration. Monitoring for blood glucose changes, as described in *Table 1*, is recommended with clozapine a
antipsychotics.

Hepatitis during clozapine therapy has been reported in patients with baseline normal or preexisting abnormal liver function.
function tests, we suggest follow-up LFTs:

- annually for patients with normal baseline values
- every 6 months for patients with minimally abnormal values
- every 3 months for patients with liver disease.

MONITORING SUBSTANCE ABUSE

Substance abuse is often associated with medical comorbidities that require laboratory workup and monitoring. These includ sexual assault, cirrhosis, endocarditis, HIV infection, viral hepatitis, tuberculosis, and syphilis. Some testing is mandated by fe methadone maintenance or opioid agonist therapy programs with methadone.

We recommend that new patients with substance abuse be screened for organic illness as described above, plus the workup careful history for hepatitis, pancreatitis, diabetes, cirrhosis, unusual infections (cellulitis, endocarditis, atypical pneumonias, H hospitalizations, falls, injuries, and blackouts.

Obtain a blood alcohol level in alcohol-intoxicated patients and urine toxicology to screen for locally-available street drugs (ty sedative/hypnotics, amphetamines, cocaine, opiates, and phencyclidine).

Confer with your laboratory staff about the capabilities and sensitivities of their drug testing methods. Marijuana may be dete weeks, depending on level of use. Cocaine can be detected for up to 2 to 4 days in urine.

Related resources

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- National Cholesterol Education Program. Guidelines for managing patients at risk for coronary heart disease. www.nhlbi.n <http://www.nhlbi.nih.gov/about/ncep/>
- Food and Drug Administration. Guidelines on hyperglycemia associated with atypical antipsychotics [example]. www.fda.gov/medwatch/SAFETY/2004/Clozaril-deardoc.pdf <http://www.fda.gov/medwatch/SAFETY/2004/Clozaril-dear

Drug brand names

- Carbamazepine • Carbatrol, others
- Clozapine • Clozaril
- Lithium • Lithobid, others
- Mesoridazine • Serentil
- Pimozide • Orap
- Thioridazine • Mellaril
- Valproate • Depakote, Depakene
- Ziprasidone • Geodon

Disclosures

The authors report no financial relationship with any company whose products are mentioned in this article or with manufactu products.

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NSBME 1243

Psychiatry/Medication Progress Note

This note is to be completed **ONLY** by a psychiatrist or advanced practice nurse with prescribing privileges for a psychopharmacology service.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person being served. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Date of Admission	Record the date of admission per agency policy (this should be the first service date for this service episode).
Organization/Program Name	Record the organization and Program for whom you are delivering the service.
DOB	Record the person's date of birth
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.
List of Names of Persons Present	Check appropriate box: *Person Present; No Show; Person Canceled.* If *Provider Canceled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Interim History	Document an interval history of client including progress made since last session, effectiveness of medications, progress related to symptoms, substance use, significant new issues, changes in family and social history and overall functioning.
Mental Status	Comment on current areas of mental status evaluation, including significant changes since last visit. Document any risk issues and if present, document action plan to address.
Takes meds as prescribed	Record whether medication was taken as prescribed since last session, *yes/no* or *n/a.* Provide additional relevant information after *Comments*.
Side Effects	Record whether side effects are present or occurred since last session, *yes/no* or *n/a.* Provide additional relevant information after *Comments*, e.g. increased thirst, dizziness, decreased sexual function.
Allergic Reactions	Record any reported or observed allergic reactions to medications. As appropriate, provide additional relevant information after *Comments.*
Changes in Medical Status	Record whether there have been any changes in medical status since last session, *yes/no or n/a.* Provide additional relevant information after *Comments.*
Other Meds	Record any new medications the person has been taking since the last session, e.g. *over the counter/herbal/ none/other.* Provide additional information after Comments. .
Goal(s) Addressed as Per Psychopharmacology Plan	Identify the specific goal(s) and objectives in the Psychopharmacology Action Plan or Individual Action Plan being addressed during this intervention.

Therapeutic Interventions Delivered in Session	Check one or more of the types of interventions delivered in the session: *Psychotherapy, Counseling/Coaching, Collaborative Medication Management, Collaborative Medication Education/Symptom/Illness Management, Injections, Physical Assessment, Coordination of Care.* For additional interventions utilized check *other.* Describe the content of the interventions. If any off-label usage or more than one anti-psychotic is prescribed it is suggested that the decision-making of the prescriber be carefully documented.
Response to Intervention Delivered in Session and Progress Toward Goals and Objectives	Document person's response to intervention(s) delivered in the session and person's progress towards goals and objectives. If no progress is made over time, this section should also address changes in strategy to produce positive change in the person.
Lab Tests Ordered	Summarize key laboratory test results received and reviewed. Check appropriate box to indicate whether key laboratory test results were *ordered* or, *reviewed* (with person). If lab results were *not received,* describe action to be taken to obtain results.
AIMS Findings	If AIMS (Abnormal Involuntary Movement Scale) test was administered, document findings.
Height/Weight/BMI Blood Pressure/VS	Record information pertaining to person's height, weight, body mass index, blood pressure, and vital signs as relevant. Document if there has been communication between the prescriber and the PCP. Provide additional relevant information as appropriate.
Diagnosis	Document whether the person's diagnosis has changed or not. If diagnosis has changed, check *yes* and proceed to Comprehensive Assessment Update form.
Data Field	**Medication Orders Today**
None Prescribed	Check box if no medications are prescribed today. If so, proceed to Next Appointment data field.
Rationale for Changes in Medications	Document rationale for any medication changes. For each medication prescribed, indicate if the medication is renewed*(renew)* /changed, newly prescribed *(new)* or discontinued (D/C). Write the name of the medication (*med*), dosage (*dose*), frequency (*frequency*), # of Days, quantity (*qty*), and number of refills *(refills)* prescribed. For each new medication prescribed, the person should be given information about medication risks and benefits. Check the appropriate box indicating whether person has given "informed consent", i.e. demonstrated an understanding of medication's risks and benefits. Documentation of "Informed Consent" is mandatory. If the person does not demonstrate an understanding of the risks and benefits, then the prescriber should indicate in the Instructions /Comments Section what steps should be taken. This section should not be a substitute for a complete listing of medications.
Instructions/Comments, as applicable:	Document any additional relevant instructions or psycho-educational information.
Next Appointment	Document time frame when the person should return to see the prescriber.
MD/DO/APN (Print Name)	**Legibly** print the MD/DO/APN's name.
MD/DO/APN Signature & Credentials	**Legibly record provider's** signature, credentials and date.
Supervisor - Print Name/Credential (If needed)	If required, **legibly** print name of supervisor, credentials and date.
Supervisor - Signature (If needed)	If required, legible record Supervisor Signature.

Malpractice Law and Psychiatry: An Overview

Richard L. Frierson, M.D., and Kaustubh G. Joshi, M.D.

Fortunately, psychiatrists are less likely to be sued for malpractice than most physicians in other specialties. However, once sued, psychiatrists must navigate a complicated and nonintuitive legal process. This article reviews the major elements of a malpractice claim, the litigation process in medical malpractice cases, and the common allegations of negligence that are encountered in such cases. The major types of malpractice insurance coverage are reviewed, and recommendations about liability prevention and how to best respond to a malpractice action are presented.

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Medical malpractice litigation serves three important purposes: to deter unsafe practices by physicians, compensate persons injured through negligence, and exact corrective justice (1). Although not immune from medical malpractice claims, psychiatrists are much less likely to be sued for medical malpractice than physicians in other medical specialties, especially those medical specialties that are procedurally based. Additionally, in malpractice cases against psychiatrists, most plaintiffs (those making the complaint) do not prevail. According to data from the National Practitioner Data Bank (NPDB), psychiatrists account for approximately 4% of all active physicians but account for only 1% of all paid medical malpractice claims in the United States (2, 3). Each year, 2%–3% of all psychiatrists in the United States face a malpractice claim, compared with 19% of neurosurgeons and 7% of all physicians (4). Although rates of malpractice actions against psychiatrists are relatively low compared with rates for other specialists, psychiatrists are more likely than other specialists to be the recipients of disciplinary actions from state medical boards (5, 6).

This article reviews the common legal principles underlying malpractice lawsuits against psychiatrists, the lengthy litigation process and different stages of a malpractice suit, and the common allegations of negligence brought against psychiatrists. Finally, this article provides an overview of the different types of malpractice liability insurance, provides recommendations for liability prevention, and outlines the proper response of the psychiatrist/defendant to limit a plaintiff's chance of success in a malpractice action.

ELEMENTS OF A MALPRACTICE ACTION: THE FOUR "DS"

Medical malpractice laws vary from state to state, but all are grounded in the legal concepts of tort law. A "tort" is a civil wrong for which a remedy may be obtained, usually in the form of damages (7). Medical malpractice involves a legal claim of negligence, with the additional requirements that negligence took place in the context of a doctor-patient relationship and that the doctor did not uphold a "professional" standard in the provision of care (8). In general, in any malpractice action, four elements must be proven. These elements have been commonly referred to as the "4Ds": duty (to the patient), dereliction (i.e., negligence) of that duty, damages, and direct causation (9).

Duty

The "duty" in medical practice begins at the time a doctor–patient relationship is established. Although states vary as to how the doctor–patient relationship is defined, it is generally formed when a physician examines, diagnoses, treats, or agrees to treat the patient. Once established, the physician is obligated to continue to treat or to properly terminate the relationship (10). Once a physician–patient relationship has been established, improper termination of the relationship could constitute abandonment. Therefore, termination must be reasonable in view of a patient's need for, and access to, further or alternative medical care (11). Finally, psychiatrists may also have a duty to patients who are harmed through the actions of their employees (e.g., psychotherapists, counselors, supervisees, or trainees) under the legal doctrine of *respondeat superior* ("let the superior make answer"). Under this doctrine, an employer or principal may be held liable for an employee's or agent's wrongful acts committed within the scope of employment (7). This concept also applies to attending physicians who supervise residents in training. In malpractice actions against residents, the attending physician is typically the party who may be held liable.

Dereliction

In establishing that a dereliction of duty exists, a plaintiff must prove that the psychiatrist's action fell below an acceptable standard of care. Psychiatrists need not be perfect

or exceptional in their treatment. They are simply held "to such reasonable care and skill as is exercised by the ordinary physician of good standing under like circumstances (12, p. 919)." Typically, to prove dereliction, the plaintiff usually provides an expert witness from the same or similar specialty who provides testimony (in a deposition and/or in court) about the appropriate standard of care for a given clinical situation. The expert witness then provides an opinion as to whether such care was rendered by the defendant psychiatrist. In cases alleging damages from egregious actions on behalf of the psychiatrist (e.g., sexual activity with a patient, assaulting a patient), expert witness testimony is not needed to establish that such actions fell below an acceptable standard of care (13), under the concept of *res ipsa loquitor* (i.e., "the thing speaks for itself"). In these cases, a jury can form a reasonable belief that the actions were derelict without hearing from an expert witness. However, in such cases, an expert may be used to assess damages suffered by the patient.

Damages

Even if a psychiatrist fails to provide an acceptable standard of care, a malpractice suit will not be successful unless the plaintiff can prove that he or she was damaged in some way by the psychiatrist's acts or omissions. Damages in malpractice cases can be divided into two categories: compensatory (or actual) and punitive (14). Compensatory damages compensate the injured party for actual loss or injury, including quantifiable losses such as past and future medical bills and lost wages. Compensatory damages also cover noneconomic losses, such as pain, mental anguish, aggravation of a preexisting mental condition, and a loss of enjoyment of life. They can also include a claim for someone else who is suffering because of the physician's negligence, such as a loss of consortium claim by a spouse. Because of tort reform efforts at the state level, recovery for noneconomic damages (i.e., pain and suffering) has been limited. Many states place caps on noneconomic damages ranging from $250,000 to $500,000 (15). As of 2019, 30 states have passed limitations on noneconomic damages (16). Punitive damages, on the other hand, are only assessed against a defendant when the defendant's negligent conduct was egregious, reckless, malicious, or intentional. Punitive damages are usually not assessed against defendants whose negligent conduct was merely accidental. Fortunately, punitive damages are not common in psychiatric malpractice cases, except sexual misconduct, because negligent behavior is more likely accidental rather than grossly reckless or intentional. Clinicians should be aware that malpractice insurance may exclude coverage for punitive damages.

Direct Causation

Finally, a plaintiff must prove that the damages suffered were a direct result of the psychiatrist's negligent conduct. This could prove difficult, because defendants may attribute a plaintiff's alleged damages to a preexisting medical condition. For this reason, many courts have adopted a "relaxed causation" rule, which prevents defendants from escaping litigation merely because a patient's preexisting condition complicates the causation issue. In these cases, a psychiatrist may be found negligent if their actions "increased the patient's risk" of illness or injury (17).

THE LITIGATION PROCESS IN MEDICAL MALPRACTICE CASES

Most civil litigation matters, including medical malpractice cases, are decided in state courts after a lengthy legal process. In one study of 10,000 malpractice claims, the mean time required to close a malpractice claim was 19.0 months: 11.6 months for nonlitigated claims and 25.1 months for litigated claims (18). Although the rules of civil procedure vary somewhat among jurisdictions, there is a common basic process. This process begins with the plaintiff filing a summons and complaint with the court (and the defendant). The complaint generally outlines, point by point, the alleged facts of the case as well as the alleged specific acts that constitute negligence and the specific damages that resulted. In some jurisdictions, the complaint must be accompanied by an affidavit from a plaintiff expert witness who has reviewed the records and determined that the care rendered by the defendant psychiatrist was likely negligent. The next step is for the defendant to file an answer, which contains a point-by-point response to all of the allegations contained in the summons and complaint. The summons and complaint require a response within a certain period, or a default judgment could be entered against the psychiatrist. Following the complaint and answer, the process of discovery begins. During the discovery process, both parties obtain facts and information about the case from each other. This is done in various ways, including, but not limited to, production of documents, interrogatories (written questions formally put to one party in a case by another party and that must be answered), and depositions of witnesses involved in the case. A deposition is a formal question-and-answer session in which one party asks a witness oral questions under oath. In discovery, depositions usually start with the parties involved and fact witnesses, followed by expert witnesses regarding the standard of care, and, finally, causation and damages experts.

Following the discovery process, the parties may negotiate a settlement. Over 90% of medical malpractice cases are settled out of court. The average court settlement for all medical malpractice cases (regardless of specialty) is about $425,000, whereas the average jury award tops $1 million (19). Therefore, there are sometimes economic advantages to settling the case and avoiding a malpractice trial. However, out-of-court settlements (as well as jury awards) are subject to mandatory reporting to the NPDB (20).

If a malpractice claim does not settle, then pretrial motions are made, a jury is selected, and a malpractice trial ensues. To find the psychiatrist negligent, the jury

TABLE 1. Psychiatrists' program, cause of loss—administrative actions, claims, and lawsuits, 1986–2018[a]

Primary allegation[b]	All states (%)
Suicide/attempted suicide	27
Incorrect treatment[c]	23
Breach of confidentiality	15
Other	10
Medication issues	8
Incorrect diagnosis	5
Unnecessary commitment	3
Improper supervision[d]	3
Boundary violation	3
Abandonment	1
Duty to warn/protect	1
Forensic	<1
Lack of informed consent	<1

[a] Copyright 2019 Professional Risk Management Services, Inc. (PRMS). Used with permission.
[b] Main allegation by plaintiffs' attorneys of what the psychiatrist did wrong.
[c] This category represents a high percentage of cases, because plaintiffs' attorneys often use a broad, general allegation initially; includes, among other cases, suicide and improper psychopharmacology.
[d] Refers to supervision of patients as well as of other providers.

must find by a preponderance of the evidence (e.g., more likely than not) that the provided treatment fell below an acceptable standard of care, that there were subsequent damages, and that the negligent treatment likely caused or contributed to the damages. There are tremendous differences in malpractice awards among jurisdictions. For example, according to the NPDB, in 2016, the average malpractice damages payout for each state ranged from a low of $1.39 per capita in North Dakota to $35.49 per capita in New York (21).

COMMON ALLEGATIONS OF NEGLIGENCE IN PSYCHIATRIC MALPRACTICE CLAIMS

Data from 30 years of psychiatric malpractice claims administered by a prominent psychiatric malpractice insurer reveal that the most common cause of a malpractice claim is suicide or attempted suicide (Table 1). This is closely followed by claims for alleged incorrect treatment. Additional articles in this issue of *Focus* cover special issues in malpractice claims for suicide, breaches of confidentiality, failure to assess risk for violence, boundary violations, improper psychopharmacology, and failure to complete mandatory reporting of child abuse.

MALPRACTICE LIABILITY INSURANCE

Medical liability insurance is required in almost all jurisdictions and many medical systems as a requirement to practice medicine. Malpractice insurance is available through traditional insurance carriers or from a medical risk retention group, a mutual organization of medical professionals organized to provide liability insurance (sometimes sponsored by state medical societies) (22). There are two main types of medical liability insurance policies: claims-made and occurrence.

In claims-made policies, coverage is provided only for claims that both occur and are reported while the policy is in effect (9). If the incident giving rise to the claim occurred while the psychiatrist had coverage but is reported after the policy has expired, the insurer does not provide coverage. Because a considerable amount of time can elapse between when potential negligence occurred and when a claim is filed, coverage must extend for a significant period to provide adequate protection. As a result, some claims-made policies are written to provide a period of coverage referred to as a "tail" that extends coverage for a set amount of time after the policy expires; tail coverage only applies to negligent acts that occurred during the time of the original policy (9, 22). If not offered as part of the original policy, tail coverage (also referred to as extended reporting period coverage) can be purchased at the time of policy expiration. Tail coverage is essential to ensure continued malpractice coverage during transition periods when the insured has been covered with a claims-made policy but is making adjustments such as changing insurance carriers or changing jobs. Claims-made policies are renewed annually (23). If the insured plans to continue practicing and is only changing insurers, the insured could obtain "nose" coverage (also referred to as prior acts coverage) from a subsequent insurer (24).

An occurrence policy provides coverage for an incident giving rise to a claim that occurs while the policy is in effect, regardless of when the claim is reported to the insurance company and even if the claim is reported after the policy expires (9). These policies ensure coverage for the life of the patient and the insured and remain in effect even if the insured makes certain transitions such as changing jobs, retiring, and so forth. Because it is considered the broadest form of coverage, this type of policy usually does not require tail coverage. Modified occurrence policies are a combination of claims-made and occurrence policies. Coverage is provided on a claims-made basis with an included tail coverage; the tail coverage applies for a limited time after expiration of the last policy issued (24). At the end of the included tail coverage, the insured may have the option of buying an unlimited tail (24).

Provider specialty, type of policy, limits of liability, location of practice, and history of settlements are examples of factors that affect the cost of a policy (23). Malpractice policies have several elements: coverage dates, liability limits, deductibles, premiums, defining coverage, endorsements (written amendments that take precedence over the original policy), exclusions that can diminish or eliminate coverage (e.g., criminal and sexual acts), and "consent to settle" provisions (9, 23). The language of "consent to settle" provisions include the following: the insured alone decides whether a case can be settled; the insurer alone decides when a case will be settled without input from the insured; the insured is allowed to accept or reject a settlement, with the caveat that the insured would be personally responsible for amounts in

excess of the previously rejected settlement amount; or the insured and insurer agree to arbitration to come to a decision if either party does not agree on settling a claim (9).

Punitive damages usually are not covered by malpractice insurance policies; however, these companies may have to cover punitive damages if their policies do not explicitly exclude punitive damages (9). If a judgment exceeds the limits of the policy, the psychiatrist is personally liable for the difference. At this point, an umbrella insurance policy (coverage beyond a primary policy), if purchased, would kick in; this policy would provide psychiatrists with an important safeguard.

LIABILITY PREVENTION AND DEFENDANT RESPONSE TO A MALPRACTICE ACTION

Being served with a lawsuit is a stressful experience for many psychiatrists (25). The accusation that psychiatrists' actions or omissions have brought harm to patients is hurtful but does not necessarily mean that psychiatrists have engaged in wrongdoing. If named in a lawsuit, psychiatrists should immediately call their malpractice insurance provider and speak with a claims examiner. Not contacting the insurer immediately could be grounds for voiding the policy (i.e., this could be considered a breach of contract) and may result in the insurer's refusing to pay the judgment or challenging a default judgment. Psychiatrists should not attempt to answer the summons and complaint alone. Most policies require psychiatrists to cooperate with their insurance provider in the defense of their suits. It is imperative for psychiatrists to be honest with their attorneys and not withhold or misrepresent facts. Psychiatrists should not attempt to alter the records (including attempts to recreate missing records); in many states, altering medical records is a crime. In addition, altering medical records could serve as a basis for revocation of a medical license and for voiding the policy.

Psychiatrists should not contact the plaintiff's attorney(s), because statements made to the plaintiff's attorney(s) can be used against the psychiatrist in court. They also should not discuss the case with colleagues, family members, or friends, because these conversations are usually not protected by attorney–client privilege and could be discoverable. Psychiatrists should not contact a potential expert witness, because such communications may be discoverable by the plaintiff as well. Answers to interrogatories must be accurate and complete; the court can impose sanctions if information is misleading, incomplete, or withheld.

Psychiatrists should prepare for deposition testimony by reviewing the treatment records and discussing their anticipated testimony with their attorney. Transcribed deposition testimony will be scrutinized by the plaintiff's attorney for inconsistencies and inaccuracies. Psychiatrists should assist their attorneys with formulating questions for the experts and other witnesses, if possible. Should the case go to a jury trial, the psychiatrist should attend the trial, because this is interpreted positively by the jury as meaning that the case is more important than business outside the courtroom. Psychiatrists should assist the attorney by listening for discrepancies and incorrect statements as well as suggesting questions for expert witnesses.

There are actions that psychiatrists can undertake to reduce their risk of liability. Good documentation and clear treatment records are crucial. Typewritten notes are usually better than handwritten notes, especially if the handwriting is illegible. Detailing a patient's symptoms and mental status, explaining how diagnoses were reached and why certain treatment modalities were used, and documenting medication dosages and amounts could reduce the risk of erroneous assumptions being made by individuals reading these records. For patients with a mood disorder, suicide and/or homicide risk should usually be assessed and documented at each encounter. Ensuring appropriate follow-up for patients, especially when transferring patients to other providers or discharging them from the hospital, is crucial to reducing the risk of a bad outcome. Psychiatrists should consider discussing challenging cases with colleagues. Regular communication with other treating providers, good communication with patients, and practicing good psychiatry can provide a solid foundation to support a defense in the event of a lawsuit. Finally, psychiatrists should keep abreast of evolving standards of treatment in the profession, practice guidelines, new advances, and new research that guides appropriate treatment. This is best accomplished through participation in an active continuing medical education program.

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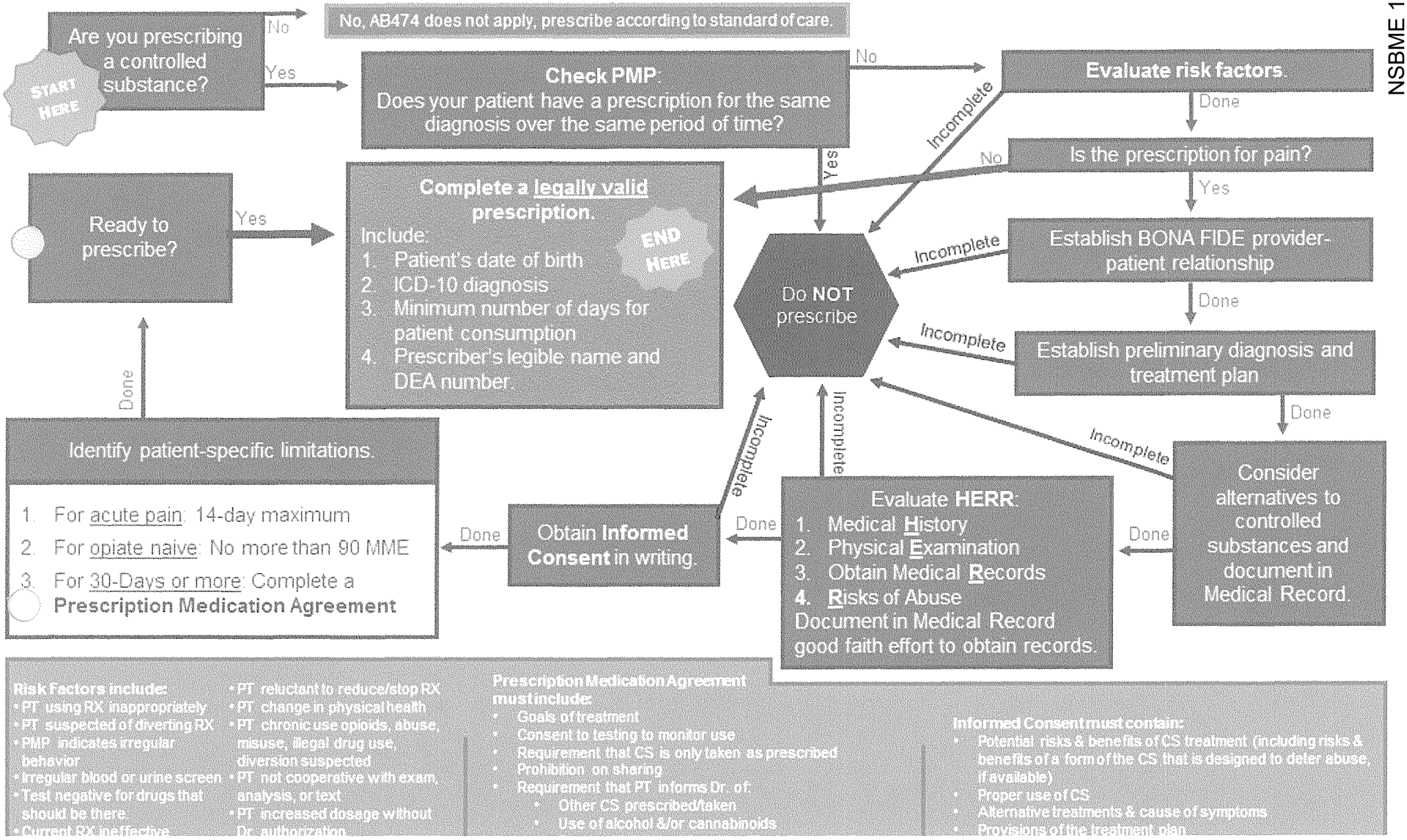
Flow Chart for the Initial Prescribing Controlled Substances under AB474

Nevada State Medical Association

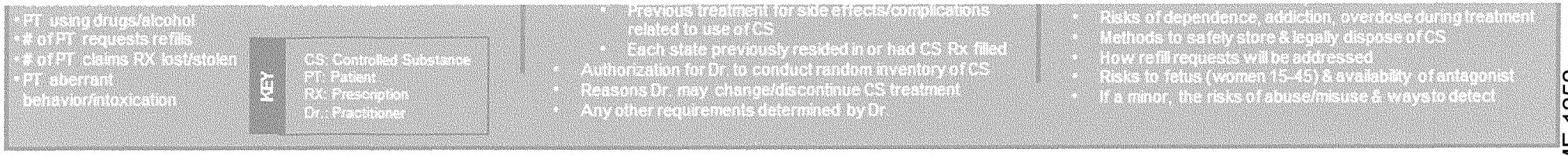
NSBME 1251



Risk Factors include:
- PT using RX inappropriately
- PT suspected of diverting RX
- PMP indicates irregular behavior
- Irregular blood or urine screen
- Test negative for drugs that should be there
- Current RX ineffective
- PT reluctant to reduce/stop RX
- PT change in physical health
- PT chronic use opioids, abuse, misuse, illegal drug use, diversion suspected
- PT not cooperative with exam, analysis, or text
- PT increased dosage without Dr. authorization

Prescription Medication Agreement must include:
- Goals of treatment
- Consent to testing to monitor use
- Requirement that CS is only taken as prescribed
- Prohibition on sharing
- Requirement that PT informs Dr. of:
  - Other CS prescribed/taken
  - Use of alcohol &/or cannabinoids

Informed Consent must contain:
- Potential risks & benefits of CS treatment (including risks & benefits of a form of the CS that is designed to deter abuse, if available)
- Proper use of CS
- Alternative treatments & cause of symptoms
- Provisions of the treatment plan


• PT using drugs/alcohol
• # of PT requests refills
• # of PT claims RX lost/stolen
• PT aberrant behavior/intoxication
Key
CS: Controlled Substance
PT: Patient
RX: Prescription
Dr.: Practitioner
• Previous treatment for side effects/complications related to use of CS
• Each state previously resided in or had CS Rx filled
• Authorization for Dr. to conduct random inventory of CS
• Reasons Dr. may change/discontinue CS treatment
• Any other requirements determined by Dr.
• Risks of dependence, addiction, overdose during treatment
• Methods to safely store & legally dispose of CS
• How refill requests will be addressed
• Risks to fetus (women 15-45) & availability of antagonist
• If a minor, the risks of abuse/misuse & ways to detect

NSBME 1252

EDITORIAL

Standard-of-Care Testimony: Best Practices or Reasonable Care?

Robert I. Simon, MD

J Am Acad Psychiatry Law 33:8–11, 2005

The standard of care is a mixed question of law and fact in which the factfinder is asked to determine what society is entitled to expect of a physician acting under certain specific circumstances. States frame this determination through case law and statutes.[1] The precise definition of the standard of care varies from one state to another. The exact language is applied to case-specific facts, to determine whether the physician's treatment of the patient was negligent.

The standard of care in malpractice cases is determined by the factfinder based on expert testimony, practice guidelines, the psychiatric literature, hospital policies and procedures, state and federal regulations, and other relevant sources. Managed care protocols and utilization review procedures are not necessarily authoritative.

Practice guidelines should be applied with caution to the highly specific fact patterns of malpractice cases. Practice guidelines evolve and change, driven by new developments in clinical practice and science. Studies find that no more than 90 percent of practice guidelines remain current after 3.6 years.[2] After 5.8 years, half of the practice guidelines are outdated. Practice guidelines set forth practice parameters that may or may not apply to a fact-specific case in litigation. Therefore, the sponsoring professional organizations issue disclaimers that the practice guidelines may not represent the standard of care. Moreover, there is considerable lag time, sometimes years, before current research and practice guidelines find their way into clinical practice.

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The standard of care is not the same as the quality of care. Quality of care encompasses the adequacy of the total care that patients receive from health care professionals and providers, including third-party payers. Quality of care also depends on the patient's health care decisions and the allocation and availability of psychiatric services. The quality of care provided by the clinician may be below, equal to, or even above the acceptable standard of care.[3]

Psychiatrists who exercise the "skill and care ordinarily employed" by the "average psychiatrist" in the same or similar circumstances will not be found liable for any resultant injury, unless the jury errs or a judicial standard of care is imposed.[4] Mistakes do not constitute malpractice, if the standard of care is not breached. The "skill and care ordinarily employed" standard, however, is changing.[5] Generally, tort law has permitted physicians to set their own standard of care—for example, the practice of the "average physician." Physicians have needed only to conform their provisions of care to the customs of their peers. Defendants in ordinary tort claims, however, are required to use reasonable care under the same or similar circumstances.

An increasing number of states have rejected the "medical custom" standard by adopting the "reasonable, prudent physician" standard.[5] The latter standard exceeds the statistical measure of the "average psychiatrist." Under the "reasonable, prudent" standard, even if 99 of 100 psychiatrists do not adequately perform and document suicide risk assessments, such omissions would be considered negligent practices that could harm patients at risk for suicide. Courts have held that negligence cannot be excused just because other physicians practice similarly.[6] More is required. Actual practice must meet a reasonable, prudent standard of care.

Best Practices

The standard of care does not require clinicians to utilize best practices or even good practices. The practices of the "average" or "reasonable prudent" psychiatrist, however, must be adequate according to the patient's clinical needs.[7] Legal standards are set at an acceptable minimum, whereas clinical standards strive for optimum care.[8] The goal of evidence-based medicine, for example, is optimum treatment of the patient. One of the major spurs in the development of evidence-based medicine is the recognition that wide variations in medical practice exist.[9] Evidence-based medicine brings together clinical expertise and best current research evidence.

Currently, there are more than 450 schools of psychotherapy. The standard of care is broad and vague. One therapist's method of therapy may be considered suspect or even negligent by another therapist who practices a different type of therapy. This is the reason talk therapy alone is rarely the basis for a successful malpractice claim. Currently, some psychotherapies are being subjected to outcome studies to prove their efficacy.

In the management of psychiatric patients, a wide variety of approaches is beneficially employed, including multiple medications given at high doses. Treatment is often empiric because the clinician does not know which treatment will be the most effective.[9] In an effort to discover new treatments for the mentally ill, psychiatry has encouraged innovation. The standard of care provided by practitioners of rational, innovative treatments would likely fall under the "respected minority rule," if a respected minority of psychiatrists would employ the same treatment under similar circumstances.[10]

It is impossible for psychiatrists to stay abreast of the hundreds of journals and the latest research developments. Textbooks are outdated before they are published. Yet current research has established that certain treatments are more effective than others, though not for every patient. Among evidence-based treatments for psychiatric disorders, the clinician has various reasonable choices. Surveys show, however, that up to 40 percent of clinical decisions made at major academic medical centers are not based on research evidence.[11] This finding does not imply, however, that the clinical decisions were wrong or that the patients were harmed.

Evidence-based medicine is necessary but not sufficient for providing effective, quality health care.[12] It is intended to support clinical decision-making in association with other relevant clinical information. Employing evidence-based treatments does not automatically establish that the standard of care has been met.

Best practice is a moving target, defined in part by the clinician's training, knowledge, and experience, as well as the severity and complexity of the patient's illness. Clinical practices may also be influenced by the decisions of third-party payers, litigation trends, risk management, commercial promotions of drugs, medical controversies in the media, administrative decrees, and other factors.[13]

Expert Opinion: Clinical Practice Versus Court Testimony

In the hierarchy of the types of clinical evidence, expert opinion is at the very bottom.[9] No standards exist to assess the reliability of expert opinion alone, in clinical settings. When there is no evidence from well-conducted clinical trials, expert opinion can play a role in treatment and management decisions.[11]

In contrast, expert psychiatric opinion is central to psychiatric malpractice litigation. Whereas evidence-based medicine aims at optimizing treatment, the law is evidence-based in the pursuit of justice. The rules of evidence are different from the rules of science. Judicial judgments are directed at upholding society's rules and values and deterring antisocial behavior.

Evidence must be relevant and competent before it can be admissible. Expert witnesses are expected to provide reasoned, factual support for their opinions. When providing standard-of-care testimony, the expert must take into account the highly diverse, complex, clinical presentations of psychiatric patients; the variety of available treatments; the relative paucity of research evidence for treatment selection; and the current restrictions on treatment resources. There is no stock answer to the question: what is the standard of care? The courts apply reasonable standards to fact-specific cases. Expert witnesses should not impose unreasonable standards of care on psychiatrists.

> Vignette: A respected academician and researcher is retained as an expert by the plaintiff in a malpractice case filed against a psychiatrist, alleging that she negligently prescribed and monitored a drug that caused the plaintiff a chronic, debilitating injury. The plaintiff's expert performed the original research on the drug. The expert lectures widely about the efficacy and

safety of the drug. During the deposition, the expert testifies that the psychiatrist committed 21 deviations in the standard of care, though few or any are related to causation. The defense expert testifies that the plaintiff's expert's criticisms are based on "best practices," not on the practice of the "average" psychiatrist as required by state statute. The number and nature of the criticisms by the expert reveal bias, which is brought out by the defense attorney on cross-examination at trial.

Credible Expert Testimony

Voltaire, in a letter to Frederick the Great, advised: "Doubt is not a very pleasant condition, but certainty is absurd." The legal standard for expert opinions by a physician requires a level of confidence expressed as "reasonable medical certainty," the meaning of which is less than clear.[14] Malpractice cases are civil suits that require plaintiffs to prove their allegations by a "preponderance of the evidence," defined as the weight of the evidence (51% vs. 49%).[10] Thus, the expert witness has considerable leeway in providing standard-of-care testimony in malpractice cases. Credible expert witness testimony is fact based. Fictional testimony is idiosyncratic, bearing little or no relationship to the "ordinarily employed" practice of the "average or reasonable, prudent" psychiatrist.

It was Edward R. Murrow who said, "Everyone is a prisoner of his own experiences. No one can eliminate prejudices—just recognize them."[15] This is the foundation for credible expert testimony. Acknowledging and correcting biases underpins the American Academy of Psychiatry and Law's ethics instruction to adhere to the principle of "honesty and striving for objectivity."[16] Unnoticed and uncorrected biases (e.g., personal, social, political, financial) are a threat to providing expert testimony in accordance with the principles of ethics.

Psychiatric malpractice cases are marked by zealous advocacy. They are usually intensively litigated. Physicians' reputations are at stake. The possibility exists that the plaintiff may receive a large monetary award. In this highly adversarial litigation, biases may arise that threaten the credibility of expert testimony. Expert testimony about the standard of care can become polarized and skewed under the intense pressure of litigation. Core biases in standard-of-care testimony may be the result of a lack of expertise, the application of personal, subjective standards and hindsight bias. The taxonomy of expert witness biases, however, is extensive.[17]

A lack of clinical expertise by the expert witness, when providing the standard-of-care testimony, is unfortunately common, especially among recently graduated psychiatrists, psychiatrists who are not actively practicing, and some academic psychiatrists. For example, expert witnesses who have not treated a psychiatric inpatient in years or been inside an inpatient unit since their residencies have opined on the standard of care in inpatient suicide cases.

Why would a psychiatrist lacking expertise take such a case? The reasons are many, but avarice, egotism, and naiveté are likely significant biasing factors. For example, the expert may have little or no understanding of how the "average or reasonable, prudent practitioner" practices in current managed-care settings. The standard-of-care testimony provided by these experts is often exposed under skillful cross-examination to be fanciful, or worse, incredible. The American Psychiatric Association Resource Document on Peer Review of Expert Testimony asks on its Peer Review Evaluation Form, "Does the expert acknowledge the limitation of his/her expertise in this area of litigation and the extent to which he/she has consulted with others in formulating an opinion?"[18]

Vignette: A forensic psychiatrist is contacted by an attorney to review the records of a patient who committed suicide on an inpatient unit. The psychiatrist has courtesy staff privileges at a local community hospital. She attends the quarterly staff meetings of the department of psychiatry. On occasion, she has sent patients for hospital admission to psychiatrists who treat inpatients. The psychiatrist has time open in her schedule to conduct the review. Additional income also would be welcomed in alleviating her strained financial situation. Since the psychiatrist has not treated an inpatient for 10 years, the attorney's request for case review is declined. The attorney is referred to a psychiatrist who currently treats inpatients.

Narcissistic bias is obvious in experts who insist that their testimony on the standard of care is the only correct one, even when the standard of care relates to a controversial area of practice.[19] Their position is, "It is so because I say it is so." The narcissistic expert does not admit to any limitation in knowledge. The expert's psychiatric practices are proffered as the standard of care "to a reasonable medical certainty," a talismanic utterance that attempts to cast a spell of certitude upon the expert's testimony. The practice of the "average or reasonable, prudent psychiatrist" is ignored or disparaged.

The hallmark of the narcissistic expert is the inability to acknowledge that there are often "two sides" to every case. Such a witness is unable to consider the strengths of the opposing expert's testimony regarding the standard of care but sees only the weak-

nesses. At deposition or trial, the narcissistic expert will not concede the possibility that credible expert opinions can differ, especially when the psychiatric literature and current research are inconclusive regarding the standard of care. "Know it all" experts perceive themselves to be the engine of the litigation vehicle that the attorney drives into court rather than, more often, the hood ornament. Humility is notably absent. If the expert is asked the question: "Doctor, do you have any biases in this case?" The answer is a dismissive, "No," instead of an acknowledgment of possible biases and the remedies undertaken to correct them. Attorneys are quick to inform juries that "no bias is high bias." This kind of testimony is vulnerable to *Daubert* scrutiny and vigorous cross-examination at trial.

Vignette: During deposition, a forensic psychiatric expert providing testimony on the standard of care is asked if he has biases. The expert acknowledges that, in forensic cases, he has a tendency to view litigants as patients. This bias exists because of having had a large clinical practice for many years. The psychiatrist states that an awareness of this bias allows him to correct for it.

Hindsight bias can afflict psychiatric experts when providing standard-of-care testimony. Since the litigation occurs after the fact, the outcome is known. A retrospective reconstruction of the standard of care that occurs years after a patient's suicide requires understanding psychiatric practice at the time of the suicide and the concurrent circumstances.[20] Retrospective bias oversimplifies a complicated clinical situation, especially the uncertainties surrounding clinical judgment at the time of the alleged negligence. The challenge for experts is to place themselves in the "shoes" of a contemporaneous observer to assess the clinical decisions made at that time.

Vignette: A psychiatrist testifies in a suicide case that the defendant psychiatrist violated the standard of care in the assessment of the patient's suicide risk. The suicide occurred six years before the trial. The psychiatrist is asked on cross-examination: "Doctor, would you agree that the psychiatrist who treats the patient is in a better position in determining what care was appropriate for the patient than you are, reviewing the case six years later?" The psychiatrist answers that while the primacy of the on-site physician should be considered, the treating psychiatrist deviated from the standard of care by relying solely on a "no harm contract," rather than performing an adequate suicide risk assessment.

Conclusion

Psychiatric testimony regarding the standard of care in malpractice cases is not solely the province of the forensic psychiatrist. In fact, most standard-of-care testimony is provided by general psychiatrists who are not forensic psychiatrists. Credible expert testimony requires that clinical standards of care determined by evidence-based medicine and best practices to optimize patients' treatment be distinguished from the legally defined "average or reasonable, prudent practitioner" standard of care. Acknowledgment and correction of biases are critical. Humility is the guardian of credible testimony.

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The Right Way to Avoid Malpractice Lawsuits

September 29, 2020

William H. Reid, MD, MPH , Skip Simpson, JD

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Practical tips for helping patients and simultaneously avoiding legal battles.

SPECIAL REPORT: FORENSIC PSYCHIATRY

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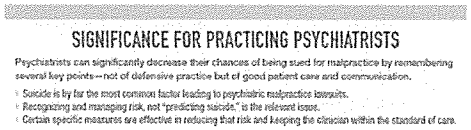
Many psychiatrists are sued for malpractice every year. Some deserve it; some do not. We offer some practical tips for helping patients (most important), decreasing the chance of being sued, and increasing the odds of winning if you are. These are not legal tricks, but practice errors that plaintiffs' lawyers look for, and ways to correct them.



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To be successful in a malpractice action, the plaintiff must prove 4 things (Table). If any of those 4 elements is not proved, then no malpractice has occurred. The level of proof required is fairly low, compared with criminal matters: preponderance of the evidence (merely more likely than not).

Table. The Plaintiff Must Prove All of These for Malpractice to Exist

- A duty (usually, but not always, to a patient)
- Negligent breach of that duty
- Damage to the person to whom the duty is owed
- A causative nexus between the breach and the damage

The authors have been involved in the clinical, legal, and administrative aspects of psychiatric malpractice cases, particularly those related to suicide, for more than 3 decades and in more than 30 states. We see the importance, to patients and courts alike, of practicing well. Neither medicine nor the law asks for perfection, but both demand competence and mindfulness of the concepts we will illustrate. Our comments are not meant to preach about clinical practice—many readers should already know most or all of what we describe—but to alert clinicians to the things that influence lawyers and juries as they consider alleged malpractice.

Most lists of the reasons people sue for psychiatric malpractice are misleading. The great majority of such lawsuits are related to one thing: *suicide*. Many apparently non-suicide topics on those lists—such as inadequate assessment, treatment or follow-up—refer to cases in which suicide occurred. Others, such as violating confidentiality, lack of informed consent, failure to monitor lab results, adverse medication reactions, and danger to others are far less common than readers might think. Another, sex with patients, is almost always adjudicated as a nonmalpractice damage issue or a criminal and/or licensure offense, rarely as "malpractice" (and rarely covered by malpractice insurance).

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Finally, some of the examples below allude to a combination of clinician and hospital responsibility. It is important to note that the standard of care (SOC) in malpractice cases requires physicians to recognize, within reason, unsafe treatment environments and procedures to which their patients are exposed, to protect patients from them, to bring them to others' attention, and to advocate for their elimination.[1]

Treat patients as you want your family members to be treated, and give time. Be sure to give the time needed in assessments, personal contact, family feedback, and follow-up. Take time explaining things, and time documenting in sentences rather than acronyms or quick words that do not reveal your thinking process and judgment. (More about medical record notes later.)

Understand the assessment, recognition, and management of suicide risk. Competently assess patients who are potentially suicidal, do so completely and regularly, not just on admission and discharge.

The point is risk assessment, not prediction. Suicide is unpredictable. So what? Don't get hung up on predictability. Your job is to deal with risk. In malpractice cases, the legal test is foreseeability, defined as anticipation of risk, not predictability.

Be the doctor. In most of the case examples, both a psychiatrist and a hospital were sued. Make no mistake, psychiatrists are important to facility policies and procedures, and to the individual actions of staff with whom they work. You are a care leader. You should know whether or not your hospital or clinic and its staff are treating patients properly. Even when hospital staff or procedures are faulty, juries often view the doctor as someone who

failed to protect the patient from inadequate care (and they may be right). You have an ethical and legal duty to do or order what your patient needs in order to be safe during, and because of, treatment, regardless of schedule crunches, staffing limitations, or administrative pressures.

Document your judgment. Write more, not less. Short notes are very often inadequate, and abbreviated terms such as "No SI/HI" say little to malpractice juries (and clinical readers). How did you assess suicide risk and arrive at your decisions? What was your thinking?

Malpractice liability rarely comes from honest errors in judgment; it comes from lack of adequate examination and failure to use intelligent reasoning (eg, *Tkacheff v Roberts*[2]). If there isn't clear evidence of reasonable professional judgment in the medical record, lawyers and jurors often assume there wasn't any. Efforts to convince them by testifying months or years later sound hollow. If there is reasonable evidence supporting your actions in the record, lawyers usually do not file suit.

So-called "positive" or "protective" risk factors are worthless for assessing individual patient risk. Loving families, good jobs, status, certain age groups, and other conditions may be statistically associated with lower group risk, but patients are individuals. Suicide occurs in all social strata, ethnic groups, religions, and age groups; in close families and broken ones; and in people with jobs and without them.

Case examples

"Dr Martin," a successful scientist at a large government laboratory, was being treated for depression and severe anxiety by his family doctor. He declined referral to a psychiatrist, fearing his security clearance

and position would be affected. One evening after dinner with his wife and children, he went into his study and shot himself in the head. The suit filed against the family doctor alleged that she had not adequately assessed the patient and inappropriately allowed his status to interfere with her pursuing necessary psychiatric referral.

"Dr Boris," a prominent physician, was hospitalized after a large overdose that he said was "accidental." The psychiatrist who assessed him strongly recommended inpatient psychiatric evaluation. The patient refused, saying he had "learned his lesson." His wife was adamantly against inpatient treatment as well, referring to their close family and promising "We'll take good care of him."

The psychiatrist asked for a second opinion. The second psychiatrist concurred with the first. An involuntary hold was accomplished and the patient was allowed to go to a distant facility for further care.

At the end of the initial protective detention (5 days), the patient convinced his inpatient psychiatrist, who was aware of the overdose but never contacted the earlier consultants, that he no longer needed hospitalization. He was discharged and died by suicide within 24 hours. Malpractice suits against the distant facility and psychiatrist were settled for an undisclosed amount.

Get consultation. Getting competent consultation before denying hospital admission, decreasing level of observation, or ordering discharge when a patient is at risk of suicide not only decreases the odds of a bad decision, it also reduces the chances of being sued if a tragedy occurs.

Don't rely solely on the patient for information about suicidal thoughts and behaviors. If there is no other information

source, be very cautious. Many patients lie or hide the truth. Even those who answer truthfully often do not understand their own symptoms, and cannot predict their future behavior.

"Mr Young" was brought to a general hospital emergency department by police officers, who had found him intoxicated and sitting precariously on an overpass railing above a busy highway. He said he was planning to jump in front of "the next 18-wheeler that comes along down there." He was admitted for intoxication with suicide risk. Mr Young's wife arrived as he was being transported to the psychiatric unit, but she was not allowed to accompany him. Staff added her contact information to the chart.

An inpatient psychiatrist saw him the next morning and reviewed the admission. Mr Young was anxious to go home, assuring the doctor that he had been drunk and had "acted stupid" the night before. "I was clearing my head, thinking about getting a divorce, not about jumping off the wall." When the doctor asked about the police report, he said "I don't remember that...they were trying to help, but I'm sober now and I don't belong here."

The psychiatrist went through the same suicide risk checklist that the emergency department social worker had used, relying on the patient's own responses. Mr Young denied prior psychiatric history, suicidal thoughts, and past attempts; the checklist score was well below "high risk." The psychiatrist ordered discharge for that morning with a note that said, "Pt. wants disch. No SI/HI apparent. No intent to die. Mar. probs./ intox... Own transp(ortation). Call PRN."

Mr Young left the hospital via a hired car service and went to a bar. Several hours later he was struck and killed by a truck on

the same highway where he had been found the prior night.

His widow sued the psychiatrist and the hospital. Past records and her deposition testimony indicated recent treatment for both substance abuse and depression, and a serious suicide attempt while intoxicated a few weeks before this incident. His wife testified that she had tried to talk with the admitting physician but was told to contact the psychiatric unit in the morning. She "thought he was safe in the hospital...[and] that they'd help him and call me and I'd tell them what he'd been doing...but they didn't call, and when I finally called them, they'd already discharged him and nobody knew where he was."

The attending psychiatrist settled out of court. The hospital, which employed the emergency department physician, lost at trial.

Never rely on "contracts for safety" (CFS, no harm contracts). Many hospitals and some psychiatrists still use these forms, despite the many studies that show their uselessness (and sometimes the damage they can do) for patients who are suicidal. Never rely on these forms when making decisions about admission, monitoring, or discharge.

"Mr Downton," a widower and retired elementary school principal, shot himself after being released on pretrial bond for allegedly exposing himself to children. He was admitted; the wound was found to be non–life-threatening, and he was transferred to the psychiatry department on continuous observation.

Mr Downton slept poorly, did not participate in unit activities, declined contact with his only son, and was often seen staring tearfully out a window. He complained bitterly that being continuously observed

made him feel worse, and said he had trouble using the restroom with an attendant talking to him through the door.

The nursing staff asked if his monitoring could be changed to checks every 15 minutes (Q15), citing a staffing shortage and 3 days of "No SI/HI" in the nursing notes. His psychiatrist talked briefly with Mr Downton, who denied suicidal thoughts, seemed optimistic as he spoke, and promised to tell staff if "those feelings" returned. Nursing policy required a CFS before the close monitoring could be stopped. He readily agreed and one-to-one monitoring was discontinued.

That evening, on the second Q15 round of the night shift, Mr Downton was found hanging by a sheet from his bathroom door.

The psychiatrist and the hospital were both sued. The plaintiff's case hinged largely on expert testimony that the psychiatrist should have recognized substantial risk in Mr Downton's history and symptoms; the suicide risk assessments were inadequate; Q15 is inadequate protection and below the standard for such patients; and it is below the SOC to rely on a CFS. The defendant psychiatrist testified that the CFS was a significant factor in eliminating continuous observation, and one that he and the staff often relied upon to decrease monitoring and "use nursing staff more wisely." The plaintiff prevailed in both cases.

This vignette illustrates several critical errors. The patient had showed no objective signs of decreased suicide risk before 1:1 was discontinued; he had merely spent a few days without talking about suicide. Neither the psychiatrist nor the nursing staff had documented evidence of adequate suicide risk assessments after his admission. The record contained little description of the physician's judgment in allowing release from 1:1 and deciding that Q15 was adequate for a greatly shamed

man who had tried to shoot himself just a few days before. There were physical inadequacies with the patient's room and bedding that made it easy for him to hang himself. In addition, posttrial juror questioning revealed that several faulted the physician for "going along with" a hospital CFS policy he should have known was wrong.

When considering discharge or decrease in monitoring level, be able to document what has changed for the patient. Make sure your documentation is more than a description of the time spent on the unit without an attempt. If there are no substantial, reliable changes, be very careful.

Beware of 2 substantial and common risk factors that are not on most checklists: instability and unpredictability. Because suicide is unpredictable, it is important to be cautious. Patients who are unstable, whether from psychosis, severe depression, bipolar disorder, severe anxiety, substance abuse, borderline syndromes, recent loss, or something else, are inherently at higher risk.

"Ms Reynolds," a young woman with a history of intensive but mercurial relationships, volatile moods, and episodes of overdose and cutting her wrists, stopped her medications and was hospitalized after stabbing herself during an argument with her boyfriend. She had accused him of causing her to miscarry and then cut herself across the abdomen.

Ms Reynolds seemed to respond to medication and support over 4 days of close observation. She denied suicidal thoughts and participated in groups. She talked with her boyfriend by phone, sometimes calmly but sometimes angry that he had not visited her. When he finally came to visit, she was inappropriately affectionate.

She requested discharge on her fifth hospital day. Nursing notes said her insight, judgment, and impulse control were "normal," based primarily on her agreeing to take medication and denying suicidal thoughts. Her psychiatrist, relying on the nursing notes and brief daily interviews, discharged her within hours of removing her from continuous observation, and without a systematic risk assessment She was given a supply of medication and a clinic appointment in 3 weeks.

Ms Reynolds was found dead from an intentional overdose a week before her outpatient appointment. In the malpractice action, the defense argued that "You can't protect patients from themselves; you have to discharge them sooner or later," and said her prior overdoses and cutting were not "real" suicide attempts. The case was settled before trial.

This vignette illustrates the need to keep patients safe until treatment response is well established, then carefully reassess their risk. In addition, transition to aftercare is important, easing the change from 24-hour observation and support to virtually none. Discharge planning should include contact with the outpatient caregiver before discharge and a first outpatient appointment within days, not weeks.

The vignette also illustrates the folly of calling self-destructive behavior "minor" or "gestures." There is no such thing as a suicide "gesture."

Fifteen-minute checks (Q15) are below the SOC for patients with even moderate suicide risk. It is easy to kill oneself in 15 minutes, or 5 minutes for that matter, even if the checks are carried out as ordered (sometimes they are not). Jayaram et al.[3], describing very successful Johns Hopkins risk management procedures, are among the many who have established continuous observation as the SOC. Chassin and Loeb[4]

agree, citing Joint Commission on the Accreditation of Healthcare Organizations experience and a large professional literature.

"Mr Kane" was placed on Q15 for suicide risk. He was found dead during shift change early the next morning. His time of death was determined to be around 3:00 *AM*, hours before he was found, but the Q15 record sheet indicated that an aide had observed him sleeping every 15 minutes through the night shift. At deposition, the aide admitted falsifying the Q15 shift record, with the excuse that "We do that all the time. I check the patient every 15 minutes, then fill everything in at the end." He couldn't explain why he had not noticed the patient hanging in the room for hours.

In the subsequent lawsuit, lack of continuous observation was found to be the main cause of Mr Kane's death. The psychiatrist was found liable for not ordering continuous observation. The hospital settled out of court.

Falsified Q15 records are not rare. Nevertheless, the primary lesson is that if Mr Kane had been on continuous observation, his death would almost certainly have been prevented.

Communicate with corroborating sources, including family members. We have long taught 1 way of gathering of important clinical and safety information does not require a release of information (so long as the informant knows that the patient is in your care). Here is how it works: The doctor tells the relative or other person, "I cannot share what (the patient) has told me, but I would very much like for you to answer a few questions and tell me what you can." Relatives and friends have no duty of confidentiality to the patient.

Do not let false confidentiality concerns threaten a patient's life or limb when they are at risk for suicide or other substantial harm.

Communicate with co-treaters. Regular contact with co-treaters is important to meeting the SOC. Unless you have terminated care entirely, you are still the patient's doctor. Be sure that counselors and programs give you regular follow-up, document it, and do the same for them. There is no issue of clinical confidentiality between co-treaters.

Know your referral resources and co-treaters. You are responsible for knowing the general qualifications of clinicians and facilities to whom you refer. If you reasonably should have known that they were incompetent or otherwise inappropriate for the referral, you may be partially responsible for a negative outcome.

Never assume that a patient's family can or will monitor the patient as well as hospital staff. Asking family to carry out hospital responsibilities is below the SOC. (Like several of the previous examples, this caveat applies to both hospital discharge and failure to admit an outpatient who is at substantial risk.)

After several days of psychiatric hospitalization following a hanging attempt, "Mr Frank" demanded release. His psychiatrist and the hospital discharge planner spoke with Mr Frank's family, who promised to watch him "24/7." Mr Frank was found hanging in their garage early on the second day after discharge to their care.

In the subsequent lawsuit, the family testified that they indeed had said they would monitor Mr Frank, and part of the psychiatrist's defense was that he had essentially discharged Mr Frank to another "care environment"—his family home—as

agreed. A jury found, however, that the psychiatrist was not entitled to rely on the family. They found that the family had no duty and no reasonable expectation of an ability to treat the patient as he would have been treated in a hospital, and releasing Mr Frank to the family was below the SOC and caused Mr Frank's death.

Understand risk. Practice well. Document scrupulously. Be the doctor.

Dr Reid *is a clinical and forensic psychiatrist who has worked with attorneys in scores of malpractice actions. He is professor of psychiatry at the University of Texas Dell Medical School and clinical professor at Texas Tech University Health Sciences Center.* **Mr Simpson** *is a malpractice attorney for psychiatric and mental health organization matters, with cases throughout the United States. He is on the Board of Directors of the American Association of Suicidology.*

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Download Issue : Vol 37, Issue 9

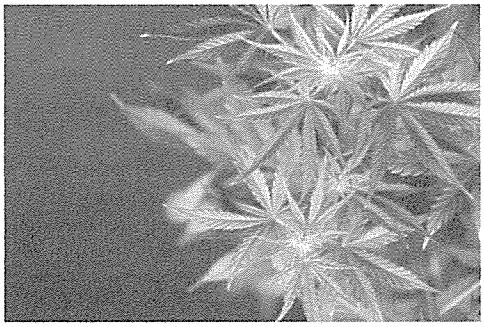
Does Cannabis Cause Psychosis?

March 11, 2021

Brian Miller, MD, PhD, MPH

Psychiatric Times, Vol 38, Issue 3,

A synthesis of quantitative reviews on the relationship between cannabis use and psychosis.



Cendeced/AdobeStock

Case Vignette

"Mr Green" is a 39 year-old African-American male with a history of chronic schizophrenia, cannabis use disorder, and alcohol use disorder. He started smoking cannabis almost daily at age 20. When he was 22, he was in a motor vehicle accident while under the influence of substances and suffered a head injury. Several months later, he was hospitalized for a first episode of psychosis (FEP). Thereafter, he participated in a long-term antipsychotic clinical trial.

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For more than a decade, he has been maintained on a long-acting injectable antipsychotic and is adherent with appointments. He tends to get paranoid during stressful times, but he has not had any subsequent psychiatric hospitalizations. However, he has continued to use cannabis regularly—daily to weekly—for almost 20 years. Although he worked prior to the onset of his psychotic disorder, he has since been chronically unemployed. He lives at home with his parents, has never married, and does not have any children. He remains precontemplative regarding the need for treatment for alcohol and cannabis use disorder.

Mr Green's case is (sadly) all too familiar for clinical practitioners in psychiatry. Substance use comorbidity in psychotic disorders has been described as the rule rather than the exception, and it is often deleterious to the clinical course of illness.[1] Cannabis (marijuana) is one of the most commonly used substances by patients with schizophrenia and related psychoses. Modulation of the endocannabinoid system by the main psychoactive component in marijuana, Δ9-tetrahydrocannabinol, can induce acute psychosis and cognitive impairment.[2] Over the past 2 decades, there has been extensive research on the association between cannabis and psychosis.

To better understand the relationship, it is important to synthesize recent research—through the lens of systematic quantitative reviews—including associations between cannabis and psychosis risk; the

epidemiology and phenomenology of psychosis and comorbid cannabis use; associations between cannabis use and clinical course; and outcomes in psychosis. Dichotomous outcomes are reported as odds ratios (OR) with 95% confidence intervals (95% CI). Continuous measures are reported as effect sizes (ES), where an ES of 0.2 is small, 0.5 is medium, and 0.8 is large.

Cannabis and Psychosis Risk

Linscott and van Os[3] investigated cannabis use and psychotic experiences in a meta-analysis of 61 cohorts. They found a significantly increased prevalence (OR=2.41, 95% CI 1.84-3.43) and incidence (OR=1.77, 95% CI 1.20-2.61) of psychotic experiences in participants who used cannabis. This association is important given that 7.4% of people with psychotic experiences at baseline developed a psychotic disorder.

Szoke and colleagues[4] meta-analyzed 29 studies of cannabis use and schizotypy (attenuated psychosis). Lifetime cannabis users had significantly greater scores for total (ES=0.42), positive (ES=0.44), negative (ES=0.18), and disorganized (ES=0.33) schizotypy versus never users. Furthermore, current cannabis users had significantly greater scores for total (ES=0.21), positive (ES=0.23), and disorganized (ES=0.27), but not negative schizotypy scores versus subjects that do not currently use cannabis.

Carney and colleagues[5] investigated the prevalence of cannabis use and its association with symptoms in participants at ultra-high risk (UHR) for psychosis. Across 30 studies (n=4205 UHR), there was a 27% current and 53% lifetime prevalence of cannabis use, and a 13% prevalence of cannabis use disorders (CUD). This corresponded to a 2.09-fold and 5.45-fold increased odds of lifetime use and CUD, respectively, in patients at UHR compared

to n=667 controls. Furthermore, UHR cannabis users had a higher prevalence of both suspiciousness (ES=0.21) and unusual thought content (ES=0.27).

Furthermore, a recent comprehensive review by Farris and colleagues,[6] which included 36 studies, found a 26% current and 49% lifetime prevalence of cannabis use, and a 15% prevalence of CUD in those at clinical high-risk for psychosis.

Kraan and colleagues[7] reviewed the association between cannabis use and transition to psychosis in people at UHR across 7 studies. They found that lifetime cannabis use was not significantly associated with transition to psychosis in people at UHR (n=1171, OR=1.14, 95% CI 0.86-1.52). However, they found that current CUD was associated with significant, increased odds of transition to psychosis (OR=1.75, 95% CI 1.14-2.71).

Semple and colleagues[8] performed a meta-analysis of 7 case-control studies of cannabis use and risk of psychotic disorder. They found that cannabis use was associated with an almost 3-fold increased odds of psychosis (OR=2.9, 95% CI 2.4-3.6), with evidence that early cannabis use may confer even greater risk for psychosis outcomes. In a meta-analysis of 7 studies, Moore and colleagues,[9] found a significant increased risk of any psychotic outcome in participants who had used cannabis (OR=1.41, 95% CI 1.20-1.65), with an even greater risk in those who used cannabis most frequently (3 studies = daily, 1 study each = weekly, >50 times, and cannabis dependence; OR=2.09, 95% CI 1.54-2.84).

Marconi and colleagues[10] also investigated the magnitude of the dose-response relationship between cannabis use and risk of psychosis. In a meta-analysis of 10 studies (n=66,816), there was a significant, almost 4-fold increased odds of psychosis

among the most severe cannabis users compared to non-users (OR=3.90, 95% CI 2.84-5.34).

Johnson and colleagues[11] conducted a large genome-wide association study of those who use cannabis (n=20,916) and controls (n=363,116). They identified 2 loci with genome-wide significance: a novel locus on chromosome 7 (*FOXP2*; OR=1.11, 95% CI 1.07-1.15), and a previously identified locus on chromosome 8 (near *CHRNA2* and *EPHX2*; OR=0.89, 95% CI 0.86-0.93). Importantly, cannabis use and CUD were significantly, positively, and genetically correlated with schizophrenia in this study.

Epidemiology of Psychosis and Comorbid Cannabis Use

In a meta-analysis of 35 studies (n=5540), and found a 16% current and 27% lifetime median prevalence of CUD in patients with schizophrenia.[12] The median prevalence of CUD was higher in FEP versus those with long-term schizophrenia (29% versus 22% for current, and 44% versus 12% for lifetime use). CUD was also more prevalent in studies with male predominance. A more recent systematic review of 69 studies in community and clinical settings found a 26% prevalence of current or lifetime cannabis use (36% in FEP samples).[13]

Myles and colleagues[14] analyzed prevalence data on current cannabis use in FEP. In 10 samples, the pooled estimate for the time between initiation of regular cannabis use and onset of psychosis was 6.3 years. In 35 samples, the estimated prevalence of cannabis use at FEP was 34% (95% CI 31-39%), consistent with findings from an earlier meta-analysis.[12] In 19 samples, cannabis use at follow-up (between 6 months and 10 years after FEP) declined about 50% over time (OR=0.56, 95% 0.40-0.79).

In a meta-analysis of 41 samples, Large and colleagues[15] found that the age of onset of psychosis was 2.7 years younger (ES=0.41) for those who used cannabis than those who did not. Given that many cannabis users also smoke tobacco, Myles and colleagues[16] compared the extent to which cannabis and tobacco use are associated with an earlier age of onset of psychosis. In 40 samples, the age of onset of psychosis was 32 months earlier for cannabis users than nonusers (ES=0.40, $p<0.01$), but 2 weeks later in tobacco smokers than non-smokers (ES<0.01, $p=0.97$). Sex was not a significant moderator of the association.

Psychopathology and Cognition in Comorbid Psychosis

Several reviews have investigated psychopathology in patients with comorbid psychosis and CUD. In pooled data from 2 studies, Potvin and colleagues[17] did not find any difference in depressive symptoms in patients with schizophrenia with versus without cannabis use (ES<0.01). This same group found significantly greater levels of negative symptoms across 3 studies in patients with schizophrenia who used cannabis (n=102) than those who did (n=168) (ES=0.51).[18] In a meta-analysis of 22 studies, Large and colleagues[19] did not find any significant differences between positive, negative, and depressive symptoms, or social function in patients with psychosis and cannabis use versus those with psychosis and other non-cannabis substance use.

Yucel and colleagues[20] conducted a meta-analysis of 10 studies (n=572) of the association between cannabis use and cognition in schizophrenia. They found significant better global cognition (ES=0.55), processing speed (ES=0.65), visual memory (ES=0.45), planning (ES=0.67), and working memory (ES=0.64) in individuals who used cannabis in their lifetime but not current/recent use . The

association between better cognitive performance and cannabis use in schizophrenia may be driven by a subgroup of patients with less cognitive impairment who developed psychosis after a relatively early onset of cannabis use.

Bogaty and colleagues[21] further investigated the association between cannabis use and cognition, focusing on younger patients with psychosis (mean age 15-45). In a pooled analysis of 14 studies, patients with psychosis and current cannabis use had significantly lower premorbid (ES=0.40) and current IQ (ES=0.17), as well as worse scores on verbal learning (ES=0.39), working memory (ES=0.0.76), and motor inhibition (ES=0.19), but significantly better scores on conceptual set-shifting (ES=0.32) compared to patients with psychosis and no lifetime cannabis use.

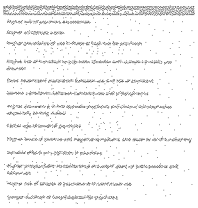
Clinical Course and Outcomes in Psychosis

The duration of untreated psychosis (DUP) is a predictor of outcome in FEP. Burns[22] analyzed 7 studies (n=1453) of DUP and cannabis use in FEP, 39% of whom were cannabis users. He found a non-significantly shorter DUP in those who used cannabis versus those who did not (28.4 vs 29.3 weeks).

In a meta-analysis of 15 observational studies (n=3678), Foglia and colleagues[23] investigated the effects of cannabis use on antipsychotic adherence in patients with psychosis. At baseline, cannabis users had a 2.5-fold increased odds of antipsychotic nonadherence compared to non-users (OR=2.46, 95% CI 1.97-3.07, n=3055). At follow-up, there was an almost 6-fold increased odds of antipsychotic nonadherence in current cannabis users compared to nonusers (OR=5.79, 95% CI 2.86-11.76, n=175 subjects). By contrast,

antipsychotic nonadherence was not significantly different between former cannabis users and non-users.

There is very limited data comparing antipsychotics head-to-head in patients with psychosis and comorbid cannabis use. Brunette and colleagues[24] found significantly less cannabis use in n=15 patients treated with clozapine versus n=16 patients treated with other antipsychotics (ES=1.08), broadly consistent with evidence for efficacy of clozapine in patients with substance use comorbidity. Another small trial found significantly less cannabis use in n=20 patients on olanzapine versus n=21 patients on risperidone.[25]



Association Between Cannabis and Psychosis

Despite the established association between cannabis use and psychosis, less is known about the effects of continued (versus discontinued) cannabis use after the onset of illness. Schoeler and colleagues[26] identified 24 studies (n=16,565) in this area. Independent of illness stage, patients who continued cannabis use had a significantly greater risk of relapse of psychosis than both patients who discontinued cannabis use (ES=0.28) and non-users (ES=0.36). By contrast, there was no difference in relapse risk between patients who discontinued cannabis use and non-users (ES=0.02). Furthermore, patients with continued cannabis use had significantly longer durations of hospitalization than non-users (ES=0.36). In meta-regression analysis, continued cannabis use (versus discontinued use) was a significant moderator of more severe positive symptoms and lower level of functioning, but not negative symptoms.

Conclusion

As summarized in the Table, there are robust associations between cannabis use and psychosis risk, with evidence for a dose-response relationship, which supports the plausibility of a causal association. Comorbid cannabis use is highly prevalent in psychosis (especially FEP, with declining use over time), with strong evidence for an earlier age of onset of illness, as well as effects of psychopathology and cognition. In patients with psychosis, continued cannabis use is associated with antipsychotic nonadherence, illness relapse, and longer hospitalizations. These findings raise the possibility of a dose-response relationship between current cannabis use and transition to psychosis. Findings suggest that targeting cannabis use during the UHR period may confer significant benefits on long-term outcomes. Continued cannabis use is also a potential target for intervention to improve antipsychotic adherence and other outcomes in patients with psychosis. Future research in this area is clearly warranted to elucidate mechanisms and novel treatment strategies for relevant populations.

Dr Miller *is professor in the Department of Psychiatry and Health Behavior, Augusta University, Augusta, Georgia. He is on the Editorial Board and serves as the schizophrenia section chief for* Psychiatric Times™*. The author reports that he receives research support from Augusta University, the National Institute of Mental Health, the Brain and Behavior Research Foundation, and the Stanley Medical Research Institute.*

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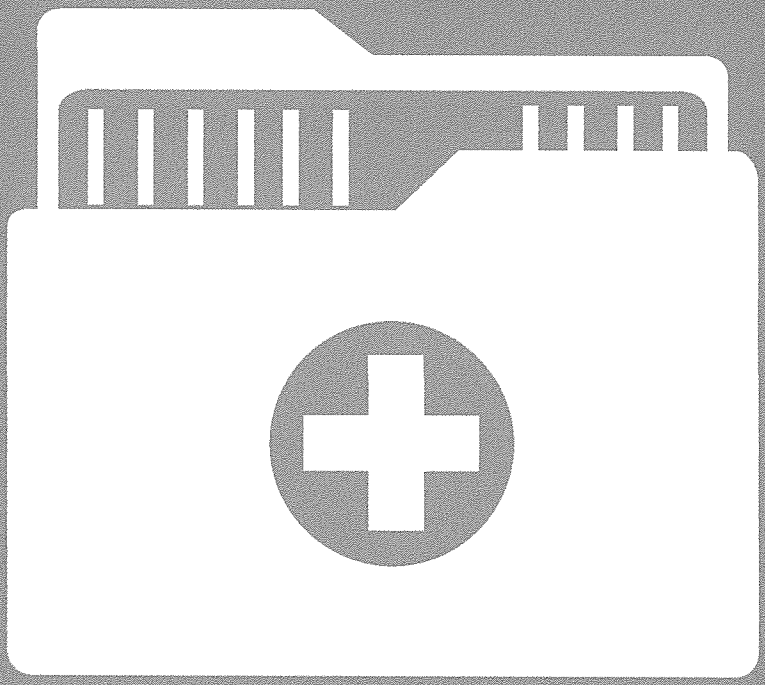
2017 | Volume 25 | Issue 2

Rx FOR RISK

Addressing risk management issues and concerns in the field of psychiatry

Documentation



Reading Rx for Risk on a screen?
Click on the page numbers below to be taken directly to that section of the newsletter!

Table of Contents

MYTHS & MISCONCEPTIONS: A PERFECT RECORD

Myth 1: It is possible to create a perfect record.

Truth: There is no such thing as a perfect record. As with most aspects of psychiatric practice, documentation remains a lifelong learning process, a perpetual skill-in-progress that must continually be reassessed in order to respond to changing demands and considerations.

A psychiatric record does not have to be "perfect," but it should be "good enough." What does that mean? While the specific *content* of a psychiatric record may vary, the *purpose* of documentation remains constant. A good record accomplishes several things: it substantiates your clinical judgment and choices, demonstrates the knowledge and skill you exercised during treatment, provides a contemporaneous assessment of the patient's needs and behaviors, and documents significant events, revisions to the treatment plan, and explanations of your decisions.

Myth 2: Unless you have a perfect record, you cannot win a lawsuit.

Truth: You do not need a "perfect record" to win a lawsuit, but you need to have one that is "good enough." It is true that documentation plays a vital role in the defense of a malpractice lawsuit; without adequate documentation it may be very difficult to demonstrate that you provided appropriate care. However, an experienced defense attorney can work well with a cooperative clinician and a "good enough" record. [See above for what constitutes a "good enough" record.] You should not become complacent, though; the reality that perfection can never be obtained should not prevent you from striving to create as complete and supportive a record as possible.

There is one *absolute* with regard to records and professional liability . . . NEVER ALTER A RECORD. Altering a record destroys your credibility in a lawsuit, could compromise your professional liability insurance coverage, could lead to sanctions from your medical licensing body, and will destroy your professional reputation. In addition, altering a record may be considered a criminal act.

YOUR MEDICAL RECORD HAS **THREE ESSENTIAL PURPOSES**:

1. To support good clinical care
2. To use in your defense and show compliance with legal requirements
3. To substantiate your billing and demonstrate your adherence to payer guidelines

PRACTICAL POINTERS FOR PSYCHIATRIC RECORDS

The importance of records in malpractice litigation cannot be overemphasized. A good psychiatric record accomplishes several things: It substantiates clinical judgment and choices; it demonstrates the knowledge and skill exercised during treatment; it provides a contemporary assessment of the patients' needs and behaviors; and it documents explanations of the provider's decisions, significant events, and revisions to the treatment plan.

Set forth below are risk management tips regarding psychiatric records.

DO know your state's laws regarding the creation and maintenance of patient records. Most states have statutes and/or regulations governing the creation and maintenance of patient records. Even when such requirements are absent, it is the standard of care to create and maintain a record for each patient.

DO review and be familiar with contractual obligations regarding record creation and maintenance in all provider contracts.

DO remember that there is no "statute of limitations" for disciplinary actions by licensing/medical boards or for ethics proceedings. Absent state and/or federal or contractual requirements, legal experts advise keeping records indefinitely and, *at a minimum*, until your state's statute of limitations runs. Remember, there are generally no statutes of limitations imposed on disciplinary actions by licensing/medical boards or on ethics proceedings.

DO establish separate sections within a record for clinical documentation, patient billing information, correspondence regarding the patient and records received from other health care providers or institutions. *Communications with personal counsel or the Risk Management Consultation Service (RMCS) should be kept separately in a personal administrative file.*

DO establish separate records for each and every person attending a patient's session. This will assist with maintaining confidentiality and will facilitate your ability to process requests for information in a timely manner.

DO keep records somewhere safe, accessible only to those who have authorization.

DO back-up computerized records and information daily, at a minimum. Be aware that if you choose to use a given technology, you will be held to the standard(s) associated with that technology. Consult equipment and software professionals for information about your system's back-up standards and capabilities.

DO document legibly. The record should be legible not only to the writer but to others, as well.

DO NOT wait to write or dictate record entries. Avoid waiting until the end of the morning/afternoon/day to make entries, because essential information can be forgotten.

DO date and sign or initial record entries. Keep a permanent listing of all past and present employees for reference. Include their names, signatures, and initials.

DO maintain the integrity of the entire record.

DO record identifying patient information on each page of the clinical documentation so that if it becomes separated from the record, it can be re-filed correctly.

DO NOT alter, amend, or expand a record. Altering records, especially to avoid looking bad, can be fatal to a case and may lead to a forced settlement due to the damage such changes would do to your credibility in court. Any alteration of medical records could jeopardize coverage under the terms of your professional liability insurance policy.

DO use accepted methods for correcting mistakes or omissions in a record. In situations where there is legitimate cause to correct a record, be sure that you carefully date the correction, clearly note that you are correcting an error, and sign or initial the correction. Make corrections using single line strike-through and date & initial the corrections. For corrections which involve more that a word or phrase, amend the original entry with a statement about where to find the correct information. Then, make a new entry (in current chronological order) indicating that a correction is being made and giving the correct information. Date and sign or initial both entries.

DO document dates (and length) of service, pertinent history, assessments, and prescriptions.

DO document informed consents, release of information authorizations, consultations with other health care providers, relevant correspondence, etc.

DO document psychological testing, physical examinations, laboratory data, etc.

DO document late shows, no shows, and appointment cancellations.

DO document what treatment options/actions were considered, what options/actions were chosen and why, and what options/actions were rejected and why.

DO document prescriptions and prescription refills.

DO document the discharge summary, if relevant.

DO document the termination of treatment process.

DO document phone calls between patients, third-parties, and the office.

DO document objectively and professionally. Documentation of the psychiatrist's thought process is an essential part of the record. S.O.A.P. notes or some variation thereof are preferable.

DO establish written policies and procedures to ensure that lab tests, consultations, and referrals have been completed, the subsequent reports have been received, reviewed, and initialed by you, and all paperwork has been filed appropriately. This system should also capture information received after an office visit regarding allergies, medications, and information received from patients' other health care providers. The timely filing of phone messages, lab slips, consultation reports, etc. greatly enhances the credibility of the record.

DO NOT include personal comments about patients, names of third parties, or other extraneous references which do not serve a therapeutic purpose.

DO NOT document contacts with personal counsel or the RMCS in patients' records. Consultations regarding legal or risk management issues should be maintained in a personal administrative file. No identifying patient information should be included.

DO NOT release information without proper authorization. Proper authorization usually means either a signed release authorization or a court order.

DO educate staff regarding the handling of records. Stress confidentiality. Ensure that all requests for release of information/records are reviewed by you for determination of proper authorization, identification of the specific information to be released, and analysis of the potential impact upon the patient(s) and others.

10 THINGS PLAINTIFF ATTORNEYS LOOK FOR

1. Documentation of informed consent/refusal
2. Documentation of a psychiatrist's thought process
3. Reasons for off-label prescribing
4. Self-serving/late entries
5. Documentation of any termination procedures
6. Finger-pointing/jousting
7. Documentation of prescriptions/refills
8. Documentation of follow-up efforts
9. Documentation of contacts with/regarding patients
10. Altered records

RETAINING AND DISCARDING PSYCHIATRIC RECORDS

It should go without saying that a patient record exists for a reason – it exists *primarily* to support good patient care. A good patient record accomplishes several things: It substantiates clinical judgment and choices; it demonstrates the knowledge and skill exercised during treatment; it provides a contemporary assessment of the patients' needs and behaviors; and it documents explanations of the provider's decisions, significant events, and revisions to the treatment plan. In short, it allows someone else (e.g., another physician) to know and understand what has happened during treatment and why.

A secondary benefit derived from a good patient record is the ability to provide a defense in an adversarial situation such as litigation or an administrative or ethics complaint. The importance of patient records in these types of situations cannot be overemphasized.

RETAINING RECORDS

How long should records be kept? There is no clear answer. Due to the variety of statutes, regulations, legal principles, and professional obligations affecting psychiatric records, the best risk management advice

dictates that records should be kept for as long as possible. The safest and most conservative option is to keep records indefinitely. Perpetual maintenance may seem excessive, but there are many reasons your records may be needed in the future. If records cannot be kept indefinitely, they should be kept as long as possible.

How long am I "legally" required to keep records?

Many states have statutes and/or regulations governing the creation and maintenance of patient records, including the time period for which records must be kept. Federal statutes and/or regulations may also address record maintenance. The time periods mandated in these statutes and regulations represent the length of time you are "legally" required to keep patient records, *at a minimum.*

In addition to statutory and/or regulatory requirements, there may be contractual obligations regarding record creation and maintenance in provider contracts, both explicit and implicit. Frequently, provider contracts include provisions mandating how long records must remain available to patients and insurance companies. If a contract requires you to keep records for a different amount of time than is laid out in the relevant statutes and/or regulations, then you should keep the records for whichever time period is the longest, at a minimum.

Absent explicit requirements, records should be kept *at least* until well after your state's statute of limitation for medical malpractice actions and/or statute of repose have run. The statute of limitations laws and/or the statutes of repose establish the time period during which a legal action may be brought against you. However, you cannot absolutely rely on these statutes to protect you from litigation. Depending on the nature and wording of a complaint, an action may be brought against you even though it is not brought within the limitation periods. In addition, statutes of limitations or repose do not apply to disciplinary actions by licensing/medical boards or to ethics proceedings. Professional complaints may be made against you at any time.

Why should I keep records indefinitely?

1) Continuity of Care

One of the most important reasons for retaining records is continuity of care. Patients may receive care from a patchwork of healthcare providers over time, and the psychiatric records may be necessary to ensure that patients continue to receive the care they need. Patients who find that they are unable to obtain their medical information whenever requested can initiate complaints with professional and licensing bodies. Increasingly, medical boards and state/federal regulators are starting to insist that patient records be available *whenever needed.*

2) Potential Lawsuits

Another reason records may be needed is litigation. In a legal proceeding against you, the record is the primary means of supporting and defending the care that was given. As mentioned above, your state's statute of limitations laws and/or statutes of repose exist to limit the time period during which an action may be filed, however there are exceptions to these statutes. For example, state law usually also contains provisions for "tolling" the statute of limitations in cases where the patient (i.e., prospective litigant) is a minor or suffers under some other legal disability or incompetence. This means that for some patients, the time in which a suit can be filed is extended.

Additionally, your state's statutes of limitations that limit the time during which malpractice actions may be filed against physicians may not limit the time litigation resulting from allegations involving fraud, conspiracy,

or criminal acts may be brought against you. Furthermore, these laws are not applicable to professional and ethical complaints or allegations involving federal laws, rules, and regulations (e.g., Medicare billing complaints).

3) Other Situations

There are other situations in which a record may be needed, besides defending you. For example, a patient may need the record to support his case against another individual (e.g., another healthcare professional or an employer) or to back-up a claim for disability benefits. Custody proceedings are another common example.

How do I store records?

Records should *always* be stored somewhere safe and secure, and should be accessible only to authorized individuals. All psychiatrists are ethically obligated to keep the psychiatric record secure. There may also be legal requirements under state law, as well as federal law. For instance, per HIPAA's privacy and security regulations, covered providers must comply with standards to ensure security and prevent unauthorized disclosure. Remember that the duty to maintain the confidentiality of patient records does not diminish over time, nor does it cease to exist upon the death of the patient.

Should you choose to keep your records indefinitely or for an extended period of time, you may want to consider using a professional records storing company. Such companies may be found online or through the records department of the local hospital or medical society. Your personal attorney or accountant may also be able to suggest a company.

If a storage company is used, it should have experience handling confidential medical information, guarantee the security and confidentiality of records, and allow access by authorized individuals. You should have a written agreement with the storage company. Topics which should be addressed specifically in the written agreement include but are not limited to confidentiality and privilege, release of information, time in which it will take to retrieve records, and destruction of information. If you are a covered provider under HIPAA's Privacy Rule, you will need a "Business Associate Agreement" with the storage company. All contracts should be reviewed by personal counsel.

DISCARDING & DESTROYING RECORDS

If, after careful consideration, you do decide to discard and destroy patient records, there are some important considerations to keep in mind. Primarily, you should develop and implement a retention schedule and destruction policies and procedures. Records involved in open litigation, investigation, or audit should *not* be destroyed.

How do I discard & destroy records?

Should you choose to discard and destroy records, it is *imperative* that you establish and follow written policies and procedures for doing so. Following an established procedure may help to mitigate potential allegations that a record was destroyed in order to conceal unfavorable information. It *cannot* be guaranteed to protect you from situations in which you need the record; the absence of a record is problematic in any type of proceeding.

Some jurisdictions require that you notify patients that their records will be destroyed. Even if not required, notifying patients is always prudent. Patients may want copies forwarded to them or their current physician for future use. Remember to always obtain a proper release authorization prior to releasing any information.

Destroy *completely* all records and copies of records selected for discarding. Different media require different methods of destruction: shred, burn, or pulverize paper records; recycle or shred microfilm or microfiche; purge and destroy computerized records. Whatever method is used, ensure that third parties cannot discern or reconstruct patient information from destroyed records.

Retain a log of what records were destroyed, how and when they were destroyed, the inclusive dates covered, what method of destruction was used, a statement that the records were destroyed in the normal course of business, and the signatures of the individuals supervising and witnessing the destruction. Maintain destruction documentation permanently.

In addition, you may want to consider keeping an abbreviated patient record containing basic information, including the intake form, dates of treatment, diagnosis, release of information forms, termination forms, and case summaries, etc.

Who else can I contact for information?

For additional information on retaining and discarding records, contact your state medical board, your local medical society, your local APA district branch, and other professional medical organizations to which you belong. The American Health Information Management Association (AHIMA), a professional healthcare information organizations, is an invaluable resource.

Risk management tips for retaining & discarding psychiatric records.

DO review and be familiar with statutory, regulatory, and contractual obligations regarding records creation, retention, and discarding. In addition to federal law, including HIPAA, most states have statutes and/or regulations governing the creation, maintenance, and discarding of patient records. Even when such requirements are absent, it is the standard of care to create and maintain a record for each patient. The safest and most conservative option is to never destroy patient records.

DO understand that you cannot absolutely rely on your state's statute of limitations for medical malpractice or the statute of repose to protect you from legal actions. Depending on the nature and wording of a complaint, a legal action may be brought against you even though it is not brought within the limitation period.

DO understand that the records of minors and patients with some other legal disability or incompetence may fall under statutory tolling provisions. This means that for some patients, the time in which a suit can be filed is extended.

DO understand that your state's statutes that limit the time during which malpractice actions may be filed against physicians would not be applicable in litigation resulting from complaints or allegations involving fraud, conspiracy, criminal acts, or federal laws, rules, and regulations. For example, your state's statute of limitations laws would not apply to allegations of Medicare billing fraud.

DO remember that there is no "statute of limitations" or "statute of repose" for disciplinary actions by licensing/medical boards or for ethics proceedings. Absent state and/or federal or contractual

requirements, legal experts advise keeping records indefinitely and, *at a minimum*, until well after your state's statute of limitations for medical malpractice and/or statute of repose have run.

DO keep records somewhere safe and accessible only to those who have authorization.

DO consider using a professional records storage company. Since you are responsible for ensuring the confidentiality of your patients' records, make sure that the records storage company agrees to protect patients' confidentiality in your agreement/contract with the company. If you are a covered provider under HIPAA's Privacy Rule, the confidentiality agreement with the records storage company is a "Business Associate Contract", containing all the elements required under that regulation

DO develop and implement a retention schedule and written policies and procedures for destroying records. Following an established procedure may help to mitigate future potential allegations that a record was destroyed in order to conceal unfavorable information. It *cannot* be guaranteed to protect you from situations in which you need the record.

DO NOT destroy records involved in open litigation, investigation, or audit.

DO destroy *completely* all records selected for discarding. Different media require different methods of destruction. Ensure that third parties cannot discern or reconstruct patient information from destroyed records.

DO retain a log of the destruction. Include information about what records were destroyed, how and when they were destroyed, the inclusive dates covered, what method of destruction was used, a statement that the records were destroyed in the normal course of business, and the signatures of the individuals supervising and witnessing the destruction. Maintain destruction documentation permanently.

Additional Resources:

American Health Information Management Association (AHIMA): www.ahima.org

American Psychiatric Association (APA): www.psych.org

American Medical Association (AMA): www.ama-assn.org

American Hospital Association (AHA): http://www.aha.org

EHRS AND DOCUMENTATION

Many psychiatrists are either now using or are contemplating the use of electronic health records. The first thing to remember is that no matter how good the system, what you get out of it will only be as good as what you put in. In other words, garbage in, garbage out. If you have not been thorough with your documentation in the past, your EHR system might make your record look "prettier" but it will not in and of itself create a record that supports good patient care and would be useful in your defense in a claim or a lawsuit.

TRANSITIONING FROM **PAPER TO ELECTRONIC RECORDS**

Unless you are starting your practice from day one using an EHR system, you are going to have a period of transition. It is during this time that you must be particularly vigilant to avoid documentation errors and gaps. Courts and licensing boards will not "cut you any slack" during your transition/learning period. You will be expected to practice to the same standard of care and are responsible for implementing procedures a reasonable provider would implement to avoid errors. To that end, you should recognize, and take steps to minimize, the following risks:

- Documentation gaps – how will you maintain and refer to your paper charts?
- Mental fatigue from treating patients while learning a new system
- Inadequate training/inconsistent use among staff leading to errors

Concerns about patient safety and the use of electronic health records have been in the news for years. As the use of this technology has grown so have these concerns. In 2015 ECRI Institute listed errors associated with EHR use among its Top 10 Patient Safety Concerns and the Joint Commission issued a Sentinel Event Alert on the Safe Use of Health Information Technology.

DOCUMENTATION SHORTCUTS

Documentation shortcuts were created with the intent of allowing physicians to create a more complete record in less time. Ironically, it is often these shortcuts that pose the greatest risks to patient safety and physician liability.

Box Checking

A written record often contains seemingly extraneous information that can become extremely important to a physician's defense. For example, who was present when a patient was informed of the risks associated with a certain medication and what questions were asked and answered, or what comments the patient made regarding her adherence to treatment. Unfortunately, some EHR systems don't provide a mechanism for users to include this information and instead they are limited to checking boxes. The absence of the ability to write a complete narrative is a frustration many physicians report with EHR use.

Templates

As will be discussed more fully in a moment, template use is an area that is undergoing scrutiny by CMS and other payers. Templates are used to easily provide additional detail to a note but may not accurately reflect treatment – for example, they may misstate a patient's age or gender. The result is often a record filled with a large number of identical notes which call into question whether the physician truly did a thorough evaluation of the patient at each encounter. If a template is used for informed consent, it may not capture all of the information you need to establish that the informed consent discussion actually took place, e.g., who was present.

Autopopulation

Some systems will automatically populate entries with information from previous visits. On occasion the system will erroneously enter information from the previous *patient*. It is often impossible to determine whether data was entered by a clinician or by the system itself. Relying on default data can cause you to make false assumptions about a patient's condition and making inaccurate default data a part of your record will cause you to lose credibility in any subsequent litigation. Further, some state medical boards have written position statements cautioning licensees against relying upon software that pre-populates fields.

Copy and Paste Functionality or Note Cloning

As with template use, this function which allows a provider to copy and paste portions of previous entries into a new note is undergoing scrutiny by CMS. While intended to improve the thoroughness and ease of documentation, this function may be misused leading to problems both for the physician and the patient. Risks include:

- The possible perpetuation of erroneous information leading to incorrect diagnosis/treatment
- The potential for copying and pasting the note to the wrong treatment date or even the wrong patient's record
- The inability to identify the author of the original note and the date of that note
- Duplication of information not relevant to the current encounter

In its *Report of the Committee on Ethics and Professionalism in the Adoption and Use of Electronic Health Records*, Federation of State Medical Boards recommends:

> *"If a provider is satisfied that copying and pasting information into a new record entry is permissible in a given instance, he or she must include the appropriate citation in the record and verify that the copied information is current. Generally, it is inappropriate to copy and paste or otherwise document an entry that is not derived from a patient encounter at the time of the visit, unless the provider makes a clear notation that the information is copied and pasted from another record. Copy and paste is only appropriate when the content is verified."* [1]

THE FALSE CLAIMS ACT (FCA)

The Federal False Claims Act (FCA) protects the federal government from being overcharged or sold substandard goods or services and imposes civil liability on anyone who knowingly submits, or causes to be submitted, a false or fraudulent claim. "Knowingly submits" includes acting in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. Penalties for violation of the FCA include fines up to three times the amount of damages sustained by the government plus $11,000 per claim filed, or jail, or both.

One example of "knowingly submitting" a false claim might be a situation involving "upcoding" where a provider bills for a higher code than is appropriate for the service actually furnished which then results in a higher payment. The use of templates or note cloning in an electronic health record may lead to upcoding which puts the physician at risk – even if the upcoding was unintentional. In September of 2012, HHS and the Justice Department sent a letter to the American Hospital Association and others advising that the use of templates and note cloning would thereafter be under scrutiny.

If you choose to use documentation shortcuts such as templates and the copy/paste function you must remember that it is you who will be responsible for insuring that the encounter is billed using the appropriate code. Though the system may create documentation that meets the coding requirements for the highest code, it does not mean that you should bill at that code. Medical necessity is the key to accurate coding – even if a coding tool suggests a higher level of service.

TOO MUCH INFORMATION

Another issue to consider is whether so much information is being captured and stored that users cannot find relevant information. This can be problematic in emergency situations as well as routine treatment. One practical solution to this dilemma is to periodically print out a patient record and evaluate it for adequacy. A good medical record is one in which a subsequent provider or an expert witness would be able to understand what happened during the treatment relationship and why.

METADATA

Metadata is literally data about data and provides an audit trail of everything that occurs within the electronic record. What this means is that every time you sign onto an electronic health record system, you leave a trail of your activity including what patient records and what portions of those records were viewed, the actual time the record was viewed, how much time was spent looking at the record (including how long it took to view and override a safety alert or other clinical support tool), what entries were made, and any changes that were made to the record. And, as with all other parts of the medical record, metadata may be discoverable in a medical malpractice lawsuit.

"In addition to affecting the risk of a lawsuit, implementation of EHRs may affect the course of malpractice litigation by increasing the availability of documentation with which to defend or prove a malpractice claim."[2] No longer will juries have to rely upon a physician's recollection as to what occurred. There will be no question as to whether a physician reviewed a lab finding or whether he or she made a self-serving entry after an adverse outcome. Any dispute may now be resolved by simply examining the metadata.

In addition to its use in malpractice litigation, metadata may also be utilized to monitor access to patient records and to uncover HIPAA violations. Another potential use is by third-party payors who wish to analyze it to determine whether physicians have actually performed the services for which the payors are being billed.

CLINICAL DECISION SUPPORT SYSTEMS

Clinical decisions support systems are designed to assist physicians by making recommendations about possible diagnoses from a set of signs and symptoms, provide alerts on possible drug interactions or critical lab values, or to question a physician's medication dosage or other orders.[3] Unfortunately these systems tend to produce alerts that are not relevant and in such a large number that they've prompted at least one author to refer to them as the electronic version of the little boy who cried wolf. In other instances, the alerts may be based on out-of-date information. In fact, your EHR vendor likely will not even stand behind them as many include in the limitation of warranties section of their vendor agreements a statement that they are not responsible for the accuracy or completeness of the alert.

A 2009 study published in the Archives of Internal medicine found that of more than 200,000 alerts generated by an outpatient electronic prescription system, physicians accepted only 9.2% of drug interaction safety alerts and only 10.4% of "high severity interaction alerts."[4]

Further, a Department of Veteran's Affairs funded study published in the April 2012 Issue of the International Journal of Medical informatics found that often prescribers were unsure of why the alert was generated or that it pertained to a group of individuals , e.g., diabetics or pregnant women, as opposed to the specific patient in question.[5]

Alerts are often seen as such a waste of time that some practices have elected to have that feature turned off if possible while others have purchased software that allows them to screen alerts for relevance. While it is true that many alerts are not clinically relevant it is also true that there are some that are and therein lies the problem. Physicians can become so accustomed to seeing alerts that are not relevant that they tend to not notice when an alert is relevant which is known as alert fatigue.

Unfortunately, a jury will not be sympathetic should you miss an alert that might have prevented patient harm. As presented by a plaintiff attorney, they will only see that you were told of potential patient harm and ignored the warning. Because the plaintiff attorney will also have access to metadata, he will be able to show how rapidly you clicked past the warning seemingly without consideration.

RISK MANAGEMENT REMINDERS

- Ensure templates used are appropriate for the specific patient
- Consider disabling the cut and paste function or use with extreme discretion and require author identification for each entry
- Do not allow autopopulation
- Periodically print out a copy of your record to look for
  - » Technical glitches
  - » Ability to pass a billing audit
  - » Ability of a subsequent treater (or an expert witness) to understand what you did and why
- Understand metadata
- Ensure appropriate security protections on hardware and software
- Ensure compliance with federal and state confidentiality law
- Prevent inappropriate access by employees – training is key

1 Federation of State Medical Boards. Report of the Committee on Ethics and Professionalism In the Adoption and Use of Electronic Health Records, April 2014.

2 Mangalmurti SS, Murtagh L, Mello MM. Medical malpractice liability in the age of electronic health records. N Engl J Med 2010 Nov 18; 363(21): 2060-7.

3 Berner, ES. Ethical and Legal Issues In the Use of Clinical Decision Support Systems, J.Healthc Inf Manag. 2002 Fall; 16(4):34-7

4. Arch Intern Med. 2009; 169(3): 305-311

5. Russ, AL, et al. Prescribers' interactions with medication alerts at the point of prescribing: A multi-method in situ investigation of the human-computer interaction. International Journal of Medical Informatics, Volume 81, Issue 4. 232-243.

MYTHS & MISCONCEPTIONS: PSYCHIATRIST'S SIGNATURES

Q: In my place of work I work with a team of healthcare professionals that provide mental health services. I am often asked to sign various forms related to patients that I have not seen. Are there any guidelines that govern the signatures on forms by psychiatrists?

A: Yes. The American Psychiatric Association has issued a resource document titled *Guidelines Regarding Psychiatrists' Signatures.* (APA Resource Document 890002, June 23, 1989.) These guidelines govern the circumstances under which a psychiatrist may sign medical records and insurance forms and provide guidance as to what the psychiatrist's signature signifies.

The signature on a diagnostic or treatment plan signifies that the psychiatrist has reviewed it, agreed with the diagnosis and approved of the plan. It does not necessarily mean that the psychiatrist has seen the patient or performed an evaluation. The psychiatrist should clarify their role by writing an annotation immediately before their signature that includes information about the role they served. Examples include: "Reviewed by (name)" or "Under the supervision of (name)" or "Team Leader Approval."

The signature on insurance forms for billing purposes signifies that the patient received the billed-for treatment. The psychiatrist must carefully check the wording of the form and make clear with an annotation the services rendered by him or her. This can be accomplished by writing in before the signature a phrase such as: "Under the supervision of (name)" or "Reviewed by (name)" or other such clarifying annotation. A psychiatrist's signature for quality assurance, peer review or other administrative review should include what was reviewed during the evaluation and approximately how long the review took.

Have any comments or questions about an article?

We would love to hear from you!

Editor@prms.com

(800) 245-3333

PsychProgram.com

EXHIBIT 15

EXHIBIT 15

JAYLEEN CHEN, M.D.

Employment

Willow Springs Center, Reno, Nevada — August 2015 - Present
Child and Adolescent Psychiatrist, Chief of Staff

True North Treatment Center, Reno, Nevada — April 2016 – Feb 2020
General/Child and Adolescent Psychiatrist, Medical Director

Education

University of Nevada-School of Medicine (UNSOM) — July 2013 - June 2015
Child and Adolescent Psychiatry Fellowship

University of Nevada-School of Medicine (UNSOM) — July 2010 - June 2013
Psychiatry Residency

University of Nevada-School of Medicine — August 2006 - May 2010
Medical Doctor

University of Nevada-Reno — August 2001 - June 2005
B.S. Biology with High Distinction, Minor in Chemistry

Board Certification

Psychiatry #71024 — September 2016
Child and Adolescent Psychiatry #10146 — September 2017

Honors and Awards

- Arnold P. Gold Foundation Humanism and Excellence in Teaching Award, UNSOM, 2012
- UNSOM Resident Teaching Honor Roll (two-time recipient), 2010 & 2011
- Richard Blurton Award for Outstanding Student in Psychiatry and Behavioral Sciences, UNSOM, 2010
- Senior Scholar for College of Science, University of Nevada-Reno, 2005
- Dean's Scholar for Biology, University of Nevada-Reno, 2005

Publications

- Meekile N. Mason, M.D. and *Jayleen Chen, M.D.* "Chapter 7: Terminal Illness in Prison." *Correctional Psychiatry*, Volume 2. Currently in editing by Civic Research Institute, Inc. 2012
- Bhakta, A., *Chen, J.*, Larsen, J., Spogen, D. "Aging Athletes," Pepid Program for PDA, <http://www.pepidonline.com/content/content.aspx?url=authorscredentials_rz.htm#spogen> April 2008

Clinical and Teaching Experience

- Collaborating Physician for Psychiatric Nurse Practitioner, 2020 - Present
- Mentor to Psychiatric Nurse Practitioner Students, 2016 - Present
- Psychiatric Medicine Small Group Leader for UNSOM 2nd year Medical Students, 2012 and 2017
- Student Outreach Clinic Volunteer, 2005 - 2007
- Chemistry Tutor, Student Academic Skills Center, University of Nevada-Reno, 2005

Relevant Research Projects

- Spirituality in Medicine, 2009

Conducted a survey assessing the prevalence of spirituality in medicine in Dayton, Nevada at Dr. Robert Chudnow's Geriatric Medicine and Family Practice Clinic

- Developmental Pediatrics, 2009

Under the direction of Lynn Kinman, M.D. Prepared a research paper detailing the "Psychological Effects of Early Childhood Maltreatment," for a local court case deposition

- Rheumatology, 2007

Under the direction of Malin Prupas, M.D. FACP Conducted a randomized study comparing the effect of follow-up phone calls to selected patients receiving intra-articular injections versus those who did not receive a courtesy call

Professional Affiliations and Activities

- Willow Springs Center – Chief of Staff, 2018 - Present
- Willow Springs Center – Interim Medical Director, 2018
- Nevada State Board of Medical Examiners – Peer Reviewer, 2017 – Present
- True North Treatment Center – Medical Director, 2016 – 2020
- Nevada Psychiatric Association – Member, 2011 - Present
- Nevada Psychiatric Association – Northern Chapter President, 2012 - 2013
- Nevada Psychiatric Association – Northern Chapter Secretary, 2011 - 2012
- American Psychiatric Association – Fellow Member, 2011 - Present
- American Academy of Child and Adolescent Psychiatry – Member, 2009 – Present

Languages

Rudimentary conversational Mandarin and Spanish

Interests

Family and friends, cooking and baking, sports, hiking, local theater

NO EXHIBITS ADMITTED FROM RESPONDENT

NO EXHIBITS ADMITTED FROM RESPONDENT

5

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

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

PATIENT DESIGNATION

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) hereby submits its **PATIENT DESIGNATION** to identify the true and correct identity of the patient(s) referenced in the filed formal Complaint, Case No. 21-22461-1.

1. Patient A's true and correct identity is as follows:

Name: [redacted]

DOB: [redacted]

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

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

FILED
NOV - 9 2021
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PROOF OF SERVICE

I, Meg Byrd, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on November 4, 2021, I mailed by USPS Certified Mail No. 9171969009350252157900 to the following recipient(s):

Matthew O. Okeke, M.D.
[redacted]

The Complaint, Patient Designation and Fingerprinting package which was confirmed delivered on November 8, 2021. *See* **Exhibit 1**.

DATED this 9th day of November, 2021.

MEG BYRD, Legal Assistant
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89521

EXHIBIT 1

EXHIBIT 1

UNITED STATES POSTAL SERVICE

November 9, 2021

Dear Meg Byrd:

The following is in response to your request for proof of delivery on your item with the tracking number: **9171 9690 0935 0252 1579 00**.

Item Details

Status:	Delivered, Front Desk/Reception/Mail Room
Status Date / Time:	November 8, 2021, 1:34 pm
Location:	LAS VEGAS, NV 89146
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™
	Return Receipt Electronic

Recipient Signature

Signature of Recipient:	RTY636 C19 RT4636C 9
Address of Recipient:	2021 S. Jones Blvd.

Note: Scanned image may reflect a different destination address due to Intended Recipient's delivery instructions on file.

Thank you for selecting the United States Postal Service® for your mailing needs. If you require additional assistance, please contact your local Post Office™ or a Postal representative at 1-800-222-1811.

Sincerely,
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475 L'Enfant Plaza SW
Washington, D.C. 20260-0004

USPS Tracking®

FAQs >

Track Another Package +

Tracking Number: 9171969009350252157900

Remove ×

Your item was delivered to the front desk, reception area, or mail room at 1:34 pm on November 8, 2021 in LAS VEGAS, NV 89146.

Delivered, Front Desk/Reception/Mail Room

November 8, 2021 at 1:34 pm
LAS VEGAS, NV 89146

Feedback

Get Updates ∨

Text & Email Updates ∨

Return Receipt Electronic ∨

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November 8, 2021, 1:34 pm
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LAS VEGAS, NV 89146
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November 7, 2021
In Transit to Next Facility

November 6, 2021, 8:09 am
Departed USPS Regional Facility
LAS VEGAS NV DISTRIBUTION CENTER

November 5, 2021, 4:12 pm
Arrived at USPS Regional Facility
LAS VEGAS NV DISTRIBUTION CENTER

November 4, 2021, 10:11 pm
Arrived at USPS Regional Origin Facility
RENO NV DISTRIBUTION CENTER

November 4, 2021, 6:35 pm
Departed Post Office
RENO, NV 89510

November 4, 2021, 6:11 pm
Acceptance
RENO, NV 89510

Feedback

Product Information

Postal Product:
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Features:
Certified Mail™
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Can't find what you're looking for?

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ANSWER

LAW OFFICES OF LIBO AGWARA, LTD
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Tel:(702) 385-4800 Phone
libolaw@yahoo.com
Attorney for Respondent

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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

RESPONDENT'S ANSWER TO NEVADA BOARD OF MEDICAL EXAMINERS' COMPLAINT

Respondent, MATTHEW OBIM OKEKE, MD., by and through counsel, LIBORIUS AGWARA, ESQ., of the Law Offices of Libo Agwara, Ltd., hereby files his Answer to the Nevada Board of Medical Examiners' ("Board") Complaint and states as follows:

1. Answering paragraph 1 of the Board's complaint, Respondent agrees with the allegations contained therein.

2. Answering paragraphs 2, 3, 4, 5, 6, 7, 9, 10, 11 and 12, Respondent denies that he did not discuss, document, address or justify the diagnoses and/or medications allegedly given to the patient.

3. Answering paragraph 8 of the Board's complaint, Respondent states that the date alleged in said paragraph (January 1, 2019) was New Year's Day and

LAW OFFICES OF LIBO AGWARA, LTD.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
702-385-4800 Phone

he did not see any patients on said day; therefore, Respondent denies the allegations contained therein.

4. Answering paragraph 13 of the Board's complaint, Respondent states that he did not see the subject patient on April 24, 2019, and a result, denies the allegations contained therein.

5. Answering paragraphs 14, 15, 16, 17, 20, 21, and of the Board's complaint, Respondent states that he is without sufficient knowledge or information as to the truth or falsity of the allegations contained therein, and as a result, denies said allegations.

6. Answering paragraphs 18 and 22 of the Board's complaint, Respondent denies any and all allegations contained therein.

7. Answering paragraphs 19 and 23 of the Board's complaint, Respondent denies that he is subject to discipline as a result of the factual allegations contained in the Board's complaint.

WHEREFORE, Respondent prays that the Board find, and therefore order, that Respondent has not violated the Medical Practice Act. Respondent further requests for such other and additional relief as the Board may find just and proper under these circumstances.

Dated this 10TH day of January, 2022.

LAW OFFICES OF LIBO AGWARA, LTD

LIBORIUS AGWARA, ESQ.
Nevada Bar No.: 7576
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
Tel: (702) 385-4800 Phone
Libolaw@yahoo.com
Attorney for Respondent

LAW OFFICES OF LIBO AGWARA, LTD.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
702-385-4800 Phone

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

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

NOTICE AND ORDER SCHEDULING PRE-HEARING AND HEARING

TO: AARON B. FRICKE, Deputy General Counsel and Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ., 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

On Friday, January 21, 2022, a telephonic Early Case Conference was conducted in this matter. Aaron B. Fricke was present on behalf of the Investigative Committee in the conference room of the Nevada State Board of Medical Examiners, and Liborius Agwara appeared telephonically on behalf of Dr. Okeke. The undersigned Hearing Officer appeared telephonically as well. The parties agreed to dates for the pre-hearing conference, exchange of documents, and the hearing date.

Accordingly, in compliance with NAC 630.465, **a pre-hearing conference will be conducted on Friday, March 25th, 2022, beginning at the hour of 10:00 A.M.**, Pacific Standard Time, in the conference room at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. The conference, to be attended by the parties in person or by counsel,[1] will be conducted before the undersigned hearing officer to assure that all written information and documentation to be presented by the parties at the formal hearing is fully and completely exchanged.

[1] Respondent or Respondent's counsel may participate in the pre-hearing conference by telephone if prior arrangements are made with counsel for the Investigative Committee.

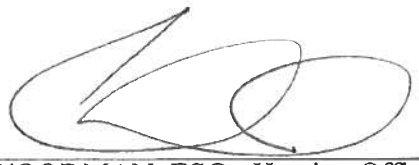
At the pre-hearing conference each party is to provide the other party with a copy of the list of witnesses they intend to call to testify, including their qualifications, as well as a brief summary of their anticipated testimony. If a witness is not included in the list of witnesses, that witness may not be allowed to testify at the hearing unless good cause is shown.

The formal hearing in this matter is hereby set for Thursday, April 28th, 2022, commencing at 9:00 A.M., and continuing to Friday, April 29th, 2022, commencing at 9:00 A.M., at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. Respondent must be present at the hearing in person. Following the hearing, the hearing officer will submit to the Board a synopsis of the testimony taken at the hearing and make a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. **NAC 630.470.**

Any other hearings previously set in this matter which conflict with the hearing schedule set out herein are vacated.

It is further ordered that legal counsel for the Investigative Committee and Respondent's counsel shall keep this hearing officer advised of each issue which has been resolved by negotiation or stipulation, or any other change in the status of this case.

DATED this 28 day of January, 2022.



CHARLES B. WOODMAN, ESQ., Hearing Officer

Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing document addressed as follows:

AARON B. FRICKE, Deputy General Counsel and Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ, 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

9171 9690 0935 0252 5654 22

DATED this 31st day of January, 2022.

Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

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

FILED
FEB - 3 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PROOF OF SERVICE

I, Mercedes Fuentes, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on January 31, 2022, I mailed by USPS Certified Mail No. 9171969009350252565422 to the following recipient(s):

MATTHEW O. OKEKE, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121

A file-stamped copy of the **NOTICE AND ORDER SCHEDULING PRE-HEARING AND HEARING**, and was delivered on February 2, 2022. *See* **Exhibit 1**.

DATED this 3d day of February, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

EXHIBIT 1

EXHIBIT 1

UNITED STATES POSTAL SERVICE

February 3, 2022

Dear Mercedes Fuentes:

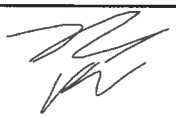
The following is in response to your request for proof of delivery on your item with the tracking number: **9171 9690 0935 0252 5654 22.**

Item Details

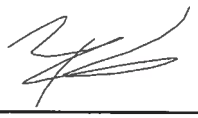
Status:	Delivered, Left with Individual
Status Date / Time:	February 2, 2022, 10:25 am
Location:	LAS VEGAS, NV 89121
Postal Product:	First-Class Mail®
Extra Services:	Certified Mail™
	Return Receipt Electronic

Recipient Signature

Signature of Recipient:



Address of Recipient:



Note: Scanned image may reflect a different destination address due to Intended Recipient's delivery instructions on file.

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Sincerely,
United States Postal Service®
475 L'Enfant Plaza SW
Washington, D.C. 20260-0004

USPS Tracking®

FAQs >

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Your item was delivered to an individual at the address at 10:25 am on February 2, 2022 in LAS VEGAS, NV 89121.

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Delivered, Left with Individual

February 2, 2022 at 10:25 am
LAS VEGAS, NV 89121

Get Updates ⌄

Feedback

Text & Email Updates ⌄

Return Receipt Electronic ⌄

Tracking History ⌃

February 2, 2022, 10:25 am
Delivered, Left with Individual
LAS VEGAS, NV 89121
Your item was delivered to an individual at the address at 10:25 am on February 2, 2022 in LAS VEGAS, NV 89121.

February 2, 2022, 3:28 am
Departed USPS Regional Facility

LAS VEGAS NV DISTRIBUTION CENTER

February 1, 2022, 4:43 pm
Arrived at USPS Regional Facility
LAS VEGAS NV DISTRIBUTION CENTER

January 31, 2022, 11:28 pm
Arrived at USPS Regional Origin Facility
RENO NV DISTRIBUTION CENTER

January 31, 2022, 6:35 pm
Departed Post Office
RENO, NV 89510

January 31, 2022, 6:23 pm
Acceptance
RENO, NV 89510

Feedback

USPS Tracking Plus™

Product Information

See Less

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Go to our FAQs section to find answers to your tracking questions.

FAQs

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

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

FILED
JUN - 7 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

NOTICE AND ORDER SCHEDULING PRE-HEARING AND HEARING

TO: AARON B. FRICKE, and SARAH A. BRADLEY, Deputies General Counsel and Attorneys for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ., 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

This matter was previously taken off calendar as the parties advised the undersigned Hearing Officer that a resolution had been reached. However, it appears that resolution did not come to fruition. Accordingly, the matter has been returned to calendar.

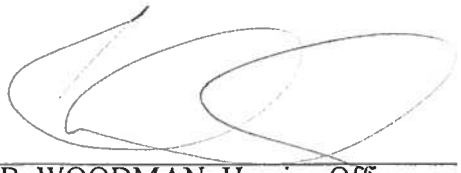
Accordingly, in compliance with NAC 630.465, **a pre-hearing conference will be conducted on Tuesday, June 21st, 2022, beginning at the hour of 11:00 A.M.**, Pacific Standard Time, in the conference room at the Office of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521. The conference, to be attended by the parties in person or by counsel,[1] will be conducted before the undersigned hearing officer to assure that all written information and documentation to be presented by the parties at the formal hearing is fully and completely exchanged.

At the pre-hearing conference each party is to provide the other party with a copy of the list of witnesses they intend to call to testify, including their qualifications, as well as a brief summary of their anticipated testimony. If a witness is not included in the list of

[1] Respondent or Respondent's counsel may participate in the pre-hearing conference by telephone if prior arrangements are made with counsel for Investigative Committee.

witnesses, that witness may not be allowed to testify at the hearing unless good cause is shown.

DATED this sixth day of June, 2022.



CHARLES B. WOODMAN, Hearing Officer
Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing document addressed as follows:

Saran A. Bradley
~~AARON B. FRICKE~~, Deputy General Counsel and Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ, 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

DATED this 7th day of June, 2022.

Legal Assistant
Nevada State Board of
Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

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

FILED
JUN 16 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89501
(775) 688-2559

PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Prehearing Conference Statement in accordance with NAC 630.465 and the Hearing Officer's Scheduling Pre-Hearing and Hearing, filed on June 7, 2022.

I. LIST OF WITNESSES

The IC of the Board lists the following witnesses whom it may call at the hearing on the charges in the complaint against Respondent filed herein:

a. Jayleen Chen, M.D.
c/o Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89501

Dr. Chen is expected to testify regarding her review of this case and Dr. Okeke's care of Patient A.

b. Ernesto Diaz, Chief of Investigations
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, NV 89501

Mr. Diaz is expected to verify documentary evidence obtained during the investigation of this case and testify regarding the investigation of this matter.

///

c. Matthew Obim Okeke, M.D., Respondent

Dr. Okeke is expected to testify regarding his actions in this case and to respond to the allegations in the Complaint.

d. All witnesses identified by Respondent in his prehearing conference statement and/or in any subsequent amended, revised or supplemental prehearing conference statement, or list of witnesses disclosed by Respondent of persons, he may call to testify at the hearing herein.

II. LIST OF EXHIBITS

The IC of the Board lists the following exhibits that it may introduce at the hearing on the charges and formal Complaint against the Respondent. All exhibits listed in Respondent's prehearing conference statement and any supplement and/or amendment thereof.

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1.	Formal Complaint filed October 26, 2021, by the Investigative Committee	0001-0008
2.	Respondent's Answer to Nevada Board of Medical Examiners' Complaint filed January 11, 2022	0009-0010
3.	Board's Allegation Letter to Respondent dated December 19, 2019	0011-0012
4.	Board's Allegation Letter to Respondent, Second Request dated January 13, 2020	0013
5.	Respondent's Response to Board's Allegation Letter received January 21, 2020	0014-0022
6.	Order to Produce Health Care Records dated December 19, 2019	0023-0024
7.	Subpoena Duces Tecum to Las Vegas Metropolitan Police Department dated December 31, 2019	0025-0028
8.	Report of Psychological Assessment RE Patient A, dated January 22, 2019	0029-0032
9.	Clark County Coroner's Autopsy Report for Patient A dated August 23, 2019	0033-0035
10.	Patient A's PMP Report dated December 16, 2019	0036-0039

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89501
(775) 688-2559

11.	Patient A's Medical Records from Grand Desert Psychiatric Services	0040-0246
12.	Patient A's Medical Records from Monte Vista Hospital	0246-0586
13.	Patient A's Medical Records from Sunrise Hospital	0587-1234
14.	Peer Review Materials	1235-1298
15.	Jayleen Chen, M.D., Curriculum Vitae	1299-1300

DATED this 16th day of June, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
Deputy Executive Director
9600 Gateway Drive
Reno, NV 89521
Tel: (775) 688-2559
Email: bradleys@medboard.nv.gov
Attorney for the Investigative Committee

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
9600 Gateway Drive
Reno, Nevada 89501
(775) 688-2559

CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 16th day of June, 2022, I served a file-stamped copy of the foregoing **PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS** with Exhibits 1-15 via Fed Ex with signature required, and courtesy copy of the Pre-Hearing Statement by email, to the following parties:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara, Esq.
Law Offices of Libo Agwara, LTD
2785 E. Desert Inn Rd., Suite 280
Las Vegas, Nevada 89121
libolaw@yahoo.com
Attorney for Respondent

Copies were also sent by U.S. Regular Mail to:

CHARLES WOODMAN, ESQ.
548 W. Plumb Lane, #B
Reno, NV 89509
hardywoodmanlaw@msn.com
Hearing Officer

DATED this 16th day of June, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

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

FILED
JUN 17 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

PROOF OF SERVICE

I, Mercedes Fuentes, Legal Assistant for the Nevada State Board of Medical Examiners, hereby certify that on June 16, 2022, I mailed by Fed Ex 2-Day Mail with signature, tracking no. 777153658223, a file-stamped copy of the **PREHEARING CONFERENCE STATEMENT OF THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS** with Exhibits 1-15 to the following recipient(s):

MATTHEW O. OKEKE, M.D.
c/o Liborius Agwara, Esq.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121

and was delivered and signed for on June 17, 2022. *See* **Exhibit 1**.

DATED this 17th day of June, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

EXHIBIT 1

EXHIBIT 1

[redacted] (https://www.fedex.com/en-us/home.html)

FedEx® Tracking

777153658226

ADD NICKNAME

Delivered
Friday, 6/17/2022 at 10:48 am

SHIPMENT IS 1 OF 2 PIECES

DELIVERED

Signed for by: J.TAGOL

GET STATUS UPDATES

OBTAIN PROOF OF DELIVERY

Adult signature required

FROM	TO
Reno, NV US	LAS VEGAS, NV US

MANAGE DELIVERY

2 Piece Shipment

TRACKING ID	STATUS	SHIP DATE	DELIVERY DATE	HANDLING PIECE UNITS	SHIPPER CITY, STATE	RECIPIENT CITY, STATE
777153658226 (master)	Delivered	6/16/22	6/17/22	0	Reno NV	LAS VEGAS NV
777153657962	Delivered	6/16/22	6/17/22	0	Reno NV	LAS VEGAS NV

Travel History

TIME ZONE
Local Scan Time

Friday, June 17, 2022

10:48 AM	LAS VEGAS, NV	Delivered

7:02 AM	NORTH LAS VEGAS, NV	At local FedEx facility
3:24 AM	LAS VEGAS, NV	At destination sort facility
2:16 AM	OAKLAND, CA	Departed FedEx hub
Thursday, June 16, 2022		
9:22 PM	OAKLAND, CA	Arrived at FedEx hub
6:05 PM	RENO, NV	Left FedEx origin facility
4:14 PM	RENO, NV	Shipment arriving On-Time
4:00 PM	RENO, NV	Picked up
3:20 PM		Shipment information sent to FedEx

Collapse History

Shipment Facts

TRACKING NUMBER
777153658226

SERVICE
FedEx 2Day

MASTER TRACKING NUMBER
777153658226

WEIGHT
6 lbs / 2.72 kgs

DELIVERED TO
Receptionist/Front Desk

TOTAL PIECES
2

TOTAL SHIPMENT WEIGHT
10 lbs / 4.54 kgs

TERMS
Shipper

PACKAGING
FedEx Pak

SPECIAL HANDLING SECTION
Deliver Weekday, Adult Signature Required

SHIP DATE
6/16/22

SIGNATURE SERVICES
Adult signature required

STANDARD TRANSIT
6/20/22 before 4:30 pm

ACTUAL DELIVERY
6/17/22 at 10:48 am

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

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

ORDER AFTER PRE-HEARING CONFERENCE

TO: SARAH A. BRADLEY, ESQ., General Counsel, Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ., Counsel for Respondent Dr. Okeke, 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

On Tuesday, June 21, the undersigned hearing officer held a Pre-Hearing telephonic conference with the parties' respective counsel identified above. At the hearing, it was determined that:

1. The Investigative Committee of the Nevada State Board of Medical Examiners ("IC") has timely served its Hearing Statement on counsel for Dr. Okeke;
2. Dr. Okeke has not timely served his Hearing Statement on counsel for the IC, but will serve that document no later than Wednesday, June 29, 2022, which will be less than 30 days prior to the formal hearing of this matter;
3. The IC may object to any item(s) raised in Dr. Okeke's Hearing Statement which are prejudicial due to a lack of timeliness. In the event of such an objection, Ms. Bradley will notify Dr. Okeke's counsel and the hearing officer via email of such objection, and a telephonic hearing on the issue will be set;
4. The formal hearing of this matter will be held on Thursday, July 28, and if necessary continuing through Friday, July 29, commencing at 9:00 a.m., in the

conference room at the office of the IC in Reno, Nevada. Dr. Okeke and his counsel may attend the hearing in person or may attend via video conference from the IC's office in Las Vegas, Nevada. In any event, Dr. Okeke must appear in person;

Following the hearing, the hearing officer will submit to the Board a synopsis of the testimony taken at the hearing and make a recommendation on the veracity of witnesses if there is conflicting evidence or if credibility of witnesses is a determining factor, and thereafter the Board will render its decision. **NAC 630.470.**

Counsel shall keep this hearing officer advised of each issue which has been resolved by negotiation or stipulation, or any other change in the status of this case.

DATED this 22 day of June, 2022.

CHARLES B. WOODMAN, Hearing Officer
Nevada State Board of Medical Examiners

548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing document addressed as follows:

SARAH A. BRADLEY, ESQ., General Counsel, Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ, 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

DATED this 28th day of June, 2022.

Legal Assistant

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

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

FILED
JUN 30 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By: _____

RESPONDENT'S PREHEARING CONFERENCE STATEMENT

Respondent, MATTHEW OBIM OKEKE, MD., by and through counsel, LIBORIUS AGWARA, ESQ., of the Law Offices of Libo Agwara, Ltd., hereby submits the following Prehearing Statement, in accordance with NAC 630.465(1).

1. LIST OF WITNESSES

The Respondent identifies the following witnesses, who Respondent intends to call at the hearing on this matter.

1. Matthew Obim Okeke, MD
   c/o Liborius Agwara, Esq.
   2785 E. Desert Inn Rd., Suite 280
   Las Vegas, NV 89121

This witness will testify regarding his diagnoses and treatment of Patient A.

///

///

///

LAW OFFICES OF LIBO AGWARA, LTD.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
702-385-4800 Phone

2. Rebuttal Expert Witness
To be named

This witness will rebut the testimony of the Board's medical expert.

1. LIST OF EXHIBITS

Respondent hereby adopts, as if attached hereto and set forth herein, the following exhibits of the IC of the Board's exhibits, for purposes of the hearing on this matter:

EXHIBIT NO.	DESCRIPTION	BATES RANGE (NSBME)
1.	Formal Complaint filed October 26, 2021, by the Investigate Committee	0001 – 0008
2.	Respondent's Answer to Nevada Board of Medical Examiners ' Complaint filed January 11, 2022	0009 – 0010
3.	Board's Allegation Letter to Respondent dated December 19, 2019	0011 – 0012
5.	Respondent's Response to Board's Allegation Letter received January 21, 2020	0014 – 0022
6.	Order to Produce Health Care Records dated December 19, 2019	0023 – 0024
8.	Report of Psychological Assessment RE Patient A, dated January 23, 2019	0029 – 0032

LAW OFFICES OF LIBO AGWARA, LTD.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
702-385-4800 Phone

10.	Patient A's PMP Report dated December 16, 2019	0036 – 0039
11.	Patient A's Medical Records from Grand Desert Psychiatric Services	0040 – 0246

Dated this 29th day of June 2022.

LAW OFFICES OF LIBO AGWARA, LTD

LIBORIUS AGWARA, ESQ.
Nevada Bar No.: 7576
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
Tel: (702) 385-4800 Phone
Libolaw@yahoo.com
Attorney for Respondent

LAW OFFICES OF LIBO AGWARA, LTD.
2785 E. Desert Inn Rd., Ste. 280
Las Vegas, NV 89121
702-385-4800 Phone

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

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

FILED

JUN 30 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

SUPPLEMENTAL ORDER AFTER PRE-HEARING CONFERENCE

TO: SARAH A. BRADLEY, ESQ., General Counsel, Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ., Counsel for Respondent Dr. Okeke, 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

Counsel for the parties have made the hearing officer aware of certain unresolved disputes which exist in this case at present. Accordingly, with good cause appearing,

IT IS HEREBY ORDERED THAT:

The parties may file any necessary pre-hearing motion(s) no later than 4:00 p.m. on Friday, July 8, 2022. Oppositions/Responses to those motions will be due the following Friday, July 15, 2022, by 4:00 p.m. Thereafter, Reply briefs must be filed no later than 4:00 p.m. the following Friday, July 22, 2022.

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Counsel is encouraged to communicate so as to resolve as many disputes as possible short of preparing and filing motions. The hearing officer will notify counsel of decisions on any timely filed motions prior to commencement of the formal hearing.

DATED this 30th day of June, 2022.

CHARLES B. WOODMAN, Hearing Officer
Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
(775) 786-9800
hardywoodmanlaw@msn.com

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing document addressed as follows:

SARAH A. BRADLEY, ESQ., General Counsel, Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ, 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

DATED this 30th day of June, 2022.

Legal Assistant

BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

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

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

OFFICE OF THE GENERAL COUNSEL
Nevada State Board of Medical Examiners
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THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO EXCLUDE TESTIMONY FROM RESPONDENT'S UNNAMED REBUTTAL EXPERT WITNESS

The Investigative Committee (IC) of the Nevada State Board of Medical Examiners (Board) submits the following Motion to Exclude Testimony from Respondent's Rebuttal Expert Witness pursuant to NAC 630.465.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Respondent's second listed witness, identified only as "Rebuttal Expert Witness To be named", in his Prehearing Conference Statement, filed June 30, 2022, must be excluded from testifying at the hearing pursuant to NAC 630.465.

II. LEGAL ARGUMENT

The plain language of NAC 630.465 is clear. Specifically, subsection 2 states "[e]ach party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. *A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.*" (emphasis added). On June 29, 2022, Respondent through his counsel submitted a Prehearing Conference Statement (Respondent's Statement) that included a list of witnesses. The second witness in Respondent's Statement is identified only as "Rebuttal Expert Witness To be named." Respondent's Statement at 2:1–3. A description of this witness's testimony is listed

simply as "This witness will rebut the testimony of the Board's medical expert." *Id.* Because Respondent did not include a name for his second witness, this witness must be precluded from testifying at the hearing pursuant to NAC 630.465(2). Further Respondent has not provided good cause for his failure to identify his second witness.

In addition, to failing to name his second witness as required by NAC 630.465(2) in his Prehearing Conference Statement, Respondent also failed to provide the qualifications of his second witness, which is usually accomplished by including the witness's Curriculum Vitae. This further violates NAC 630.465(2) and unfairly prejudices the IC.

Upon information and belief, Respondent failed to identify his second witness by name in his Prehearing Conference Statement and to include his second witness's curriculum vitae with his Prehearing Conference Statement due to his mistaken belief that the IC must include an expert report when identifying its expert witness. Respondent is incorrect and his belief is not supported by Nevada law.

In contested administrative agency cases in the State of Nevada, the only discovery that respondents are entitled to receive is that the agency's attorney (prosecutor) intends to rely on in the hearing on the matter. *See* NRS 622A.330. The remainder of the investigative file is confidential. *Id.* In addition, NRS 630.336(4) specifically states that the investigative file consisting of "all documents and other information compiled as a result of an investigation" is confidential. In the instant matter, the IC appropriately named its expert witness and summarized her anticipated testimony in its Prehearing Conference Statement, provided Respondent the exhibits that it intends to rely on as part of its Prehearing Conference Statement, including the curriculum vitae for its expert witness, and Respondent is not entitled to any additional discovery, including any report prepared by its expert witness. *See* NAC 630.465.

In *Sarfo v. Board of Medical Examiners*, the Court held that NRS 630.336(4) "is unambiguous" and the Board's interpretation that it prohibited the Board from providing the name of the complainant and the consumer complaint in a disciplinary matter "falls 'within the plain language of the statute.'" 134 Nev. 709, 714, 429 P.3d 650 (2018) (quoting *Dutchess Bus. Servs., Inc. v. Nev. State Bd. of Pharmacy*, 124 Nev. 701, 709, 191 P.3d 1159, 1165 (2008)).

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In *Sarfo*, the Respondent sought additional discovery from the Board outside the discovery authorized by statute and regulation. Specifically, the Respondent in that case wanted to know the identity of the complainant and to receive a copy of the consumer complaint. The Board did not provide this information pursuant to NRS 630.336, and the *Sarfo* Court held that the Board's interpretation of the confidentiality provided in NRS 630.336 was "a reasonable interpretation of the statute's plain language." 134 Nev. at 715. "[W]hen the language of a statute is plain and unambiguous, and its meaning clear and unmistakable, there is no room for construction, and the courts are not permitted to search for its meaning beyond the statute itself." 134 Nev. at 714 (quoting *Dykema v. Del Webb Cmtys., Inc.*, 132 Nev. 823, 826, 385 P.3d 977, 979 (2016)).

There is no case law construing NRS 622A.330, but the plain language is clear. NRS 622A.330(1) authorizes the respondent in a contested case to submit a written discovery request for "a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses." NRS 622A.330(2) provides that "[t]he investigative file for the case is not discoverable *unless* the prosecutor intends to present materials from the investigative file as evidence in support of the case." (emphasis added). NRS 622A.330 should be read in its entirety to give plain meaning to all of its parts. *Gilman v. Nevada State Bd. of Veterinary Medical Examiners*, 120 Nev. 263, 271, 89 P.3d 1000, 1005–06 (2004), *disapproved of on other grounds by Nassiri v. Chiropractic Physicians' Bd.*, 130 Nev. 245, 327 P.3d 487 (2014). Reading NRS 622A.330 in its entirety, it is clear the discovery available in subsection 1 is the exception to the general confidentially of the investigative file provided in subsection 2.

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III. CONCLUSION

For the foregoing reasons, Respondent's second witness must be excluded from providing testimony in the hearing on this matter.

DATED this 8th day of July, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D., MBA
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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 8th day of July, 2022, I served a file-stamped copy of **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS' MOTION TO EXCLUDE TESTIMONY FROM RESPONDENT'S UNNAMED REBUTTAL EXPERT WITNESS** via U.S. Mail, to the following parties:

LIBORIUS AGWARA, ESQ.
Law Offices of Libo Agwara, Ltd.
2785 E. Desert Inn Rd., Suite 280
Las Vegas, NV 89121

Courtesy copy by electronic mail to:

LIBORIUS AGWARA, ESQ.
libolaw@yahoo.com
Attorney for Respondent

CHARLES WOODMAN, ESQ.
hardywoodmanlaw@msn.com
Hearing Officer

DATED this 8th day of July, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

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

FILED
JUL 11 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

RESPONDENT'S MOTION TO STRIKE THE BOARD'S EXPERT WITNESS, OR IN THE ALTERNATIVE TO ALLOW RESPONDENT TO DESIGNATE A REBUTTAL EXPERT TO TESTIFY AFTER HEARING THE TESTIMONY OF THE BOARD'S EXPERT

Respondent, MATTHEW OBIM OKEKE, MD., by and through counsel, LIBORIUS AGWARA, ESQ., of the Law Offices of Libo Agwara, Ltd., hereby files his Motion to Strike the Board's Expert Witness, or in the Alternative to allow Respondent to Designate a Rebuttal Expert Witness to Testify after Hearing the Testimony of the Board's Expert.

This motion is made, pursuant to NAC 630.465(3), and based on the attached memorandum of points and authorities.

MEMORANDUM OF POINTS AND AUTHORITIES

I.

FACTS

In its prehearing statement, the Board designated, as its primary witness, Dr. Jayleen Chen, who is expected to "testify regarding her **review** of this case and Dr.

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Okeke's care of Patient A." (emphasis added). When the Board's exhibits were delivered to Respondent's counsel's office, they were missing Dr. Chen's expert report. To date, the Board has declined to supplement its exhibits by producing Dr. Chen's report.

II.
LEGAL ARGUMENT

NRS 622A.330 provides as follows:

> 1. At any time after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses.
> 2. The investigative file for the case is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case. The investigative file for the case includes all communications, records, affidavits or reports acquired or created as part of the investigation of the case, whether or not acquired through a subpoena related to the investigation of the licensee.

Unless the Board is not planning on presenting Dr. Chen's testimony in support of its case, then her testimony is discoverable. NRS 622A.330 does not limit "materials" to documents only. Materials include testimonial materials. The Board did not list Dr. Chen as a factual witness. Rather, she is listed as a witness, who will review documents and testify regarding her review of those documents. This makes her an expert witness. There is also nothing confidential about her impending testimony. Respondent has, in accordance with NRS 622A.330(1),

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requested and is hereby requesting that a report or summary of Dr. Chen's testimony be made available before the hearing, so that Respondent may hire a rebuttal expert, as allowed under Nevada law. As the Board has continued to refuse to produce this report/summary, Respondent hereby requests that the hearing officer strike Dr. Chen as a witness in this matter.

Additionally, NAC 630.465(3) provides the following exception for rebuttal evidence: "All evidence, **except rebuttal evidence**, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown." This exception makes it clear that the deadline that applies to other evidence or witnesses does not apply to rebuttal evidence. This exception recognizes the importance of rebuttal evidence. However, to rebut evidence, Respondent would need to know what that evidence is. The Board has provided Respondent with everything it plans to rely on for the hearing, except for what Dr. Chen's will say. Both parties have Patient A's medical records. The Board has Dr. Okeke's responses and Answer to the Complaint. The only unknown in this case is what Dr. Chen is going to testify to. The Board wants this to be a surprise. However, never law and civil rules do not permit such trial by surprise. See NRCP 16.1(a)

A license to practice medicine is a recognized economic right that is protected by the due process clause of the constitution. See *Goldberg v. Kelly*, 397

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U.S. 254, 262 n.8 (1970). To the extent that the instant matter may result in any restrictions being placed on Respondent's license, then he is entitled to all due process, including the right to rebut the Board's expert testimony.

III.
CONCLUSION

In light of the foregoing, Respondent respectfully requests that Dr. Chen be be striken as an expert witness in this matter for continued failure to produce a report or summary of her expected testimony. Alternatively, Respondent requests that he be allowed to designate a rebuttal expert witness, who will testify after hearing Dr. Chen's testimony. Respondent further requests such other and additional relief as the Hearing Officer may deem just and proper under these circumstances.

Dated this 8th day of July 2022.

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

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

FILED
JUL 15 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINER'S OPPOSITION TO RESPONDENT'S MOTION TO STRIKE

The Investigative Committee (IC) for the Nevada State Board of Medical Examiners (Board), by and through its attorney, Sarah A. Bradley, J.D., Deputy Executive Director for the Board, hereby files its Opposition to Respondent's "Motion to Strike" dated and served on July 8, 2022. Respondent's motion is untimely and lacking in merit, and therefore should be denied.

MEMORANDUM OF POINTS AND AUTHORITIES

I. BACKGROUND

On June 16, 2022, the IC timely filed and served a Prehearing Conference Statement listing the witnesses it may call and the exhibits it may introduce at the hearing in this matter, *see* NAC 630.465, in which it identified Jayleen Chen, M.D. as one of its prospective witnesses. With leave of the Hearing Officer, on June 29, 2022, Respondent submitted an untimely Prehearing Conference Statement, in which he listed as one of his prospective witnesses a "Rebuttal Expert Witness To be named."[1]

On July 8, 2022, the IC filed a timely motion to exclude testimony from Respondent's unnamed rebuttal expert witness. In an apparent attempt to circumvent the application of the

[1] On June 7, 2022, the Hearing Officer entered a "Notice and Order Scheduling Pre-hearing and Hearing," in which he directed that the prehearing conference in this matter would be conducted on June 21, 2022, and conducted to "assure that all written information and documentation to be presented by the parties at the formal hearing is fully and completely exchanged." *See* NAC 630.465(2), (3). Respondent failed to comply with the order and did not file or serve the required documents by June 21, 2022. The Hearing Officer noted this failure and allowed Respondent until June 29, 2022, to comply with the directive.

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authorities set forth in the IC's July 8, 2022 motion, Respondent then filed an untimely and unavailing motion to strike, which argues that Dr. Chen should be "stricken" as a witness or, alternatively, that Respondent be allowed to designate a witness to rebut Dr. Chen's testimony.

II. ARGUMENT

A. The Motion to Strike is Untimely.

Pursuant to the "Supplemental Order After Pre-Hearing Conference" filed June 30, 2022, any prehearing motions were due to be filed no later than 4:00 p.m. on July 8, 2022. Respondent's counsel submitted the Motion to Strike at 4:55 p.m. on July 8, 2022, and thus it was untimely.

Notably, NRS 622A.360(2) limits the types of prehearing motions that may be brought in administrative proceedings such as this:

> A party may file only the following prehearing motions:
>
> (a) A motion requesting a continuance or an extension of time.
>
> (b) A motion requesting, for good cause, the recusal of the hearing officer, a member of the hearing panel or a member of the regulatory body from participation in the case.
>
> (c) A motion requesting the separation of consolidated cases.
>
> (d) A motion requesting a more definite statement regarding the allegations in the charging document on the ground that there is not enough information in the charging document to formulate a defense.
>
> (e) A motion requesting dismissal of the charging document for failure to state facts which, if true, would form a sufficient basis for discipline.
>
> (f) With leave of the regulatory body or hearing panel or officer, any other motion requesting appropriate action or relief before the date of the hearing.

The Nevada Legislature is deemed to act with intention when including a list in a statute. *See Galloway v. Truesdell*, 83 Nev. 13, 26, 422 P.2d 237, 246 (1967) (recognizing Nevada's consistent application of the maxim "the expression of one thing is the exclusion of another"). Respondent's Motion to Strike is not one of the types listed in NRS 622A.360(2)(a)-(e), and the Hearing Officer's allowance for other motions was limited to those submitted prior to 4:00 p.m. on July 8, 2022. Consistent with his previous indifference to deadlines in this matter, the motion to strike was submitted beyond the time clearly set forth in the June 30, 2022 Order, and Respondent's counsel did not move to extend the time to file the motion or otherwise explain its

untimeliness. Respondent's repeated failures to comply with or even acknowledge the deadlines in this matter evince a disregard for the disciplinary process and a lack of respect for the Board. The motion should be denied as untimely.

B. Respondent's Motion to Strike Fails as a Matter of Law.

Even if Respondent's Motion to Strike were timely filed, it fails as a matter of law. Throughout the Motion to Strike, Respondent incorrectly refers to the nature of a document, conflates discoverable materials with anticipated testimony, and makes conclusory statements about Nevada law and what he believes he is entitled to without citation to supporting authority.

First, Respondent refers to an "expert report" by Dr. Chen. *See Motion to Strike* 2:1-4. Respondent appears to be referring to a written report of an expert witness as contemplated by NRCP 16.1(a)(2) (requiring that disclosure of an expert witness in a civil proceeding in the district court be accompanied by a written report). However, the requirements of NRCP 16.1 do not apply in an administrative forum. *See Dutchess Bus. Servs., Inc. v. Nev. State Bd. Of Pharmacy*, 124 Nev. 701, 710, 191 P.3d 1159, 1165 (2008) (noting that pursuant to NRCP 1, Nevada's rules of civil procedure govern procedure in civil actions in the district courts and thus are not binding on a state agency in an adjudicatory proceeding unless expressly adopted).

In its investigation of this matter, the IC requested that Dr. Chen, who, like Respondent, is a licensee of the Board specializing in psychiatry, complete a peer review of Respondent's treatment of Patient A. A peer review is not an "expert report" as contemplated by NRCP 16.1, and its confidentiality is clear. "[A]ll documents and other information compiled as a result of an investigation conducted to determine whether to initiate disciplinary action [against a Board licensee] are confidential." *See* NRS 630.336(4). The Nevada Supreme Court considered NRS 630.336 in *Sarfo v. Board of Medical Examiners*, where, similar to here, the Respondent sought discovery beyond that authorized by statute and regulation. *See* 134 Nev. 709, 429 P.3d 650 (2018). In *Sarfo*, the Respondent wanted to know the identity of the complainant and to receive a copy of the consumer complaint that initiated the matter. Pursuant to NRS 630.336, the Board did not provide this information. The Court held that NRS 630.336(4) "is unambiguous" and the Board's interpretation that it prohibited the Board from providing the requested materials "falls

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'within the plain language of the statute.'" 134 Nev. at 714, 429 P.3d at 654 (quoting *Dutchess*, 124 Nev. at 709, 191 P.3d at 1165). Further, the IC does not intend to introduce the peer review as evidence or rely on it at the hearing. Thus, to the extent that Respondent seeks a nonexistent "expert report" or the plainly confidential peer review, such request must be denied.

Respondent attempts to sidestep his lack of entitlement to any written report by Dr. Chen by trying to stretch the meaning of the word "materials," which is used once in NRS 622A.330:

> 1. At any time after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses.
>
> 2. The investigative file for the case is not discoverable unless the prosecutor intends to present *materials* from the investigative file as evidence in support of the case. The investigative file for the case includes all communications, records, affidavits or reports acquired or created as part of the investigation of the case, whether or not acquired through a subpoena related to the investigation of the licensee.
>
> 3. A party may not serve any interrogatories on another party or take any depositions relating to the case, unless permitted by the regulations of the regulatory body.

(emphasis added). Thus, pursuant to the plain language of NRS 622A.330(2), any "materials" are discoverable here only if the IC's counsel intends to present them as evidence in support of its case. The IC has repeatedly stated to Respondent's counsel, and again here, states that it does not intend to present any written report prepared by Dr. Chen as evidence in support of its case. In trying to overcome this, Respondent baldly claims that the "materials" referenced in the statute "include testimonial materials." *See Motion to Strike* 2:21-22. Although Respondent does not define "testimonial materials" or cite any authority in support of this claim, it appears Respondent is referring to "a summary of Dr. Chen's testimony," which he requests be made available prior to the hearing. *See Motion to Strike* 3:1-3. The IC already appropriately summarized Dr. Chen's anticipated testimony in its Complaint and Prehearing Conference Statement, which was served on Respondent, and Respondent has failed to demonstrate that he is entitled to anything additional in

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this regard. Respondent has failed to offer any supporting basis for his attempt to prevent the IC from calling a properly and timely designated witness, and his Motion to Strike Dr. Chen as a witness must be denied.

As an alternative to disallowing Dr. Chen to testify in this matter, Respondent requests that he be allowed to designate a "rebuttal expert witness, who will testify after hearing Dr. Chen's testimony." *See Motion to Strike* 4:8-10. However, as the Nevada Supreme Court has explained, "[r]ebuttal evidence explains, contradicts, or disproves evidence introduced by a *defendant* in his case-in-chief. The test for determining what constitutes rebuttal evidence is whether the evidence offered tends to contradict *new* matters raised by the adverse party." *See Andrews v. Harley Davidson, Inc.*, 106 Nev. 533, 539, 796 P.2d 1092, 1096 (1990) (internal citation omitted). The rebuttal evidence contemplated by NAC 630.465(3) (excepting rebuttal evidence from the requirement that all evidence must generally be provided at the prehearing conference if it is to be introduced or admitted at the hearing), is evidence the IC may present in rebuttal to new matters raised by Respondent during the hearing. Thus, Respondent's request to designate a "rebuttal" witness, especially before any presentation of either parties' case-in-chief, is unavailing, and must be denied.

III. CONCLUSION

For the foregoing reasons, Respondent's motion to strike must be denied in its entirety.

DATED this 14th day of July, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Brandie Mooneyhan #7451
for SARAH A. BRADLEY, J.D.
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Attorney for the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 15th day of July, 2022, I served a file-stamped copy of the foregoing **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINER'S OPPOSITION TO RESPONDENT'S MOTION TO STRIKE** via U.S. Regular Mail, with courtesy copy by email, to the following parties:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara, Esq.
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Attorney for Respondent

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Hearing Officer

DATED this 15th day of July, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

* * * * *

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

FILED

JUL 15 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

RESPONDENT'S OPPOSITION TO THE IC'S MOTION TO EXCLUDE TESTIMONY FROM RESPONDENT'S UNNAMED REBUTTAL EXPERT WITNESS

Respondent, MATTHEW OBIM OKEKE, MD., by and through counsel, LIBORIUS AGWARA, ESQ., of the Law Offices of Libo Agwara, Ltd., hereby files his Opposition to the IC's Motion to Exclude Testimony from Respondent's Unnamed Expert Rebuttal Witness.

On July 8, 2022, the IC filed a motion seeking to exclude Respondent's unnamed rebuttal expert witness. The basis for the IC's motion was NAC 630.465(2), which provides that:

> Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.

Counsel for the IC argues that because Respondent listed an unnamed rebuttal expert, the hearing officer should exclude testimony from the unnamed rebuttal

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expert witness, in accordance with the above-referenced NAC provision. The problem with the IC's argument is that the IC did not finish reading the provisions of NAC 630.465. Had it bothered to read further, it would have learned that NAC 630.465(3) makes an exception for rebuttal evidence, thus providing that "All evidence, **except rebuttal evidence**, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown." (emphasis added). This exception makes it clear that the deadline in NAC 630.465(2), which the IC is relying on for its motion to exclude, does not apply to rebuttal evidence. This is because the administrative code recognizes that to rebut evidence, Respondent would need to know what that evidence is.

For its motion, the IC further relies on *Sarfo v. Board of Medical Examiners*, 134 Nev. 709, 429 P.3d 650 (2018). The IC's reliance on this case is misplaced and baffling, as the key holding in the case is that "when the language of a statute is plain and unambiguous, and its meaning clear and unmistakable, there is no room for construction, and the courts are not permitted to search for its meaning beyond the statute itself." *Id.*, at 714. What part of NAC 630.465(3), which exempts rebuttal evidence from the deadline imposed by NAC 630.465(2), does the IC claim is ambiguous? Additionally, the Respondent in *Sarfo* was seeking the identity of the person who filed the complaint with the Board, which is different

from the information Respondent herein seeks, i.e., Dr. Chen's expert opinion. As NRS 622A.330(1) provides, any information that the Board intends to rely on in its case must be disclosed to the Respondent. In *Sarfo*, the Board was not going to rely on the identity of the complainant in its case against the Respondent, so under NRS 622A.330(1), the Respondent was not entitled to that information. However, in the instant matter, the IC plans to rely on Dr. Chen's testimony for its case against Dr. Okeke. Accordingly, Dr. Chen's anticipated expert testimony should be disclosed before the hearing on this matter. Because the IC has refused, and continues to refuse, to disclose Dr. Chen's anticipated testimony, the Respondent herein had no choice but to delay hiring a rebuttal expert witness, but reserved the right to name one in the future, who would testify after hearing Dr. Chen's testimony, unless Respondent's motion to strike Dr. Chen is granted by the hearing officer.

Finally, if the IC is really convinced that Respondent herein rendered care that was below the standard, then why is the IC fighting so hard to keep Respondent from defending himself. It would seem that no matter what expert witness Respondent or the IC uses, the standard of care is the standard of care, no matter who is testifying. How does Respondent using a rebuttal expert witness prejudice the IC's case? The fact is that it does not. So, why does the IC not want its expert's opinion disclosed prior to the hearing? Maybe, it is because Dr. Chen's

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opinion may amount to nothing more than one doctor second-guessing another, several years after the service was initially rendered. As we all know, doctors make judgments everyday regarding the care they render to their patients. Perhaps, the IC should let the hearing officer her from as many other psychiatrists as are willing to opine on the care Dr. Okeke rendered to Patient "A."

CONCLUSION

In light of the foregoing, Respondent respectfully requests that the IC's motion to exclude testimony of Respondent's unnamed rebuttal expert witness be denied. Respondent further requests such other and additional relief as the Hearing Officer may deem just and proper under the circumstances.

Dated this 15th day of July 2022.

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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

* * * * *

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

FILED

JUL 22 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINER'S REPLY IN SUPPORT OF MOTION TO EXCLUDE TESTIMONY FROM RESPONDENT'S UNNAMED REBUTTAL WITNESS

The Investigative Committee (IC) for the Nevada State Board of Medical Examiners (Board), by and through its attorney, Sarah A. Bradley, J.D., Deputy Executive Director for the Board, hereby files its Reply in Support of Motion to Exclude Testimony from Respondent's Unnamed Rebuttal Witness filed on July 8, 2022.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Respondent's second listed witness, identified only as "Rebuttal Expert Witness To be named", in his Prehearing Conference Statement, filed June 30, 2022, must be excluded from testifying at the hearing pursuant to NAC 630.465.

II. LEGAL ARGUMENT

Respondent appears to be confused regarding what constitutes rebuttal evidence. "Rebuttal evidence explains, contradicts, or disproves evidence introduced by a *defendant* in his case-in-chief." *See Andrews v. Harley Davidson, Inc.*, 106 Nev. 533, 539, 796 P.2d 1092, 1096 (1990). NAC 630.465 does state that rebuttal evidence does not need to be contained in a party's pre-hearing conference statement. However, Respondent is not entitled to offer rebuttal evidence. Rebuttal evidence is put on by the plaintiff or prosecutor in a matter in order to allow that party to

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explain, contradict, or disprove evidence introduced by a defendant during his case-in-chief. *See Morrison v. Air California*, 101 Nev. 233, 235–36, 699 P.2d 600, 602 (1985). In rare circumstances, a defendant may be allowed to present surrebuttal evidence if the plaintiff or prosecutor presents rebuttal evidence. Respondent's counsel's alma mater defines surrebuttal as follows[1]:

> Surrebuttal is the response to a rebuttal that the responding party may be allowed to make in rare circumstances. Usually, a court will only allow the moving party to have a rebuttal to the evidence and arguments of the responding party. However, a court in some jurisdictions may allow the responding party to have their own rebuttal (surrebuttal) when the court thinks they deserve an opportunity to respond to new arguments or evidence made in the moving party's rebuttal. A surrebuttal will be limited to discussing only the points made in the rebuttal.

In the instant matter, the IC is potentially allowed to offer rebuttal evidence at the hearing after Respondent rests his case-in-chief. Following that rebuttal evidence presentation, with leave of the Hearing Officer, Respondent could request to offer surrebuttal evidence if the IC's rebuttal evidence introduced new arguments or evidence.

Inasmuch as Respondent seeks to introduce testimony of an unnamed witness identified only as "Rebuttal Expert Witness To be named" at the hearing in his case-in-chief, the testimony of that witness must be excluded pursuant to Nevada law.

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[1] Legal Information Institute, Cornell Law School, accessed July 22, 2022, available at https://www.law.cornell.edu/wex/surrebuttal#:~:text=Surrebuttal%20is%20the%20response%20to,arguments%20of%20the%20responding%20party.

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III. CONCLUSION

For the foregoing reasons, Respondent's second witness must be excluded from providing testimony in the hearing on this matter.

DATED this 22nd day of July, 2022.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Sarah A. Bradley

SARAH A. BRADLEY, J.D.
Deputy Executive Director
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Attorney for the Investigative Committee

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CERTIFICATE OF SERVICE

I hereby certify that I am employed by the Nevada State Board of Medical Examiners and that on the 22nd day of July, 2022, I served a file-stamped copy of the foregoing **THE INVESTIGATIVE COMMITTEE OF THE NEVADA STATE BOARD OF MEDICAL EXAMINER'S REPLY IN SUPPORT OF MOTION TO EXCLUDE TESTIMONY FROM RESPONDENT'S UNNAMED REBUTTAL WITNESS** to the following parties by U.S. Regular Mail and by email:

MATTHEW OBIM OKEKE, M.D.
c/o Liborius Agwara, Esq.
Law Offices of Libo Agwara, LTD
2785 E. Desert Inn Rd., Suite 280
Las Vegas, Nevada 89121
libolaw@yahoo.com
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CHARLES WOODMAN, ESQ.
548 W. Plumb Lane, #B
Reno, NV 89509
hardywoodmanlaw@msn.com
Hearing Officer

DATED this 22nd day of July, 2022.

MERCEDES FUENTES
Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

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

FILED

AUG 16 2022

NEVADA STATE BOARD OF MEDICAL EXAMINERS

By:

ORDER ON MOTIONS

TO: SARAH A. BRADLEY, ESQ., General Counsel, Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners
9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ.,
Counsel for Respondent Dr. M. O. Okeke, MD
2785 E. DESERT INN RD., SUITE 280
LAS VEGAS, NV 89121

Before the hearing officer are the following moving papers:

The motion of the Investigative Committee of the Nevada State Board of Medical Examiners ("IC") to exclude Respondent's unnamed rebuttal expert witness, with Respondent's opposition thereto, and the IC's reply ("the IC's Motion"), and;

The motion of Respondent to strike the IC's expert witness, or to allow Respondent to designate an expert witness to testify after testimony is given by the IC's expert witness, and the IC's opposition thereto (the "Respondent's Motion"). These motions shall be addressed in turn.

The IC's Motion

In his Pre-hearing Statement, Respondent did not name an expert witness. Rather he designated a "Rebuttal Expert Witness To Be Named." The moving papers of both the IC and Respondent essentially reduce the contested issue in the IC's Motion to the question of whether

Respondent complied with NAC 630.465[1] insofar as the definition of "rebuttal" evidence is concerned. That section of the code states in pertinent part that "All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown."

It is Respondent's contention that his expert witness will be called to rebut the evidence of the IC's expert. That may be grammatically correct in some settings. However, the plain meaning of the code is that the IC may withhold its rebuttal evidence from the Pre-hearing Statement. As set out in Andrews v. Harley Davidson, Inc., 106 Nev. 533, 539, (1990), "rebuttal evidence explains, contradicts, or disproves evidence introduced by a defendant in his case-in-chief." This statement of law is completely consistent with a general understanding of how a contested case is presented to a tribunal, i.e., the initiating party with the burden of proof presents its case in chief, after which the responding/defending party presents its defense case in chief, (should it choose to do so), and then - in large part because it has the burden of proof - the initiating party is allowed to present evidence to rebut the defense case. That rebuttal evidence is not a reiteration of the initiating party's case in chief, but rather, is evidence aimed at the responding party's defense case evidence. (It is correctly pointed out by the IC that the adjudicating tribunal may allow surrebuttal evidence after the initiating party's rebuttal evidence, but that matter is beyond the scope of the immediate issue before the hearing officer.)

Hence, addressing the IC's motion by itself, Respondent has failed to comply with NAC 630.465 in that he did not name an expert witness in his Pre-hearing Statement. Accordingly, absent a showing of good cause, any witness called by Respondent at the formal hearing "whose name does not appear on the list of proposed witnesses may not testify at the hearing."

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[1] **NAC 630.465 Hearings: Prehearing conference. (NRS 630.130, 630.275)**

1. At least 30 days before a hearing but not earlier than 30 days after the date of service upon the physician or physician assistant of a formal complaint that has been filed with the Board pursuant to NRS 630.311, unless a different time is agreed to by the parties, the presiding member of the Board or panel of members of the Board or the hearing officer shall conduct a prehearing conference with the parties and their attorneys. All documents presented at the prehearing conference are not evidence, are not part of the record and may not be filed with the Board.
2. Each party shall provide to every other party a copy of the list of proposed witnesses and their qualifications and a summary of the testimony of each proposed witness. A witness whose name does not appear on the list of proposed witnesses may not testify at the hearing unless good cause is shown.
3. All evidence, except rebuttal evidence, which is not provided to each party at the prehearing conference may not be introduced or admitted at the hearing unless good cause is shown.

Respondent's Motion

In his motion, Respondent claims that under NRS 622A.330[2], the testimony of the IC's expert witness Dr. Chen is discoverable. Generally speaking, Respondent is correct. Respondent asserts however that the statute's use of the word "materials" in defining part of that which is discoverable includes "testimonial materials." (Respondent's brief, p.2, l.22.). For all practical purposes, it appears clear that Respondent is seeking a written "expert report" or a summary of the expert's anticipated testimony. That would also be correct in the event the IC were to use any such report in its case in chief. NRS622A.330.

However, the IC's opposition motion makes clear that there is no such document which will be used by the IC in its case in chief. Accordingly, there is nothing discoverable in this regard under NRS 622A.330(2). Further, the parties are on notice that any attempt to offer a document in the party's case in chief which was not produced in the Pre-hearing Statement will be denied upon objection.

Finally, Respondent would have the hearing officer order that he be allowed to designate an expert witness after the IC's witness testifies. Such a designation is not authorized, nor does it appear to be in any way contemplated by the NAC, NRS, or applicable case law. Such an authorization would certainly require that the hearing be suspended after the IC's expert testifies, an expert designated by Respondent, the expert noticed, and the hearing re-convened at a later date. Such a tortured process and the resulting delay does not in any way appear consistent with the statutory and codified scheme for resolving these cases.

The hearing officer mentions here that from within the content of his motion, including but not limited to his claim that the IC wants to surprise Respondent with its expert witness testimony, it appears that Respondent might have sought the deposition of Dr. Chen. However, from the record no such discovery has been requested, nor can the tenability of such discovery at

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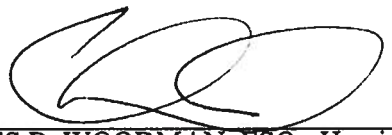
[2] **NRS 622A.330 Discovery; limitations on interrogatories and depositions.**

1. At any time after being served with the charging document, the licensee may file with the regulatory body or hearing panel or officer a written discovery request for a copy of all documents and other evidence intended to be presented by the prosecutor in support of the case and a list of proposed witnesses.
2. The investigative file for the case is not discoverable unless the prosecutor intends to present materials from the investigative file as evidence in support of the case. The investigative file for the case includes all communications, records, affidavits or reports acquired or created as part of the investigation of the case, whether or not acquired through a subpoena related to the investigation of the licensee.
3. A party may not serve any interrogatories on another party or take any depositions relating to the case, unless permitted by the regulations of the regulatory body.

this time be addressed as such is outside the scope of this Order.

Given the reasoning set out above, the hearing officer need not address the IC's arguments concerning the lack of Respondent's timeliness.

DATED this 15th day of August, 2022.



CHARLES B. WOODMAN, ESQ., Hearing Officer

Nevada State Board of Medical Examiners
548 W. Plumb Lane, Suite B
Reno, Nevada 89509
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hardywoodmanlaw@msn.com

CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing document addressed as follows:

SARAH A. BRADLEY, General Counsel, Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ, 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

DATED this 16th day of August, 2022.

Legal Assistant
Nevada State Board of Medical Examiners

BEFORE THE BOARD OF MEDICAL EXAMINERS

OF THE STATE OF NEVADA

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

FILED
AUG 19 2022
NEVADA STATE BOARD OF MEDICAL EXAMINERS
By:

NOTICE AND ORDER SCHEDULING HEARING

TO: SARAH BRADLEY, General Counsel and Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ., 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

Pursuant to a telephonic conference with counsel, the hearing for this matter is scheduled for Monday, September 12, 2022 at 9:00 a.m. in the conference room at Board's Northern Nevada Office, 9600 Gateway Drive, Reno, NV 89521.

It is further ordered that legal counsel for the Investigative Committee and Respondent's counsel shall keep this hearing officer advised of each issue which has been resolved by negotiation or stipulation, or any other change in the status of this case.

DATED this 16 day of August, 2022.

CHARLES B. WOODMAN, ESQ., Hearing Officer

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CERTIFICATE OF SERVICE

I certify that on this day, I personally delivered or mailed, postage pre-paid, at Reno, Nevada, a true file-stamped copy of the foregoing document addressed as follows:

SARAH BRADLY, General Counsel and Attorney for the Investigative Committee of the Nevada State Board of Medical Examiners, 9600 Gateway Drive, Reno, Nevada 89521

LIBORIUS AGWARA, ESQ, 2785 E. DESERT INN RD., SUITE 280, LAS VEGAS, NV 89121

DATED this 19th day of August, 2022.

Legal Assistant
Nevada State Board of Medical Examiners