COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1625

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, 1506 BRISTOL COURT, ELIZABETHTOWN, KENTUCKY 42701

ORDER OF INDEFINITE RESTRICTION

At its October 15, 2015, meeting, the Kentucky Board of Medical Licensure (hereinafter "the Board"), acting by and through its Hearing Panel A, took up this case for final action. The members of Panel A reviewed the Complaint, filed of record November 24, 2014; the Hearing Officer's Findings of Fact, Conclusions of Law and Recommended Order, filed of record August 21, 2015; Dr. Patel's Exceptions to Findings of Fact and Conclusions of Law and Request for Appearance, filed of record September 3, 2015; and memorandum from Board counsel, dated September 3, 2015. The licensee was given notice of the meeting and was present.

Having considered all the information available and being sufficiently advised, Hearing Panel A ACCEPTS the hearing officer's Findings of Fact and Conclusions of Law and ADOPTS those Findings of Fact and Conclusions of Law and INCORPORATES them BY REFERENCE into this Order. (Attachment) Hearing Panel A FURTHER ACCEPTS AND ADOPTS the hearing officer's recommended order and in accordance with that recommended order, Hearing Panel A ORDERS:

1. The license to practice medicine held by Sharad C. Patel, M.D., SHALL BE RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME to begin immediately upon the date of filing of this Order of Indefinite Restriction and continuing until further order of the Board;

2. During the effective period of this Order of Indefinite Restriction, the licensee's Kentucky medical license SHALL BE SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS OF RESTRICTION/LIMITATION:

    a. The licensee SHALL NOT perform any act which would constitute the "practice of medicine," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - unless and until approved to do so by the Panel;

    b. The licensee SHALL NOT request, and the Panel SHALL NOT consider any request by the licensee, to amend or terminate this Order of Indefinite Restriction in any way, unless and until the licensee has provided proof of completion and compliance of the following TERMS AND CONDITIONS, and the licensee SHALL NEITHER propose NOR request any alternative to the following TERMS AND CONDITIONS:

        i. The licensee has obtained a clinical skills assessment and an education plan (if so recommended), from the Center for Personalized Education for Physicians (CPEP), 720 South Colorado Boulevard, Suite 1100-N, Denver, Colorado 80246, Tel. (303) 577-3232, at his expense;
            1. Said clinical skills assessment and education plan must contain a statement from CPEP affirming that the licensee is safe and competent to resume practice independently or pursuant to an education plan;
            2. Said clinical skills assessment and education plan must and shall be dated no more than six (6) months prior to the date of submitting any request to amend or terminate this Order of Indefinite Restriction; and
            3. The licensee must and shall execute all necessary waivers and/or consent forms required to ensure that CPEP will provide a copy of any evaluations, reports or plans to the Board's Legal Department prior to submitting any request to amend or terminate this Order of Indefinite Restriction;

        ii. The licensee has "unconditionally passed" the *ProBe* Program offered through the Center for Personalized Education for Physicians (CPEP), 720 South Colorado Boulevard, Suite 1100-N, Denver, Colorado 80246, Tel. (303) 577-3232, at his expense;
            1. The licensee must and shall execute all necessary waivers and/or consent forms required to ensure that

CPEP will provide a copy of any evaluations, reports or essays from the *ProBe* Program to the Board's Legal Department promptly after their completion;

iii. The licensee has successfully completed a Board-approved course relating to HB1 from the approved course list available on the Board's website at http://kbml.ky.gov;
    1. Said course must and shall be completed no more than six (6) months prior to the date of submitting any request to amend or terminate this Order of Indefinite Restriction; and

iv. The licensee has fully reimbursed the Board the costs of these proceedings in the amount of $13,837.84, prior to the date of submitting any request to amend or terminate this Order of Indefinite Restriction; and

c. The licensee SHALL NOT violate any provisions of KRS 311.595 and/or 311.597.

SO ORDERED on this 16th day of October, 2015.

C. William Briscoe MD

C. WILLIAM BRISCOE, M.D.
CHAIR, HEARING PANEL A

CERTIFICATE OF SERVICE

I certify that the original of the foregoing Order of Indefinite Restriction was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222 and copies were mailed, first-class postage prepaid, to Thomas J. Hellmann, Esq., Hearing Officer, 810 Hickman Hill Road, Frankfort, Kentucky 40601 and via certified-mail return receipt requested to the licensee, Sharad C. Patel, M.D., License No. 20851, 1506 Bristol Court, Elizabethtown, Kentucky 42701, and his counsel, Marc S. Murphy, Esq., Stitles & Harbison, PLLC, 400 West Market Street, Suite 1800, Louisville, Kentucky 40202-3352, on this 16th day of October, 2015.

Leanne K. Diakov

Leanne K. Diakov
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
Tel. (502) 429-7150

EFFECTIVE DATE AND APPEAL RIGHTS

Pursuant to KRS 311.593(1) and 13B.120, this Order will be effective immediately on filing. It is the Panel's opinion that based upon sufficient reasonable cause, the health, welfare, and safety of Dr. Patel's patients or the general public would be endangered by delay.

The licensee may appeal from this Order, pursuant to KRS 311.593 and 13B.140-.150, by filing a Petition for Judicial Review in Jefferson Circuit Court within thirty (30) days after this Order is mailed or delivered by personal service. Copies of the petition shall be served by the licensee upon the Board and its General Counsel or Assistant General Counsel. The Petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested, along with a copy of this Order.

COMMONWEALTH OF KENTUCKY
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FINDINGS OF FACT, CONCLUSIONS OF LAW, AND RECOMMENDED ORDER

The Kentucky Board of Medical Licensure brought this action against the license of Sharad C. Patel, M.D., charging him with several violations of the Board's statutes governing the practice of medicine. The administrative hearing was held on May 18-20, 2015. Hon. Sarah Farmer represented the Board, and Hon. Marc C. Murphy represented Dr. Patel.

After considering the evidence admitted at the hearing and arguments of counsel, the hearing officer finds Dr. Patel guilty of some of the violations set forth in the *Complaint* and recommends the Board take any appropriate action against his licence for those violations. In support of that recommendation the hearing officer submits the following findings of fact, conclusions of law, and recommended order.

FINDINGS OF FACT

1. Dr. Sharad C. Patel graduated from the University of Bombay Medical School in India, and he performed residency training in psychiatry at Nassau County Medical Center, which is the clinical campus for the State University of New York at Stony Brook. DVD of Administrative Hearing on May 18, 2015 [hereinafter DVD I], 9:30 a.m.

2. In 1979 Dr. Patel became board certified in psychiatry and neurology and has practiced medicine in Elizabethtown, Kentucky, for over thirty-five years. DVD I, 9:31 a.m.; Exhibit 4.

3. For the past three and a half years Dr. Patel has focused his medical practice on addiction psychiatry, and after receiving certification from the federal government, he has provided treatment for addiction patients with Subutex and Suboxone, a form of buprenorphine. DVD I, 9:32 a.m.

4. As a recovering alcoholic with twenty-five years of sobriety, Dr. Patel believes he is uniquely qualified to treat others with addiction issues. DVD I, 9:32-9:33 a.m.

5. In this action the Board alleges that Dr. Patel failed to comply with the provision of the *Fourth Amended Agreed Order*, and with requirements set forth in a letter dated January 30, 2014, from the Board's General Counsel as an alternative to being recertified by the American Board of Psychiatry and Neurology under the terms of the *Fourth Amended Agreed Order*. Exhibit 2, *Complaint*, pages 9-10; Exhibit 3; Exhibit 5, Tab B.

6. The Board also charges Dr. Patel with offering to provide the person identified in the *Complaint* as Patient A with narcotic medications if he would provide a discount on a new automobile from the dealership where Patient A worked. Exhibit 2, *Complaint*, pages 10-11.

7. Related to that same allegation involving Patient A, the Board charges that when Dr. Patel subsequently decided he had not received a favorable sale price from Patient A, he filed a police report accusing Patient A of stealing a prescription pad from Dr. Patel. Id., pages 11-12.

8. In this action, the Board also asserts that Dr. Patel misdiagnosed Patient B as

suffering from a bipolar disorder when several other psychiatrists had diagnosed him as schizophrenic. Id., page 12.

9. After the allegations related to Patients A and B arose, the Board asked one of its consultants to review Dr. Patel's medical records for those two patients and for fourteen other patients who'd been prescribed buprenorphine, and based upon that review, the Board alleged numerous additional violations against Dr. Patel of the standards for the prescribing of controlled substances. Id., pages 12-14.

10. The Board alleges that Dr. Patel's conduct violated KRS 311.595(9), as illustrated by KRS 311.597(1)(c), (1)(d), (3), (4); KRS 311.595(12); and KRS 311.595(13). Id., page15.

11. Dr. Patel has been the subject of investigations and orders of the Board since at least March 1999, that have placed various conditions, restrictions, or limitations on his practice of medicine. Exhibit 3, *Fourth Amended Agreed Order*, marked pages 1-9.

12. On June 9, 2000, the Board and Dr. Patel entered into an *Agreed Order of Surrender* of his medical license after he decided to discontinue his relationship with the Kentucky Physicians Health Foundation, but in July 2002, he requested the Board to reinstate his license. Id., marked page 2.

13. The Board deferred action on the request until Dr. Patel obtained a clinical skills assessment from the Center for Personalized Education for Physicians ["CPEP"]. Id.

14. The assessment found numerous deficiencies in Dr. Patel's medical skills, and as a result, the Board again deferred action on reinstating his license until he obtained an Educational Intervention Education Plan from CPEP. Id., marked pages 2-4.

15. Thereafter, the Board and Dr. Patel entered into the *Agreed Order of Indefinite Restriction*, dated November 7, 2006, that allowed him to resume the practice of medicine with certain conditions. Id., marked page 5.

16. Following an additional CPEP assessment in 2010 following Dr. Patel's request to practice medicine in an in-patient setting, the Board and Dr. Patel entered into the *Fourth Amended Agreed Order*. Exhibit 3, marked pages 6-9.

17. In that order, which was filed of record on April 28, 2011, Dr. Patel agreed he "SHALL SUCCESSFULLY become re-certified by the American Board of Psychiatry and Neurology ["ABPN"] within two calendar years of the date of filing of this Fourth Amended Agreed Order." Exhibit 3, marked page 12 [emphasis in original].

18. Dr. Patel also agreed under the terms of the order to work with a preceptor, and there's no allegation that he failed to comply with that requirement. Id., marked pages 11-12; Exhibits 15 and 16.

19. When Dr. Patel did not notify the Board that he had been recertified by the ABPN within the two-year period required by the agreed order, the Board asked him to appear before Panel B of the Board on January 16, 2014. Exhibit 5, Tab A.

20. At the panel meeting Dr. Patel asserted he could not sit for the ABPN recertification examination while there were any restrictions remaining on his license to practice medicine. Exhibit 14, CD of Panel B meeting of January 16, 2014, starting approximately halfway through the recording.

21. At the conclusion of its meeting, Panel B presented Dr. Patel with two options to meet the terms of the agreed order: He could complete ABPN's appeal process from the denial of

the request for recertification and present the Board with ABPN's official resolution of the issue, or he could submit to a CPEP Post-Education Evaluation. Exhibit 5, Tab A.

22. Those options that had been presented orally to Dr. Patel at the panel meeting were also conveyed to him in writing by letter dated January 30, 3014, from the Board's General Counsel at the time, Hon. C. Lloyd Vest. Exhibit 5, Tab B.

23. At the administrative hearing Dr. Patel asserted he never agreed to the requirement of the *Fourth Amended Agreed Order* to obtain ABPN recertification, but instead, he asserted he signed the document only because "I had to sign." DVD I, 9:53 a.m.

24. Dr. Patel also asserted he could not recall having been provided the two options by Panel B, but the audio recording of the panel meeting clearly reflects that Panel B presented Dr. Patel with same two specific options for complying with the terms of the agreed order that are included in Mr. Vest's letter. Exhibit 14, beginning approximately halfway through the recording; DVD I, 9:45 a.m.

25. Dr. Patel stated he could not recall having receiving the letter from Mr. Vest, although Dr. Patel acknowledged the letter contains his correct mailing address. DVD I, 9:45-9:48 a.m.

26. Dr. Patel admitted that he had not been recertified by the ABPN, but he reiterated at the administrative hearing the assertion previously made at the panel meeting that ABPN would not authorize him to sit for the examination while he had any restrictions on his license to practice medicine. DVD I, 9:40-9:41 a.m.

27. As for Panel B's directive that he complete ABPN's internal appeal process from

the denial of recertification, Dr. Patel offered into evidence two letters from the ABPN dated December 22, 2008, and February 4, 2011. DVD I, 9:49-9:52 a.m.; Exhibits 17 and 18.

28. Those letters, the last of which was sent almost three years before his meeting with Panel B, indicate a physician may not be licensed by the ABPN if he has restrictions placed on his license. Exhibits 17 and 18.

29. The letters, however, do not support the assertions that Dr. Patel completed ABPN's internal appeal process or that he provided a copy of the written final decision on the matter to the Board as required by Panel B at it's January 16, 2014, meeting. Exhibit 5.

30. Dr. Patel asserted that after the January 16, 2014, panel meeting, he talked with a representative of the ABPN's credentialing committee, and that person later sent him an email stating he could not sit for the examination with the current restrictions on his license. DVD I, 11:26 a.m.

31. That email was not offered into evidence at the administrative hearing, and there was no evidence presented that the email was sent by an official of the ABPN who had authority to make a final decision on a request for recertification or that Dr. Patel forwarded that email to the Board in compliance with Panel B's directive.

32. Thus, even construing Dr. Patel's contact with a representative of the ABPN credentialing committee as an "appeal," and the email response to him as a "final resolution," Dr. Patel did not provide a copy of that written final decision to the Board as required by Panel B.

33. Dr. Patel acknowledged he took no additional steps to comply with his second option presented by Panel B as an alternative to obtaining ABPN recertification, the completion of a CPEP Post-Education Evaluation. DVD I, 11:27 a.m.

34. Dr. Patel explained that he had dealt with CPEP for over five years, had already spent over $50,000 trying to meet CPEP's requirements, but "had problems" satisfying them. DVD I, 11:27 a.m.

35. Dr. Patel asserted that CPEP was "too idealistic" in its requirements and wouldn't allow him access to his individual evaluator's report, which he considered more important than the conclusions contained in CPEP's report. DVD I, 11:27 a.m.

36. Thus, in spite of Panel B's attempt to provide Dr. Patel with an alternative to recertification, Dr. Patel made little effort to clarify ABPN's position regarding his request for recertification, did not appeal an ABPN official notification of denial, did not provide ABPN's decision to the Board in writing, and did not complete a CPEP Post-Education Evaluation.

37. After the grievances were filed on behalf of Patient A and B and at the request of the Board, the Office of Inspector General in the Cabinet for Health and Family Services's Division of Audits and Investigations performed a KASPER review of Dr. Patel's prescribing practices from April 18, 2013, to April 18, 2014. Exhibit 19.

38. The Inspector General's report identified several areas of concern, including Dr. Patel prescribing buprenorphine to 70% of his patients, prescribing benzodiazepine to 50% of those same patients, providing early refills of controlled substances, prescribing controlled substances to family members, and patients using multiple pharmacies and prescribers. Exhibit 19, marked page 3 of 4.

39. The report also noted Dr. Patel had not reviewed KASPER reports for patients prior to prescribing controlled substances as required by the Board's regulations. Id.

40. The report identified fourteen patients whose medical charts the Board could review to assess the medical care Dr. Patel provided to the patients. Id.

41. On May 5, 2014, the Board served Dr. Patel with a subpoena for those fourteen patients' records, and they, along with the records for Patients A and B, were provided to Dr. Stephen C. Cox, the Board's consultant in this action, for his review. Exhibit 21.

42. Dr. Cox graduated from the University of Kentucky School of Medicine in 1975, completed a psychiatry residency at that same institution in 1978, and has a subspecialty in Anxiety Disorders. Exhibit 24.

43. At the administrative hearing Dr. Patel objected to Dr. Cox serving as the Board's expert witness since he does not treat addiction disorders, but the hearing officer found Dr. Cox to be generally qualified to testify as an expert witness in the field of psychiatry. DVD of Administrative Hearing on May 19, 2015 [hereinafter DVD II], 9:36 a.m.

44. Based upon his review of Dr. Patel's patient charts, Dr. Cox described Dr. Patel as an excellent psychiatrist with superior psychiatric clinical skills regarding patient diagnosis and treatment and with very good clinical notes for those patients. DVD II, 9:52 a.m.

45. Dr. Cox found, however, that Dr. Patel routinely violated several provisions of the Board's regulation governing the prescribing of controlled substances contained in 201 KAR 9:260, which was admitted into evidence as Exhibit 45.

46. Dr. Cox found that Dr. Patel did not obtain KASPER reports for many patients, did not have the patients provide urine drug screens, and did not have drug contracts or photo identification for the patients in the patient files. DVD II, 9:54 a.m.

47. In addition, there were few instances in Dr. Patel's patient notes that showed he addressed patients' use of multiple pharmacies or multiple physicians to obtain prescriptions for controlled substances. DVD II, 9:54-9:55 a.m.; Exhibit 27, pages 2-3.

48. Dr. Cox also noted instances in which Dr. Patel provided patients with early refills of their prescriptions without recording a reason for the refill, and Dr. Cox found other instances in which no rationale was provided for changes in the patient's dosage of the controlled substance. DVD II, 9:55 a.m.; Exhibit 27, page 2-3.

49. Dr. Cox found that Dr. Patel prescribed narcotics to a majority of the patients whose charts were reviewed, and some of the patients were also prescribed amphetamines for attention deficit disorder and benzodiazepines for anxiety. Exhibit 27, page 2.

50. Dr. Cox found that Dr. Patel did not taper his patients from their initial prescription dosage for Suboxone, contrary to the stated intention in the patient chart at the onset of treatment, but instead, he appeared to simply maintain the patients on the medication, a practice that Dr. Cox described to be "rightly or wrongly" as "the standard of practice of [Dr. Patel's] Kentucky peers in that field." Exhibit 27, page 3.

51. It's a departure from the standards of acceptable and prevailing medical practice in Kentucky for a physician not to obtain a KASPER report, not to react to a patient obtaining early refills or switching pharmacies, not to document the rationale for allowing early refills or for switching amounts of medication, and not to have written contracts with patients requiring them to adhere to standards for the use of the prescribed controlled substances. DVD II 10:01-10:03 a.m.

52. Although finding several deficiencies in Dr. Patel's prescribing practices, Dr. Cox did not find that Dr. Patel prescribed the medications with the intent or knowledge they would be used for other than an accepted therapeutic purpose, and Dr. Cox found that Dr. Patel did not make any false statements in his medical documentation and did not prescribe or dispense controlled substances for himself. Exhibit 27, page 2.

53. Overall, Dr. Cox found that Dr. Patel engaged in "unacceptable clinical practice" for thirteen of the fourteen patients. He also found that Dr. Patel engaged in conduct that departed from the standards of accepted and prevailing medical practice in Kentucky and that he committed a pattern of acts during the course of his medical practice that constituted gross negligence and constituted a danger to the health and safety of his patients. Exhibit 27, page 1.

54. Patient E was the only patient for whom Dr. Cox found no deficiencies in th care and treatment provided by Dr. Patel. Exhibit 27, page 5.

55. In his written response to Dr. Cox's review, Dr. Patel described his medical practice as "one of the few that combines the treatment of psychiatric disorders with the treatment of substance abuse." Exhibit 11, page 2.

56. Dr. Patel asserted this combination of psychiatric and substance abuse treatment was "complex" and "likely one that can be easily misunderstood by those who are not intimately familiar with, or experienced in, the overlapping issues involved." Id.

57. In his written response Dr. Patel also asserted that "the reality of this practice" is that opioid dependent individuals often obtain buprenorphine or Subutex illegally prior to their admission to a treatment program or when they are required to undergo opioid withdrawal as part of a treatment program. Id, page 3.

58. Yet at the same time, Dr. Patel admitted that prior to April 2014, he regularly violated the Board's regulation governing the prescribing of controlled substances that had been adopted in order to help decrease the diversion and illegal use of controlled substances and to help physicians address drug seeking behavior by patients. Exhibit 11, DVD II, 2:08 p.m.

59. Dr. Patel characterized Dr. Cox's opinions regarding the deficiencies in his medical practice as relating to his "alleged failure to appropriately monitor the many checks and balances the modern practice of medicine places upon patients' behavior when they are *out* of the office." Exhibit 11, page 2 [emphasis in original].

60. Presumably, Dr. Patel was referring to the monitoring requirements for urine drug screens, pill counts, KASPER reports, and other measures to ensure proper use of controlled substances.

61. Dr. Patel asserted the Board's "checks and balances" are important but they "aren't perfect," are "frequently difficult to enforce," and are "depend upon the good or bad intention of the patient." Exhibit 11, page 2.

62. In spite of acknowledging he should be diligent in monitoring the patients' use of controlled substances, Dr. Patel admits in his written response that he failed to adequately monitor those patients.

63. Dr. Patel admitted that prior to April 2014, he "had not been performing routine drug screens on patients who were in treatment for chronic pain" Exhibit 11, page 8.

64. He admitted that prior to April 2014, "we were not obtaining Casper [sic] reports routinely" for patients being treated for chronic pain. Exhibit 11, page 8; DVD I, 1:26 p.m.

65. He admitted that prior to April 2014, he had failed to adequately monitor the prescriptions he had issued in order to ensure patients were not obtaining early refills of their controlled substances. Id, page 5.

66. At the administrative hearing Dr. Patel asserted that until April 2014 he had been unaware of the requirement that he routinely obtain KASPER reports on his patients, and he asserted that he only discovered the requirement because the Board's investigator, Stephen Manley, had informed him of the requirement during the investigation of Patient A's allegations. DVD I, 1:14-1:15 p.m.

67. Dr. Patel stated that sometime prior to April 2014 he had been informed by his office manager that pharmacists, rather than physicians, were required to obtain KASPER reports. DVD I, 1:14 p.m.

68. Dr. Patel cited several factors that contributed to his poor oversight of patients who had been prescribed controlled substances, but he asserted that he has "made significant changes" in his medical practice since April 2014. Exhibit 11, page 3.

69. Dr. Patel admitted that his "charting is imperfect" but asserting the deficiency was caused, at least in part, by his "adjusting to EMR [Electronic Medical Records] and the practical issues associated with it." Exhibit 11, page 2.

70. Dr. Patel admitted that prior to April 2014 his office "was a mess" and that "the state of [his] practice was bad." DVD I, 1:15 p.m.

71. Yet, Dr. Patel did not implement any changes in his medical practice until after the Board's investigator informed him on or around April 1, 2014, that the Board was reviewing his prescribing practices. DVD I, 1:14-1:15 p.m.

72. He attributed the problems in his medical office to two factors: incompetent office staff and an overwhelming number of patients. DVD I, 1:03-1:04 p.m. and 1:15-1:16 p.m.

73. Dr. Patel acknowledged his staff had not routinely pulled files in anticipation of patient appointments, had not taken patient vital signs, and had not performed urine drug screens and other lab work. DVD I, 1:06-1:07 p.m.

74. From Dr. Patel's perspective those shortcomings were the result of his spending too much clinical time with his patients, which caused him to be lax in dictating office notes after seeing a patient and to take weeks or months to dictate a progress note based upon the few notes he jotted down during the patient encounter. DVD 1:05 p.m.

75. In addition, as the result of a heroin epidemic in Elizabethtown, Dr. Patel asserted there was an increased the demand for his psychiatric services, which prevented him from cutting back on the number of patients he treated. DVD I, 1:16-1:17 p.m.

76. In order to address the problems in his medical practice, Dr. Patel fired three employees, and with the help of his daughter, who is also a physician, he reorganized the medical practice to make it more efficient, which Dr. Patel asserted had resolved the practice's deficiencies before the Board suspended his medical license. DVD I, 1:03 and 1:10-1:13 p.m.

77. In spite of the problems with his medical practice, Dr. Patel asserted that patient care was never compromised. DVD I, 1:08 p.m.

78. Although admitting that there had been many problems in his office practice, Dr. Patel disagreed with Dr. Cox's findings regarding deficiencies in the care and treatment of the individual patients whose charts he reviewed.

79. Dr. Patel asserted that Dr. Cox did not have adequate experience to know the appropriate treatment that should be provided to opiate addicted patients. DVD I, 1:20 p.m.

80. In addition, Dr. Patel asserted Dr. Cox did not have all of the medical records related to his patients due to the fact the Board's subpoena for records had been mishandled by himself and his staff. DVD I, 1:18 and 1:20 p.m.

81. Dr. Patel was directed to produce the patient records by May 23, 2014, in response to the subpoena personally served on him on May 5, 2014. Exhibits 21 and 22.

82. Shannon Cole, who was not working in Dr. Patel's office during the time period the Board sought the subpoenaed patient records but who returned to her position shortly after they had been provided to the Board, testified that due to the incompetence of the staff, not all of the patients' records were provided to the Board. DVD II, 3:47 and 3:52 p.m.

83. Consequently, when she read Dr. Cox's report, she collected additional records for nine of the fourteen patients, which were admitted at the administrative hearing as Exhibit 46. DVD II, 4:06-4:07 p.m. and 4:11 p.m.

84. The hearing officer reviewed those records, and most relate to the time period after Dr. Patel became aware of the Board's investigation and after the Board obtained the subpoenaed records reviewed by Dr. Cox. Thus, to the extent Dr. Patel asserts the records show he performed urine drug screens or obtained KASPER reports during the time period reviewed by Dr. Cox, the vast majority of the records in Exhibit 46 are irrelevant to that issue, and they do not call into question Dr. Cox's findings and conclusions regarding Dr. Patel's medical practice.

85. In fact, the supplemental records suggest Dr. Patel added information to his progress notes after the originals was provided to the Board, thereby making some notes substantially

more detailed and comprehensive than the originals. For example, a comparison of the subpoenaed progress note for Patient G in Exhibit 35, page 5, to the supplemental note in Exhibit 46 for the patient, at marked page 107, shows that the subpoenaed progress note lists a SOAP format but contains no information under the categories for S, O, or A, and just lists Patient's G's prescribed medications under P category. The note for the same date provided by Dr. Patel as part of his supplemental patient records has extensive information under the S, O, and A categories, and there is a detailed explanation of Dr. Patel's plan under the P category.

86. Another example of the same discrepancy between the subpoenaed and supplemental patient records can be found in a comparison of the subpoenaed progress note for Patient M in Exhibit 41, page 6, and the supplemental patient note for Patient M in Exhibit 46, marked page 315.

87. As for Dr. Cox's findings regarding Dr. Patel's failure to adequately monitor patients who had been prescribed controlled substances, the hearing officer found that the preponderance of the evidence supported Dr. Cox's findings and conclusions.

88. Under the provisions of 201 KAR 9:260, effective March 3, 2013, all physicians were required to comply with new standards regarding the prescribing or dispensing of controlled substances for the treatment of pain and related symptoms. Those standards require physicians who are involved in the long term treatment of patients with controlled substances to monitor their use and to take appropriate action in response to evidence of drug seeking behavior or diversion. 201 KAR 9:260, Section 5(2).

89. The standards in 201 KAR 9:260 are intended to help physicians practice defensive medicine and to address patients who exhibit drug seeking behavior. DVD II, 2:08 p.m.

90. Under the regulation, a physician is required to document all relevant information in sufficient detail in the patient's medical record regarding the prescribing of controlled substances for a patient. 201 KAR 9:260, Section 2.

91. The standards of acceptable and prevailing medical practice also require a physician to record adequate progress notes in the patient chart and to obtain KASPER reports and drug screens. DVD II, 11:22 a.m.

92. Dr. Patel violated those standards for many of the patients at issue in this action.

93. The following is not a comprehensive listing of all the instances in which Dr. Patel violated the Board's regulation governing the prescribing of controlled substances, but instead, the cited instances provide a representative sample of the different types of deficiencies found in Dr. Cox's review of the fourteen patient records.

94. Prior to prescribing controlled substances for pain or other medical conditions a physician is required to obtain "an appropriate medical history relevant to the medical complaint." 201 KAR 9:260, Section 3(1) and Section 7(1)(a).

95. It is a violation of the standards of acceptable and prevailing medical practice for a physician not to perform a complete history and physical on the patient prior to prescribing controlled substances. DVD II, 11:50 a.m.

96. Dr. Patel did not obtain an initial history and physical for Patient L prior to initiating her treatment with buprenorphine on October 14, 2013. Exhibit 40, pages 16 and 27; DVD II, 1:15 p.m.

97. Likewise, Dr. Patel did not obtain a history and physical for Patients J prior to

prescribing her Subutex on February 27, 2014. Exhibit 38, pages 2 and 14; and DVD II, 11:49 a.m.

98. Under 201 KAR 9:260, Section 2(1), a physician who prescribes controlled substances "shall obtain and document all relevant information in a patient's medical record in a legible manner and in sufficient detail to enable the board to determine whether the physician is conforming to professional standards for prescribing or dispensing controlled substances and other relevant professional standards."

99. It is a deviation from the acceptable and prevailing medical standards for a physician not to include in the patient's progress notes any information other than the patient's vital signs and medications prescribed. DVD II, 11:08-11:09 a.m.

100. The examples listed above for Patients G and M in which Dr. Patel listed nothing under the S, O, and A portions of a SOAP note while prescribing controlled substances are examples of his violation of 201 KAR 9:260, Section 2(1).

101. In addition, Dr. Patel's effort to later amend those patient notes after the Board began its investigation of his medical practice are a tacit admission by him of the inadequacy of his original notes under the governing Board standards.

102. There are numerous other examples of Dr. Patel failing to list any information in a patient's progress notes other than the medications prescribed. See for example, Exhibit 36, pages 128-133, which include changes in the Subutex prescription and the addition of Valium for Patient H; Exhibit 37, pages 22, 26, 27, 30, 34, which include changes in the prescriptions for controlled substances and the addition of other controlled substances for Patient I; and Exhibit

40, pages 2-11, which include changes in prescriptions for controlled substances and the addition of other controlled substances for Patient L.

103. Upon initiating the treatment of a patient with controlled substances, a physician is required to "obtain and review a KASPER report for that patient for the twelve (12) month period immediately preceding that patient encounter, and appropriately utilize that information in the evaluation and treatment of the patient." 201 KAR 9:260, Section 3(2). See also 201 KAR 9:260, Section 7(1)(b).

104. In addition, a physician who treats a patient for pain and related symptoms with controlled substances for more than three months must obtain a KASPER report "at least every three months." 201 KAR 9:260, Section 5(2)(i).

105. As an example of his failure to obtain KASPER reports, Dr. Patel began treating Patient D on May 3, 2013, with buprenorphine, but he did not request a KASPER report for the patient until April 10, 2014. Exhibit 32, pages 4-6, 81. [The date at bottom left of a page of a KASPER report is date the request for the report was made. DVD I, 2:40 p.m.]

106. Dr. Patel began treating Patient H for chronic pain and other symptoms on September 30, 2013, with Subutex and Valium, but did not request a KASPER report for her until April 29, 2014. Exhibit 36, pages 9 and 144-146.

107. Dr. Patel began treating Patient L with Valium and buprenorphine on October 11, 2013, for unstated reasons, although she had previously been diagnosed with chronic pain, and he did not request a KASPER report until May 12, 2014. Exhibit 40, pages 16, 27, and 51-52.

108. A physician is required to utilize drug screens upon the initiation of the long-term

use of controlled substances and periodically during the course of the long-term prescribing of those medications. 201 KAR 9:260, Section 4(1)(h) and Section 5(2)(k).

109. Dr. Patel did not request a urine drug screen for Patient H until May 22, 2014, which was almost eight months after he began treating her with Subutex and Valium. Exhibit 36, pages128-146; Exhibit 46, Patient H, pages 185-187; DVD II, 11:32 a.m and 2:49 p.m.

110. Dr. Patel began treating Patient J on February 28, 2014, with Subutex and added clonazepam a week later, but did not obtain a urine drug screen for the patient until May 8, 2014. Exhibit 38, pages 6 and 14.

111. Patient P was prescribed Subutex and clonazepam for chronic pain and other conditions beginning on November 20, 2013, but Dr. Patel never obtained a urine drug screen on the patient. Exhibit 44, pages 2-4 and 27; DVD II, 1:35 p.m.

112. If a patient's drug screen indicated he is noncompliant with the long-term treatment plan, the physician is required to take some action to address the noncompliance. 201 KAR 9:260, Section 5(2)(k).

113. It is a deviation from the standards of acceptable and prevailing medical practice for a physician not to address inappropriate results from a drug screen. DVD II, 11:05 a.m.

114. Patient D's urine drug screens were positive for unprescribed amphetamines and benzodiazepines on numerous occasions between June 4, 2013 and April 16, 2014, but Dr. Patel took no action in response until April 2014. Exhibit 32, pages 18, 22, 26, 30, 34, 38, 42, 45, 48, 51, 54, 61, and 79. DVD II, 11:04 a.m.

115. A physician should not allow early refills of a prescription except upon the patient providing a reasonable explanation and not on a routine or frequent basis. DVD II, 11:20 a.m.

116. Patient F filled his prescriptions for lorazepam early on nineteen occasions between June 22, 2013, and April 17, 2014, and at multiple pharmacies as shown on the KASPER report dated May 12, 2014, but Dr. Patel had no comment on his progress note for May 13, 2014, which lists only the patient's vital signs and the medications prescribed. DVD II, 11:14-11:15 a.m.; Exhibit 34, pages 2-3 and 7.

117. Dr. Cox stated that Dr. Patel "knew or should have known" the patient was filling his prescriptions early. Exhibit 28, page 3.

118. Even assuming an early refill is authorized, it is a deviation of the standards of acceptable and prevailing medical practice for a physician not to document in the patient's progress notes the reasons for early refills of controlled substances. DVD II, 11:14 a.m.; Exhibit 28, pages 2-3.

119. Patient F filled his lorazepam prescription for ninety 1mg tablets on December 14, 2013 at two different pharmacies, which Dr. Cox stated "suggests the patient was clearly aware they (sic) were doing wrong and was attempting to get away with it." Exhibit 28, page 3; Exhibit 34, page 2.

120. On February 14, 2014, Patient F again filled his lorazepam prescription at two different pharmacies. Exhibit 34, page 2.

121. On March 5, 2013, Dr. Patel prescribed Patient K ninety tablets of Subutex for chronic pain, which Dr. Cox asserted seemed excessive, but he stated since he had no training in prescribing the medication and would defer to Dr. Patel's judgment. DVD II, 2:58-3:00 p.m.; Exhibit 39, page 20.

122. In response, Dr. Patel explained that patient did not want to be seen on a weekly basis but was willing to be seen on a monthly basis, and treatment with two to three Subutex tablets per day were appropriate for Patient K's age and size. Exhibit 11, page 4.

123. Therefore, Dr. Patel prescribed the ninety tablets with the understanding "that the daily dose of Subutex would be titrated upwards slowly on a weekly basis, by telephone," but "unfortunately, after the first few weeks he stopped calling." Id.

124. At the least, Patient K is representative of Dr. Patel's lax oversight of his patients who had been prescribed controlled substances.

125. There were several patients who did not have drug contracts in their patient file, including Patients A, H, J, N, and P. Exhibits 29, 36, 38, 42, and 44 respectively.

126. Dr. Cox found there were several documentation deficiencies in the medical records for Patient C, Dr. Patel's daughter, that were similar to those found for the other patients whose charts were reviewed. In this instance, however, Dr. Patel asserted there was an emergency situation which justified the issuance of the prescription.

127. On November 6, 2013, Dr. Patel, prescribed his daughter, Patient C, ninety Adderall 7.5 mg. Exhibit 13, page 2; Exhibit 27, page 4.

128. Patient C is a physician and is currently in a residency training program at a hospital in Toledo, Ohio. DVD I, 11:33 a.m.

129. Dr. Cox found that Patient C have "virtually no chart" from Dr. Patel, and there was no evidence he evaluated the patient, performed a urine drug screen, or obtained a KASPER report prior to issuing the prescription, all in violation of the Board's regulations. Exhibit 13; Exhibit 27, page 4.

130. As a result, Dr. Cox asserted Dr. Patel's care and treatment of Patient C was "unacceptable clinical practice." Id.

131. Dr. Patel acknowledged that he did not perform a history or physical for Patient C, did not have her submit to a urine drug screen, and did not obtain a KASPER report for her. DVD I, 10:25 a.m.

132. In his defense, Dr. Patel asserted that Patient C had been seeing a physician at the University of Louisville for several months who had been treating her with Adderall, but she was unable to contact him to obtain a refill for several days prior to her scheduled trip to India. Exhibit 11, pages 4-5.

133. Consequently, Dr. Patel asserted the prescription was written in an emergency situation, and he did not intend to violate the American Medical Association's Code of Medical Ethics regarding the prescribing of controlled substances to family members. DVD II, 2:26 p.m.

134. In this action, the Board does not specifically charge Dr. Patel with a violation of the AMA Code of Medical Ethics, but the Board's allegation that there were no records to support Patient C's prescription was unrefuted and is consistent with Dr. Patel's lack of appropriate records for other patients.

135. Patient B came to the attention of the Board as a result of a grievance filed by his sister. She asserted that in her brother's evaluation Dr. Patel ignored her assertion that Patient B suffered from delusions and ignored the extensive record from previous treating physicians who had diagnosed him as schizophrenic. Exhibits 9 and 30.

136. At the time of Dr. Patel's evaluation of Patient B he was fifty-eight-years-old and

had filed a petition to have his sister removed as his guardian as part of his effort to return to his previous career as a truck driver. Exhibit 31, pages 13-14, 17.

137. Dr. Patel performed a court-ordered functional examination of Patient B in response to his petition, and he provided a favorable evaluation of Patient B. Exhibit 31, pages 13-14.

138. Dr. Patel found that Patient B was suffering from Bipolar Disorder or Major Depression, rather than schizophrenia, and found that his mental status was stable and that he was "fully competent to make his own decisions." Id.

139. In his Expert Review Worksheet, Dr. Cox asserted Dr. Patel's diagnosis was below minimum standards, even though Dr Cox largely agreed with it, found the treatment and patient records to be within minimum standards, and found overall that the case was "borderline." Exhibit 26.

140. Dr. Cox agreed with Dr. Patel's opinion that Patient B was not schizophrenic, "favoring" a diagnosis of bipolar disorder. Exhibit 26, page 2; DVD II, 2:21 p.m.

141. Dr. Cox faulted Dr. Patel for "disregarding the opinions of more than half a dozen mental health personnel, and the family's opinion, and history of delusions," asserting that ignoring those opinions "without explanation is not wise medical diagnosis strategy." Exhibit 26, page 3.

142. At the administrative hearing Dr. Cox clarified the fact that his main concern was that Dr. Patel had not read all of the patient notes from the previous healthcare professionals, but at the same time, Dr. Cox stated he had read them and arrived at the same conclusion as Dr. Patel. DVD II, 2:25 p.m.

143. Considering all the evidence related to Patient B, it's clear that Dr. Patel had communication issues with Patient B's sister and failed to fully explain the basis for his opinions in light of the treatment provided by previous healthcare professionals. The preponderance of the evidence, however, does not support the conclusion that Dr. Patel violated any standards governing the practice of medicine in his care and treatment of Patient B.

144. Dr. Patel treated Patient A from March 4, 2013, until at least April 8, 2014. Exhibit 29, pages 1-17; Exhibit 20, pages 130-131.

145. In early 2014 Patient A filed a grievance with the Board alleging that in the fall of 2013 Dr. Patel had offered to increase his prescription for Subutex if he would provide Dr. Patel with a discount on a new car at the dealership where he worked. Exhibit 6.

146. Patient A alleged that shortly after Dr. Patel completed the purchase, he complained that Patient A had not provided an adequate discount, and allegedly in retaliation, Dr. Patel had accused Patient A of stealing a prescription pad from Dr. Patel's office, which Patient A asserted had resulted in him being fired by the dealership. Exhibit 6.

147. After the Board's investigator interviewed Dr. Patel regarding the allegations, Patient A submitted a letter to the Board asserting "this whole ordeal was a big misunderstanding" and requesting to withdraw his complaint. Exhibit 8.

148. Patient A's letter was delivered to the Board from the fax machine in Dr. Patel's office along with Dr. Patel's response to Patient A's grievance.

149. In his response to Patient A's grievance Dr. Patel denied as "nonsense" the allegation that he committed any misconduct in the purchase of his automobile, and he denied

telling the police that Patient A had stolen the prescription pad, asserting he told them only that Patient A had been present in the office shortly before the pad was discovered missing. Exhibit 7.

150. Dr. Patel also notified the Board in his response that he had found the prescription pad under the seat of his automobile two days after reporting it stolen and had promptly notified the police of that fact. Exhibit 7.

151. The Board has been unable to contact Patient A since he requested the withdrawal of his grievance, and he did not testify at the administrative hearing. DVD I, 2:48 p.m.

152. Kathy McCubbin, the general manager at the Toyota dealership, testified Patient A had worked for approximately four months and had been fired on November 15, 2013, for reasons unrelated to Dr. Patel's accusations, but his general dishonesty was one of the factors. DVD I, 2:12 and 2:14-2:15 p.m.

153. In addition, Ms. McCubbin stated there was nothing unusual regarding the sale of the automobile or the price paid by Dr. Patel. DVD I, 2:20 p.m.

154. Dr. Cox noted in his review of Patient A's patient file and KASPER report that on September 23, 2013, Patient A began filling a full 30-day prescription for buprenorphine when he had previously been authorized to obtain from the pharmacy amounts ranging from three to seventeen. DVD II, 10:09 a.m. and 10:11 a.m.; Exhibit 20, page 130.

155. On September 23, 2013, Patient A also filled the prescription approximately a week early and at a new drugstore. DVD II, 10:10 a.m.; Exhibit 20, page 130.

156. That information would have been available to Dr. Patel if he had obtained a KASPER report on Patient A, but there were no KASPER reports in Patient A's patient chart. DVD II, 10:13 a.m.; Exhibit 29.

157. Thereafter, Patient A filled prescriptions for thirty-day supplies of the medication on October 16 and November 14, 2013, but the amounts he could obtain reverted to one to sixteen day supplies starting on December 12, 2013. Exhibit 20, page 130-131.

158. The progress notes for Patient A provide no information or discussion regarding any changes in the amount of the medication Patient A was authorized to receive on each occasion from the pharmacy. Exhibit 29.

159. Thus, the deficiencies in the medical records for Patient A are similar to the deficiencies contained in the records for most of the other patients at issue in this action.

160. The preponderance of the evidence, however, does not support the conclusion that Dr. Patel agreed to exchange additional buprenorphine for a discounted price on his purchase of an automobile. Without testimony from Patient A and the hearing officer's ability to assess Patient A's credibility, the only evidence directly supporting Patient A's charge of trading controlled substances for a discounted automobile was his hearsay statement to that effect, which he later withdrew. Although Dr. Patel received a discount off the sticker price for the automobile, he did not receive a discount larger than other customers could expect to negotiate. Patient A received an early refill on his prescription, but so did other patients who had not been adequately monitored by Dr. Patel, and other patients received similar amounts of buprenorphine from Dr. Patel. The reason why Dr. Patel began authorizing monthly refills of Patient A's prescription is not clear from the his medical chart, but there are similar deficiencies in the charts for other patients. If Dr. Patel had the alleged agreement with Patient A and decided to retaliate against him by accusing him of stealing a prescription pad, Dr. Patel would not be expected to continue to prescribe monthly amounts of buprenorphine into December 2013. Certainly, Dr. Patel's

actions raise suspicions of misconduct and show he used questionable judgment in purchasing the automobile and in not severing the professional relationship with Patient A after accusing him of theft. Those lapses in professional judgment, however, do not render Patient A's hearsay allegation believable or constitute a preponderance of evidence to support a finding that Dr. Patel agreed to exchange the patient's access to additional controlled substances for a discount on the purchase of an automobile.

161. In spite of the deficiencies found in the chart review, Dr. Cox thought Dr. Patel was a generally excellent psychiatrist who would have an acceptable clinical practice if he improved his charting and KASPER review. DVD II, 2:07-2:09 p.m.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over this action pursuant to KRS 311.591 and KRS 311.595.

2. The administrative hearing was conducted in accordance with the provisions of KRS Chapter 13B and KRS 311.591.

3. Under KRS 13B.090(7), the Board had the burden to prove by a preponderance of the evidence the allegations against Dr. Patel.

4. The Board has met its burden of proof on most of the allegations against Dr. Patel.

5. Although Dr. Cox was qualified at the administrative hearing as an expert witness in the field of psychiatry, the hearing officer reserved a ruling on whether Dr. Cox was qualified to provide expert testimony in this action until all of the evidence had been presented. Dr. Patel asserted that since Dr. Cox's subspecialty in psychiatry is the treatment of anxiety disorders, which is distinct from the treatment of addiction disorders, Dr. Cox did not have to appropriate

qualifications to offer opinions on whether Dr. Patel violated the standards of acceptable and prevailing medical practice in Kentucky. During the hearing, the hearing officer ruled that Dr. Cox's qualification as an expert witness would depend upon the scope of his opinions regarding the deficiencies in Dr. Patel's medical practice. Since Dr. Cox's opinions addressed almost exclusively Dr. Patel's failure to comply with the requirements for prescribing controlled substances under the Board's regulations, and do not focus on the standards related to the care and treatment of patients with addiction disorders, the hearing officer finds Dr. Patel's objections to Dr. Cox testifying as an expert witness in this action are without merit. Dr. Cox was well qualified to offer testimony on the information included in Dr. Patel's medical charts and whether Dr. Patel complied with the Board's regulation and standards for prescribing controlled substances. Furthermore, there was no testimony offered to suggest the Board's regulation governing the prescribing of controlled substances, 201 KAR 9:260, exempted psychiatrists who treat patients with addiction issues or that different standards apply to physicians treating such disorders.

6. Dr. Patel was charged with violating KRS 311.595(9), as illustrated by KRS 311.597(1)(c), (1)(d), (3), (4); KRS 311.595(12); and KRS 311.595(13).

7. Pursuant to KRS 311.595(9), a physician is subject to discipline if he has "engaged in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public or any member thereof."

8. Under KRS 311.597(1)(c), the term "dishonorable, unethical, or unprofessional conduct" is defined to include the prescribing or dispensing of medication to his immediate

family "when the licensee knows or has reason to know that an abuse of a controlled substance is occurring, or may result from such a practice."

9. Although Dr. Patel prescribed Adderall to his daughter on one occasion, there was no evidence to support a conclusion that she abused the controlled substance or that Dr Patel had a concern she might abuse it.

10. Under KRS 311.597(1)(d), the term "dishonorable, unethical, or unprofessional conduct" is defined to include the prescribing or dispensing of medication "in such amounts that the licensee knows or has reason to know, under the attendant circumstances, that said amounts so prescribed or dispensed are excessive under accepted and prevailing medical practice standards."

11. The preponderance of the evidence supports the conclusion that Dr. Patel knew or should have known Patient F was receiving an excessive amount of controlled substances since he consistently pbtaomed early refills without explanation or justification by Dr. Patel.

12. Pursuant to KRS 311.597(3), the term "dishonorable, unethical, or unprofessional conduct" is defined to included "a serious act, or a pattern of acts committed during the course of his medical practice which, under the attendant circumstances, would be deemed to be gross incompetence, gross negligence, or malpractice."

13. Dr. Cox asserted that the conduct of Dr. Patel would violate KRS 311.595(9), as illustrated by KRS 311.597(3) if Patient A's allegations were true. Since the hearing officer has found that the preponderance of the evidence does not support the conclusion Dr. Patel traded controlled substances for the discounted purchase of an automobile, he has not violated those statutes.

14. A physician is subject to discipline under KRS 311.595(9), as illustrated by KRS 311.597(4), if he engages in:

> conduct which is calculated or has the effect of bringing the medical profession into disrepute, including but not limited to any departure from, or failure to conform to the standards of acceptable and prevailing medical practice within the Commonwealth of Kentucky, and any departure from, or failure to conform to the principles of medical ethics of the American Medical Association or the code of ethics of the American Osteopathic Association.

15. The preponderance of the evidence supports the conclusion that Dr. Patel violated KRS 311.595(9), as illustrated by KRS 311.597(4), in his care and treatment of Patient D and Patients F through P.

16. The preamble of 201 KAR 9:260 states that the regulation establishes "the professional standards for prescribing and dispensing controlled substances," and Section 10(1) of the regulation states that "any violation of the professional standards established in this administrative regulation shall constitute a violation of KRS 311.595(12) and (9), which may result in the imposition of disciplinary sanctions by the board, pursuant to KRS 311.595."

17. Under Section 12(2) of 201 KAR 9:260, a violation of the regulation must be established through expert testimony by a physician who has reviewed patient records and KASPER reports. In this action Dr. Cox found multiple violations by Dr. Patel based upon his review conducted in accordance with the provisions of the regulation.

18. On March 4, 2013, 201 KAR 9:260 became effective, and Dr. Patel himself asserted that due to his own ignorance of the regulation, he failed to comply with any of its provisions until April 2014. As set forth in the Findings of Fact, Dr. Cox found numerous instances of Dr. Patel failing to comply with the standards of acceptable and prevailing medical practice in

Kentucky and of 201 KAR 9:260 during the year following its promulgation. Dr. Patel failed to maintain patient records in sufficient detail to show his compliance with the regulation or other relevant professional standards, failed to provide in his medical records an adequate explanation for his prescribing practices, and failed to perform patient history and physicals. In addition, he failed to obtain initial or follow-up KASPER reports, failed to conduct periodic drug screens or to otherwise adequately monitor the patients who had been prescribed controlled substances, failed to have patients sign drug contracts, and failed to take action in response to evidence of a patient's noncompliance with the patient's treatment program or the regulation's standards. In short, for over a year after 201 KAR 9:260 was promulgated Dr. Patel did not comply with any of the regulation's standards. Therefore, by his conduct Dr. Patel violated 201 KAR 9:260 and KRS 311.595(9), as illustrated by KRS 311.597(4).

19. A physician is subject to discipline under KRS 311.595(12) if he violates a valid regulation of the Board, and 201 KAR 9:260, Section 10(2), provides that a violation of the regulation constitutes a violation of that same statute. Therefore, by his violation of 201 KAR 9:260, Dr. Patel has also violated 311.595(12).

20. Pursuant to KRS 311.595(13) a licensee is subject to discipline for violating and agreed order of the Board. Dr. Patel has violated that statute by failing to comply with the terms of the *Fourth Amended Agreed Order*.

RECOMMENDED ORDER

Based upon the foregoing findings of fact and conclusions of law, the hearing officer recommends that the Kentucky Board of Medical Licensure find Sharad C. Patel, M.D., has violated the provisions of KRS 311.595(9), as illustrated by KRS 311.597(4), and of KRS

311.595(12) and (13), and the hearing officer recommends the Board take any appropriate action against Dr. Patel's license as a result of the violations.

NOTICE OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4) a party has the right to file exceptions to this recommended decision:

> A copy of the hearing officer's recommended order shall also be sent to each party in the hearing and each party shall have fifteen (15) days from the date the recommended order is mailed within which to file exceptions to the recommendations with the agency head.

A party also has a right to appeal the Final Order of the agency pursuant to KRS 13B.140(1) which states:

> All final orders of an agency shall be subject to judicial review in accordance with the provisions of this chapter. A party shall institute an appeal by filing a petition in the Circuit Court of venue, as provided in the agency's enabling statutes, within thirty (30) days after the final order of the agency is mailed or delivered by personal service. If venue for appeal is not stated in the enabling statutes, a party may appeal to Franklin Circuit Court or the Circuit Court of the county in which the appealing party resides or operates a place of business. Copies of the petition shall be served by the petitioner upon the agency and all parties of record. The petition shall include the names and addresses of all parties to the proceeding and the agency involved, and a statement of the grounds on which the review is requested. The petition shall be accompanied by a copy of the final order.

Pursuant to KRS 23A.010(4), "Such review [by the circuit court] shall not constitute an appeal but an original action." Some courts have interpreted this language to mean that summons must be served upon filing an appeal in circuit court.

SO RECOMMENDED this 19th day of August, 2015.

THOMAS J. HELLMANN
HEARING OFFICER
810 HICKMAN HILL RD
FRANKFORT KY 40601
(502) 330-7338
thellmann@mac.com

CERTIFICATE OF SERVICE

I hereby certify that the original of this RECOMMENDED ORDER was mailed this 19th day of August, 2015, by first-class mail, postage prepaid, to:

JILL LUN
KY BOARD OF MEDICAL LICENSURE
HURSTBOURNE OFFICE PARK STE 1B
310 WHITTINGTON PKWY
LOUISVILLE KY 40222

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THOMAS J. HELLMANN

1625FC Patel

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1625

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, 1506 BRISTOL COURT, ELIZABETHTOWN, KENTUCKY 42701

EMERGENCY ORDER OF SUSPENSION

The Kentucky Board of Medical Licensure ("the Board"), acting by and through its Inquiry Panel B, considered this matter at its November 20, 2014, meeting. At that meeting, Inquiry Panel B considered a Memorandum prepared by Stephen Manly, Medical Investigator, dated October 28, 2014; grievance from Patient A, undated; grievance from Jo Dowell, dated February 27, 2014; an Investigative Report from the Office of Inspector General, Carrie Gentry, PharmD, RPh, dated April 29, 2014; correspondence from Patient A, faxed from the licensee's office, dated March 28, 2014; American Board of Psychiatry and Neurology – verifyCERT, dated April 24, 2014; correspondence from the licensee, faxed April 2, 2014; Expert Review Worksheets, dated April 15 and 16, 2014; correspondence from the Board consultant, dated June 22, 2014; correspondence from the licensee's counsel, Marc Murphy, dated August 5, 2014; correspondence from the Board consultant, dated August 31, 2014; and the Fourth Amended Agreed Order, filed of record April 28, 2011. The licensee, Sharad C. Patel, M.D., was given notice of the meeting and his counsel appeared and was heard by the Panel.

Having considered this information and being sufficiently advised, Inquiry Panel B ENTERS the following EMERGENCY ORDER OF SUSPENSION, in accordance with KRS 311.592(1) and 13B.125(1):

FINDINGS OF FACT

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel B concludes there is probable cause to make the following Findings of Fact, which support its Emergency Order of Suspension:

1. At all relevant times, Sharad C. Patel, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On March 8, 1999, the licensee filed with the Board an Amended Letter of Agreement, which he executed on March 5, 1999. Condition One (1) of the Amended Letter of Agreement specified: "Physician shall fully maintain a contractual relationship with the Impaired Physician Committee and abide by all conditions placed upon him by the Impaired Physician Committee."
4. On March 16, the licensee verbally notified a Board Investigator that he desired to convert his license to inactive status and that he intended to discontinue his relationship with the Kentucky Physicians Health Foundation ("the Foundation"). In a Memorandum to the Board's Inquiry Panel B, dated March 22, 2000, the investigator notified the Board of this information.
5. In a letter dated March 17, 2000, Burns M. Brady, M.D., Medical Director of the Foundation, confirmed a telephone conversation he had with the licensee. In his letter, a copy of which was received by the Board on March 21, 2000, Dr. Brady stated, "As I understand it, you [the licensee] are not going to renew your Kentucky medical license at this time and would like to discontinue your relationship with [the Foundation]." Seeking confirmation of his understanding,

Dr. Brady further stated in same: "I look forward to your response and if I have not heard from you within 14 days of your receipt of this letter, then I will assume this establishes for our records and for the Kentucky Board of Medical Licensure that you are discontinuing your relationship with this organization."

6. Given these circumstances, the Panel required the licensee to enter into an Agreed Order of Surrender, which he did and which was filed on June 9, 2000. He had not practiced medicine in the Commonwealth since that time.

7. At its July 2002 meeting, the Panel considered the licensee's request to resume the active practice of medicine. The Panel deferred any action until the licensee completed a clinical skills assessment at the Center for Personalized Education for Physicians (CPEP).

8. The licensee completed that assessment January 27-28, 2003. The Assessment Report included the following findings:

   A. Medical Knowledge

   During this Assessment, Dr. Patel's medical knowledge was fairly broad but it lacked depth and was not current. He was aware of the general initial psychiatric assessment process including the mental status examination. However, he omitted important historical areas and lacked necessary details and clarity on the mental status exam. He was knowledgeable about substance abuse issues as well as pain management and psychiatric treatment in workman's compensation patients. He accurately assessed suicidal and homicidal risk. His level of knowledge of the civil commitment process was adequate, although it lacked detail. He demonstrated a general knowledge of anxiety, psychotic, and personality disorders but it lacked depth. Dr. Patel's diagnosis of mood disorders was unacceptable. His knowledge of psychotropic medications including antidepressants, antipsychotics, and mood stabilizers was incomplete and not current. His differential diagnosis did not always reflect the most likely possibilities. Dr. Patel was not well-versed in the DSM IV-R categories of the mood disorders. Dr. Patel's diagnostic and assessment skills lacked sufficient detail and completeness.

   B. Clinical Reasoning

Overall, Dr. Patel's clinical reasoning was inconsistent. One consultant thought that, based on the few charts reviewed, Dr. Patel's clinical decision-making was adequate. Another consultant noted that Dr. Patel provided an adequate account of the issues from a drug overdose patient and a workman's compensation injury. Dr. Patel demonstrated flexibility in his ability to modify his management strategies based on changes in the patient's clinical course; however, his approach to pharmacology was more rigid.

Many of Dr. Patel's stated management strategies were reasonable; he did not apply these principles to the actual patient cases reviewed. This included use of mood stabilization in bipolar disorder and use of informed consent. He ordered laboratory tests and developed treatment plans that were not supported by the diagnostic possibilities. Dr. Patel's differential diagnosis did not always reflect the facts of the case. He occasionally assigned a diagnosis without sufficient clinical data, in contrary to the patient's clinical presentation, or without integrating important social issues. His follow-up recommendations did not always correlate with the clinical status and needs of the patient. Dr. Patel did not have an organized theory of psychopathology upon which to guide his prescription for non-pharmacologic-psychiatric treatments.

C. Communication

Dr. Patel's communication skills with the Simulated Patients were adequate but his skills were weak due to the time since he left practice. He demonstrated the core skills needed to be an effective communicator. He asked open-ended questions, listened without interruption, made effective use of summary statements, and had good eye contact. With practice his interactions became more conversational. His initial attempts at rapport were difficult but these improved over the course of the interview. He sometimes confused the patients by changing his line of questioning too quickly and without the use of transition statements. He did not provide patient education. His interactions with the peer consultants were acceptable.

D. Documentation

Dr. Patel's documentation skills were inadequate. His intake assessments were organized. His documentation of the mental status exams was acceptable. He provided a reasonable accounting of the patient's clinical progress. However, there was no documentation of medication side effects, reasons for psychotherapy or cognitive behavior therapy, or explanations for changes in medications. Dr. Patel did not document all patient encounters with an appropriate note. His management strategies were not consistently reflected in the chart. He did not record a formal diagnosis of PTSD in a patient he was treating for this disorder. He did not enumerate manic or depressive symptoms in a bipolar patient. He did not provide a clear plan of

action in some cases. Comments about psychosocial issues were brief and general. The notes generated during the CPEP Assessment were unorganized and lacked any detail about his clinical thought processes. His treatment plans were vague.

CPEP recommended that Dr. Patel participate in structured, individualized Education Intervention to address the identified areas of need, and noted that such an intervention would likely require significant time and effort.

9. After reviewing the report, the Panel voted to defer action until Dr. Patel had obtained an Educational Plan from CPEP and presented it to the Panel for review. The licensee obtained an Educational Intervention Education Plan from CPEP in July 2006 and it was considered by the Panel at its October 19, 2006 meeting.

10. The parties entered into an Agreed Order of Indefinite Restriction on November 7, 2006. Conditions 2d and 2e of that Agreed Order provided:

    d. The licensee SHALL fully comply with the directives of Phase I of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Agreed Order of Indefinite Restriction. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase I of the Education Plan;

    e. The licensee SHALL NOT proceed to or perform any act under Phase II of the CPEP Education Plan, unless and until approved to do so by the Panel by Amended Agreed Order of Indefinite Restriction.

11. Both the licensee and CPEP have advised the Panel that, due to circumstances beyond the licensee's control, he has been unable to complete Phase I of the Education Plan, because of CPEP's lack of ability to properly evaluate the licensee's completion of that Phase. CPEP and the licensee have tried to develop an alternative means of evaluating the licensee's completion of Phase I. However, to date, they have been unable to implement an evaluation process

which would provide CPEP with the level of assurance necessary to recommend his transition to Phase II of the Education Plan. Part of the difficulty in formulating and implementing an alternative evaluation process has been the perceived requirement to obtain the Panel's approval of a specific alternative Phase I evaluation process before it is implemented. In order to facilitate this process, the Panel has determined to delegate the authority to CPEP to develop and implement an alternative evaluation process for Phase I.

12. In their Point of Care Education and Evaluation Report for July 2009, CPEP reported:

> Dr. Patel successfully completed this simulated patient exercise. CPEP recommends that he progress to Phase II of his Education Plan. Dr. Patel should notify CPEP of his intent to reactivate his Education Plan and engage in educational activities, starting with Phase II.
>
> Dr. Patel will need to identify a qualified preceptor to work with him for the duration of Phase II. Because there has been a lengthy delay for Dr. Patel to begin Phase II of his Plan, it will be important that he participate in the educational activities in a timely manner. Therefore, if he has not already begun a preceptor search, Dr. Patel is encouraged to do so immediately. CPEP recommends that he submit the preceptor candidate's curriculum vitae within 15 days of reactivating his Plan (date to be determined). CPEP also recommends that Dr. Patel carefully review his Plan prior to initiating Phase II.

13. At the Panel's October 15, 2009 meeting, when they took up the licensee's request to modify his Amended Agreed Order of Indefinite Restriction, James. T. Jennings, M.D., Medical Director, Kentucky Physicians' Health Foundation, asked the Panel to consider terminating Condition 2h, based upon the length of the licensee's involvement with the Foundation and the primary focus of the present Amended Agreed Order.

14. Following his statement to CPEP staff that he would also like to pursue the possibility of practicing in an in-patient setting, CPEP conducted an Addendum

Assessment on April 8-9, 2010. In their report, CPEP made the following findings and recommendations:

Medical Knowledge:

- Psychopharmacology: especially newer agents:
  - Available dose forms and typical dosing of Depakote;
  - Dosing of Risperdal and Risperdal Consta;
  - Atypical antipsychotics:
    - Blackbox warning: risk of death in elderly patients treated with antipsychotics;
  - Familiarity with the use of drugs used to treat Alzheimer's dementia, such as acetylcholinesterase inhibitors;
  - Drug interactions: Depakote and Lamictal;
  - Risk of polycystic ovarian syndrome with Depakote;
  - Pregnancy categories: nomenclature;
- Bipolar disorder:
  - Treatment of psychotic mania;
  - Treatment of bipolar depression, including:
    - Treatment of refractory bipolar depression;
    - Knowledge of drugs to be avoided because they can destabilize the patient and lead to mania or a mixed state (stimulants, antidepressants);
- Full understanding of the risk factors for completed suicide;
- Obsessive-compulsive disorder:
  - Pharmacologic management: lack of effectiveness of benzodiazepines; options to augment SSRIs in treating OCD;
- Substance abuse:
  - Alcoholism:
    - Role of Antabuse;
    - Current perspectives on controlled drinking;
    - Disadvantages of benzodiazepines in the rehabilitating alcoholic (as opposed to in acute withdrawal);
  - Opioid abuse: advantages and disadvantages of the three main treatment options of Suboxone, methadone, and abstinence;
- Personality disorders:
  - General knowledge;
  - Narcissistic personality D/O: psychodynamic explanation;
  - Sociopathic personality disorder: psychodynamic underpinnings;
  - Borderline personality disorder: see psychotherapy, below;
- Psychotherapy:

    - OCD: fuller understanding of important components of the therapy;
    - Dialectical behavioral therapy for borderline personality disorder and chronic self-harm/mutilation;
- Reasons for self-mutilation in psychiatric patients;
- Procedures for administering involuntary medications;
- Electroconvulsive therapy: body of evidence indicating that ECT can lead to long-term retrograde memory loss;
- Obstructive sleep apnea: as a comorbidity, medical complications and risks.

Clinical Judgment and Reasoning:

- Balance between the role of testing (laboratory and psychological) and clinical assessment and judgment;
- Awareness and recognition of one's idiosyncratic approaches that are not supported by literature, with a goal to examine the evidence in those instances.

Implications for Education and Other Interventions:

Based on the findings of the Second Assessment Addendum, the following educational recommendations should be completed if Dr. Patel includes inpatient care in his scope of practice:

- Point of Care Experience: Dr. Patel should participate in an inpatient clinical experience to provide the necessary supervision required as he addresses the areas of demonstrated need in inpatient psychiatry. The experience would be designed to allow appropriately graduated levels of independence.
    - Dr. Patel should initially have all cases reviewed with a preceptor prior to initiation of treatment;
    - He should practice in a setting where he would have the availability of immediate consultation with another attending on the inpatient psychiatric ward.

- Educational Preceptor: Dr. Patel should establish a relationship with an experienced educational preceptor in psychiatry, with experience in inpatient care. This involves regularly scheduled meetings to review cases and documentation, discuss decisions related to those cases, review specific topics, and make plans for future learning.

- Continuing Medical Education and Self-Study: Dr. Patel should engage in continuing medical education courses and self-study which include, but are not limited to, the topics indicated in areas of demonstrated need.

15. At the Board's request, CPEP staff also identified the following learning objectives of Phase II of the original Education Plan that still need to be addressed by the licensee:

LEARNING OBJECTIVES III – IV: INCOMPLETE ("I")

III. To improve clinical decision-making in the following areas:	I
1. Consistent application of medical knowledge;	I
2. Organized, detailed, comprehensive, and integrated approach to diagnostic evaluation that includes differential diagnoses;	I
3. Development of comprehensive and integrative treatment plans for an adequately wide range of psychiatric diagnoses; these plans should include documentation of the patient's progress;	I
4. Consideration of medication management options;	I
5. Application of psychopathology.	I

Preceptor Meetings and Chart Reviews – Not Initiated
For more information, see Education Plan.

IV: To improve patient care documentation, specifically:	I
1. Organized and complete chart components, including flow sheets;	I
2. Consistently organized, detailed and complete notes, that include but not limited to the following elements:	I
a. Presenting complaint;	I
b. Psychiatric history;	I
c. Family and social history;	I
d. Mental status exam;	I
e. Differential and final diagnoses;	I
f. Detailed treatment plans;	I
g. Patient/family education;	I
h. Consultant reports/communications;	I
i. Testing;	I
j. Detailed clinical reasoning;	I
3. Consistent documentation of all patient encounters.	I

Dr. Patel attended the *Patient Care Documentation Seminar (Seminar)* in December 2006. The AMD will monitor Dr. Patel's documentation to determine if he should attend the *Seminar* again, or if his educational needs would be sufficiently addressed if he enrolled in the follow-up component to the December 2006 *Seminar*.

V. To monitor physician-patient communications:	I
1. Effective core communication skills.	I

Dr. Patel completed reading The Medical Interview as recommended in his Education Plan. This objective should be addressed with the Preceptor during Phase II.

VI. To determine a plan to maintain current standards within the field of psychiatry.	I

16. On April 28, 2011, the licensee entered into a Fourth Amended Agreed Order. The relevant term of that order is 2g, which states:

> The licensee SHALL SUCCESSFULLY become re-certified by the American Board of Psychiatry and Neurology within two calendar years of the date of filing of this Fourth Amended Agreed Order.

17. On January 6, 2014, the licensee appeared before the Panel when it reviewed a report of non-compliance, as the licensee had not become recertified by the American Board of Psychiatry and Neurology. The Panel deferred action and gave the licensee two options to address his non-compliance: (1) either complete the appeals process with the American Board of Psychiatry and Neurology for recertification and present their official resolution to the Panel, or (2) submit to a CPEP Post-Education Evaluation and present those results for review by the Panel.

18. As of the Panel meeting on November 20, 2014, the licensee had neither completed the appeals process and presented the official resolution to the Panel nor submitted to a CPEP Post-Education Evaluation and presented those results to the Panel.

19. In February 2014, the Board received a grievance filed by Patient A, who described an incident in which the licensee offered to prescribe additional narcotic drugs if he was provided with a discount on a new Toyota Avalon. Patient A was a salesman for Toyota at the time. Patient A stated that he did assist the licensee

in purchasing the Toyota Avalon, and that about a week later the licensee called the patient stating he had damaged the car but did not have insurance on it. Patient A stated that the licensee asked him to change dates on the paperwork and say that the car was damaged in the car lot. Patient A declined the request. Patient A stated that a few weeks later, the licensee called him upset about his bill from Toyota. Patient A explained that the bill was higher due to the licensee's purchase of $4000 worth of additional services and products, and the licensee seemed upset. Patient A stated that about a week later, a police officer approached Patient A at work, interrogating Patient A about stealing the licensee's prescription pad. Patient A's employment was subsequently terminated. Subsequently, Patient A was notified by the licensee's office that they would be increasing the costs of his appointment.

20. During an interview with Board investigator Steve Manley, Patient A stated that the licensee was the only physician he could find to prescribe him Subutex instead of Suboxone, because Suboxone was out of the patient's financial reach. Patient A did not have health insurance and paid cash for his appointments and medications.

21. On March 28, 2014, Patient A sent a fax to the Board wherein he stated his desire to withdraw the grievance he filed against the licensee. The fax was sent from the licensee's office.

22. On April 1, 2014, the licensee responded in writing to the grievance filed by Patient A. The licensee admitted that he provided the licensee's name to the police in connection with a missing prescription pad. The licensee acknowledged that he later found the "missing" prescription pad under the seat in his car. The

licensee stated "As far as the nonsense about buying a car from the complainant and committing fraud as charged by the complainant, is concerned, I have no knowledge of it."

23. In an interview with Board investigator Steve Manley, Kathy McGubbins, sales manager at the Toyota business in Elizabethtown, confirmed that she did terminate Patient A's employment after the police interviewed him regarding the licensee's missing prescription pad. She further confirmed that the licensee did purchase a vehicle from Patient A at invoice price with $4000 worth of additional services and products. She stated that Patient A never had an inappropriate drug test and at no time did she find him to be dishonest, even when it was to his detriment.

24. During an investigation with Board investigator Steve Manley, Officer Elam with the Elizabethtown Police Department confirmed that the licensee contacted the police department and reported that his prescription pads had been stolen and that he suspected Patient A was the thief. Officer Elam stated that a few days later, the licensee's office employees contacted the police to report that the prescription pads had been located in the licensee's car.

25. Within four weeks of receiving the grievance from Patient A, a second grievance was received from the guardian of Patient B, who was concerned about the diagnosis given to her brother by the licensee. The grievant stated that her brother has previously been diagnosed as schizophrenic by several other psychiatrists and it is documented in his medical history, but the licensee diagnosed him as bipolar.

26. On April 1, 2014, the licensee responded in writing to the grievance submitted by the guardian of Patient B. The licensee defended his diagnosis of Patient B.

27. Based upon these two grievances, a request was made to the Office of the Inspector General, Division of Audits and Investigations ("OIG") to review the licensee's prescribing habits.

28. On or about April 29, 2014, Carrie Gentry, PharmD, RPh, OIG, reviewed and analyzed the license's KASPER records (dated April 18, 2013 to April 18, 2014) and noted several concerns, including:

- 70% of patients received a non-abuse deterrent formulation of buprenorphine;
- 50% of patients receiving buprenorphine also received a benzodiazepine;
- Inappropriate buprenorphine induction/maintenance prescribing based on KBML Opinion relating to the use of Suboxone and Subutex for the treatment of Opiate Dependency
- Patient use of multiple pharmacies
- Patient use of multiple prescribers (including Indiana prescribers)
- Early refills of controlled substances based on day supply
- Prescribing controlled substances for family

Ms. Gentry identified fourteen (14) of the licensee's patients for further investigation by the Board.

29. A Board consultant reviewed the chart regarding the grievance filed by Patient A and found the licensee's treatment and overall care to be below standards of care. The consultant opined that if Patient A's allegations are true, the licensee's conduct would constitute gross ignorance, gross negligence, and/or gross incompetence. The consultant found the following problems with the licensee's care: unethical or unprofessional conduct, false statements, excessive fees, and prescribing. The consultant stated, in part:

> The minimum standards of practice in Kentucky prohibit a physician from making a deal to prescribe excessive narcotics for a discount on a car.
> The minimum standards of practice in Kentucky prohibit a physician from lying to the KBML about an investigation.
>
> Regarding prescribing minimal standard of care, I noticed that Patient A did not fill many days quantity according to KASPER until September 23, 2013. Starting on that date it looks like Patient A started filling 30 day supplies of Subutex (24mg/day) for the first time, whereas, up until September 23, he was filling an average of perhaps 9 days at a time with a high of only 17 days. It was in this Fall of the year that I believed the alleged "more pills for a car deal" was to have occurred. On 10/16/2013, [the licensee] prescribed another 30 day supply unnecessarily a full week before a new prescription was needed. And, the patient for the first time filled his prescription at a different drug store. I suspect the original druggist would not have filled this "too early" prescription.
>
> ...I see no chart evidence of KASPERs being checked on Patient A. The minimum standard of practice in Kentucky is to check KASPERs for patients on Schedule II drugs or stronger.

The Board consultant's report is attached and incorporated herein in its entirety.

30. The Board consultant reviewed Patient B's chart regarding the grievance filed by Patient B's guardian. The consultant found the licensee's diagnosis to be below minimum standards in diagnosis and borderline overall. The consultant stated, in part:

> [The licensee's] next to last sentence in his response is concerning to me though. "...and seemed to have been stable for a few years." [The licensee] has a right as a clinician to come to his own opinion, based on his clinical judgment. However, in the same letter to KBML, he implied to the KBML that he read the "mammoth" "several hundred pages" of medical records. It appears that he did not read that "mammoth filed" of records from the Veterans Hospital. In these records are more than a half a dozen mental health professionals who gave witness to the patient's delusions and strange experiences at most encounters over a few years. In fact, on only one encounter, in Owensboro, did [Patient B] have no psychotic expressions. So, sometimes [Patient B] looked OK, but at most hospitalizations he was obviously overtly delusional.
>
> ...[The licensee] implies in his letter that he did examine [the records] later. But if he did examine them as he stated he did, why would he

disregard the opinions of more than half a dozen mental health personnel, and the family's opinion, and history of delusions? And how could he, in truth state, "...and seemed to have been stable for a few years," referring to this same time period from 2008-2012 during which time the patient was documented to be frankly delusional? Regarding medical diagnosis, either not reading medical records or disregarding the opinions of so many colleagues and of the family without explanation is not wise medical diagnosis strategy.

The Board consultant's report is attached and incorporated herein in its entirety.

31. The Board consultant reviewed fourteen (14) of the licensee's patient charts and found the following:

- the licensee did engage in conduct which departed from or failed to conform to prevailing medical practice standards within the Commonwealth of Kentucky;
- the licensee did commit a pattern of acts, during the course of his medical practice, which under the attended circumstances, would be deemed to be gross negligence;
- the licensee's practice of medicine did constitute a danger to the health and safety of his patients;
- the licensee did prescribe a controlled medication for use of or by his immediate family;
- the licensee did prescribe medicines in other than appropriate amounts for the disorders he was treating by, in more than one patient, authorizing early refills for them on more than one occasion without documental clinical justification for the increased level of dosage dispensed.

The Board consultant's report is attached and incorporated herein in its entirety.

32. On or about August 5, 2014, the licensee responded in writing, through counsel, to the Board consultant's findings. The licensee responded in general and specifically to comments by the consultant on each patient, disagreeing with the consultant's findings.

33. The licensee's response was provided to the Board's consultant. On or about August 31, 2014, the Board's consultant stated that "many of the counsel's explanations state facts that are not in the record." With regard to Patient C, the

consultant stated, "Based upon this deeper look, my opinions are unchanged. I think that the degree of [the licensee's] failure in the case of Patient C is more grave than I had opined."

34. On or about November 20, 2014 the Board's Inquiry Panel B determined that the licensee's practices place his patients and the public at risk and in danger. As a result, the licensee was suspended from the practice of medicine in the Commonwealth of Kentucky pending resolution of the Complaint.

CONCLUSIONS OF LAW

Pursuant to KRS 13B.125(2) and based upon the information available to it, Inquiry Panel B finds there is probable cause to support the following Conclusions of Law, which serve as the legal bases for this Emergency Order of Suspension:

1. The licensee's Kentucky medical license is subject to regulation and discipline by this Board.
2. KRS 311.592(1) provides that the Board may issue an emergency order suspending, limiting, or restricting a physician's license at any time an inquiry panel has probable cause to believe that a) the physician has violated the terms of an order placing him on probation; or b) a physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.
3. There is probable cause to believe that the licensee has violated KRS 311.595(9) - as illustrated by KRS 311.597(1)(c) and (d), (3) and (4) - and KRS 311.595(12) and (13). The Panel concludes there is probable cause to believe this physician's practice constitutes a danger to the health, welfare and safety of his patients or the general public.

4. The Board may draw logical and reasonable inferences about a physician's practice by considering certain facts about a physician's practice. If there is proof that a physician has violated a provision of the Kentucky Medical Practice Act in one set of circumstances, the Board may infer that the physician will similarly violate the Medical Practice Act when presented with a similar set of circumstances. Similarly, the Board concludes that proof of a set of facts about a physician's practice presents representative proof of the nature of that physician's practice in general. Accordingly, probable cause to believe that the physician has committed certain violations in the recent past presents probable cause to believe that the physician will commit similar violations in the near future, during the course of the physician's osteopathic practice.

5. The United States Supreme Court has ruled that it is no violation of the federal Due Process Clause for a state agency to temporarily suspend a license, without a prior evidentiary hearing, so long as 1) the immediate action is based upon a probable cause finding that there is a present danger to the public safety; and, 2) the statute provides for a prompt post-deprivation hearing. Barry v. Barchi, 443 U.S. 55, 61 L.Ed.2d 365, 99 S.Ct. 2642 (1979); FDIC v. Mallen, 486 U.S. 230, 100 L.Ed.2d 265, 108 S.Ct. 1780 (1988) and Gilbert v. Homar, 117 S.Ct. 1807 (1997). Cf. KRS 13B.125(1).

KRS 13B.125(3) provides that the Board shall conduct an emergency hearing on this emergency order within ten (10) working days of a request for such a hearing by the licensee. The licensee has been advised of his right to a prompt post-deprivation hearing under this statute.

EMERGENCY ORDER OF SUSPENSION

Based upon the foregoing Findings of Fact and Conclusions of Law, Inquiry Panel B hereby ORDERS that the license to practice medicine in the Commonwealth of Kentucky held by Sharad C. Patel M.D., is SUSPENDED and Dr. Patel is prohibited from performing any act which constitutes the "practice of medicine," as that term is defined by KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities - until the resolution of the Complaint setting forth the allegations discussed in this pleading or until such further Order of the Board.

Inquiry Panel B further declares that this is an EMERGENCY ORDER, effective immediately upon receipt by the licensee.

SO ORDERED this 24th day of November, 2014.

Randel C Gibson DO

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Emergency Order of Suspension was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; and copies were mailed via certified mail return-receipt requested to the licensee, Sharad C. Patel, M.D., 1506 Bristol Court, Elizabethtown, Kentucky, 42701 and his counsel, Marc S. Murphy, 400 West Market Street, Suite 1800, Louisville, Kentucky 40202-3352, on this 24th day of November, 2014.

Sara Farmer

Sara Farmer
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._none listed____ Patient Name_____[redacted]_____

Expert's Name_____Stephen Cox_____

1. Brief description of symptom, dx and course of treatment: _____

Narrative:

This is an odd complaint. It was submitted in writing with great clarity and passion in February 2014, only to be withdrawn hurriedly on March 28, 2014 without sufficient explanation to make one feel at ease. Seems fishy. Dr. Patel's response to the complaint was dated 3 days after the complaint was withdrawn..

The patient who complained is a heroin narcotic addict and bipolar disorder person who saw Dr. Patel for treatment. He alleged in June 2013 Dr. Patel offered to prescribe higher doses of narcotics in exchange for a financial break on a new car. He said the doctor spent the patient's sessions (paid for by the patient) talking about the car details. In the Fall of 2013, he says Dr. Patel bought the car from patient and the discounts were arranged. Dr. Patel was angry according to the patient when he got his first bill from Toyota, it being higher than he expected. A week later [redacted] said the police came where [redacted] was employed and arrested him with great show for stealing Dr. Patel's prescription pad which resulted in [redacted] being fired. Dr. Patel's office raised [redacted] fees 30% and billed him for fees [redacted] was not in agreement with. Dr. Patel found his missing preseription pads under his car seat that [redacted] was accused of stealing.

[redacted] accused Dr. Patel of not seeing people that he prescribes medication to. He accuses him of hiring people he gives drugs to. He said he manipulates people.

He said he had audio recordings of evidence of Dr. Patel admitting what he has done. He said he could prove Dr. Patel purchased the vehicle and leveraged it against [redacted]

Medical records

A review of [redacted] records shows a neat, well-kept record. There are initial evaluations, progress notes in good order. There is a record of prescriptions written. The progress notes are typical of today's EMR records with copy and paste sentences that repeat verbatim in many progress notes. There are relevant sentences too that indicate doctor's individual treatment at many of these visits, which is a good thing.

The dose of Subutex prescribed for [redacted] heroin addiction was commonly three of the maximum strength doses per day, that is a total of 24mg/day, (max dose permitted = 32mg.).

In the area where [redacted] lives it appears that no doctor except Dr. Patel will prescribe [redacted] his Subutex. Despite this complaint against Dr. Patel, [redacted] virtually has to continue with Dr. Patel, assuming Dr. Patel will allow him to do so.

2. Can you form an opinion?

YES. All of this depends on whether the allegations from [redacted] are true or not. I, for the remainder of this report am assuming the allegations are factual, which may or not be so.

Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

___X___ Yes, I can form an opinion.
_____ No, I cannot form an opinion.
_____ I need more information (specify): _____
_____
_____
_____
_____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards
__X____ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

___X___ Below minimum standards
_____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards
__X____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

__X____ Clearly below minimum standards. (If allegations are true)
____ Clearly within minimum standards
_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the

physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

Yes, if allegations are true.

4. Other questions from the Medical Board (ignore if blank): _____

I saw no problems in:

- MENTAL OR PHYSICAL CONDITION
- MEDICAL NECESSITY
- DEPENDENCY
- GROSSLY IMPROBABLE CLAIMS
- SUBSTANDARD CARE

Assuming [redacted] allegations are factual I see the following problems in this case:

- UNETHICAL OR UNPROFESSIONAL CONDUCT
- FALSE STATEMENTS
- EXCESSIVE FEES (The 30% increase rate)
- PRESCRIBING

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

The minimum standards of practice in Kentucky prohibit a physician from making a deal to prescribe excessive narcotics for a discount on a car.

The minimum standards of practice in Kentucky prohibit a physician from lying to the KBML about an investigation.

Regarding prescribing minimal standard of care, I noticed that [redacted] did not fill many days quantity according to Kasper until Sept 23,2013.
Starting on that date it looks like [redacted] started filling 30 day supplies of Subutex (24mg/day) for the first time, whereas, up until September 23, he was filling an average of perhaps 9 days at a time with a high of only 17 days. It was in this Fall of the year that I believe the alleged "more pills for a car deal" was to have occurred. On 10/16/2013 Dr. Patel prescribed another 30 day supply unnecessarily a full week before a new prescription was needed. And, the patient for the first time filled his prescription at a different drug store. I suspect the original druggist would not have filled this "too early" prescription.

The minimum standard of practice in Kentucky is to write prescriptions such that patients do not double up on narcotic pills, having twice as many as needed and intended.

I see no chart evidence of Kasper's being checked on [redacted] The minimum standard of practice in Kentucky is to check Kaspers for patients on Schedule II drugs or stronger.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board. NO

Or,

Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger? Yes, if the allegations in the complaint are factual

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

I f the allegations in the complaint are factual, dangerous controlled drugs are at risk of harming patients or street drug users who purchase such pills.

That concludes my comments of my opinions. If failed to observe some part of a record that concerns you, please bring it to my attention.

Thank you for what you do.

Aristotle pointed out in his Nicomacean Ethics. "For this good is the same for the individual and the state, yet the good of the state seems a grander and more perfect thing both to attain and to secure; and glad as one would be to do this service for a single individual, to do it for a people, and for a number of states is nobler and more divine."

Thus, what you and the Board does, and to a tiny degree what I do, is "good". It is an honor to serve the Commonwealth to review these records and to express my clinical opinion, for what it's worth, to assist the KBML in securing our state physicians' practices of medicine.

Respectfully,

4.16.14
Date of Review

Stephen Cox MD
Signature of Expert

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No. none listed Patient Name [redacted]

Expert's Name Stephen Cox

1. Brief description of symptom, dx and course of treatment: _____

Narrative:

Dear Investigator Lewis

[redacted] was a long distance truck driver. Then a local driver. Then unemployed. He was struck by a motor vehicle while walking to another town to look for work. His leg was fractured. He was taken to the hospital and treated 10/5/09. A consulting psychiatrist who saw him deemed him to be mentally ill as per the VAH impression of diagnosis; but no hallucinations or delusions were manifest at the time.

Before that injury he was treated at VAH in 2008 for psychiatric delusions, but since not deemed dangerous, he was dismissed to mental health outpatient follow-up.

Then he received much diagnostic and treatment work at the VAH in Louisville KY in 2010 and 2012. He carried a diagnosis of psychosis consistently, but the details were debated and uncertain as to the specific diagnosis. Mostly, he seemed thought to be schizophrenic, but bipolar was mentioned every time as a possible diagnosis. Oddly, he was never treated with Lithium or meds like Depakote for bipolar disorder. It seemed that Risperdal suited his symptoms and compliance the best. Geodon failed. He usually quit medicine more than took it when left to his responsibility. Fortunately for him his sister or daughter supervise his medication.

His symptoms over these 4 years, as detailed in the VAH records included recurring delusions of snake(s) in his body that occasionally would appear, headless, once coming out his mouth when he tried to kiss his wife (Freudian for sure!) or as a more modest worm coming out of his face. Additionally, he had grandiose delusions that he had been shot three times when three years old, that he constructed his first aircraft at age 6 years, that he was to work for a

manufacturer like Lockheed as an aircraft engineer, and that his designed plane was used in Vietnam.
He was admitted to one of these hospitalizations after a fight with his son in law and threatening to hit grandson with a bat and choke him.

He was never known to have auditory hallucinations. Schizophrenics quite commonly have voices. Not him.

His mood was, when abnormal, most often angry, typical for bipolar. His mother was said to have the same behaviors.

Some of Dr. Patel's records are puzzling. There is a page of dates and vital signs. It lists dates down the column for visits of:

- 10/9/2013
- 10/15/13
- 2/26/13 {probably 2/26/2014}

I only see one clinical note for this 4 month time span "seen by Linda Pickering seen on 09 October 2013". The same note was "electronically signed by: Dr. Sharad Patel, MD signed on Thursday 27 Feb 2014. I cannot find any notes from Dr. Patel for 10/09/13 or 10/15/13. This one note appears to have been finished at the date of 2/26/13 ("At the present time and over the past 4 months, this patient's mental status has been stable."). So, this only note in the chart for a case that lists three visits; and it seems to have been done very recent to the complaint which was dated almost the same day. There appear to be no doctor notes written earlier than the day before the complaint over the 4 months of care. This is irregular. There should be a progress note for the three visits dated on the days of care. One wonders if Dr. Patel's evaluation was written in response to the complaint.

The sister who filed the complaint dated the following day 2/27/2014 was [redacted] guardian.

The sister, in her complaint, was perturbed that Dr. Patel in his evaluation did not agree with the VAH doctors. Dr. Patel felt that [redacted] was not schizophrenic. (I share that impression myself, favoring bipolar disorder.)

The family is frustrated with Dr. Patel's clinical impression and opinion which they do not agree with whatsoever. These women are astonished and dismayed at being dismissed by Dr. Patel. They do not feel Dr. Patel is listening to them. Dr. Patel implies that at that time there was little reason for concern about the patient returning to work driving trucks. His impression remained these were" tall tales"

not symptoms and signs of illness. He believed the patient was "fully competent" consequently there was no need for continued guardianship. That alarms the family.

Dr. Patel's complaint response letter dismisses the family's history. Dr. Patel believes [redacted] account and explanations. Dr. Patel did a thorough mental status examination which checked out fine.

His next to last sentence in his response is concerning to me though. "...and seemed to have been stable for a few years."

Dr. Patel has a right as a clinician to come to his own opinion, based on his clinical judgment. However, in the same letter to KBML, he implied to the KBML that he read the "mammoth""several hundred pages" of medical records.

It appears that he did not read that "mammoth file"of records from the Veterans Hospital. In these records are more than a half dozen mental health professionals who gave witness to the patient's delusions and strange experiences at most encounters over a few years. In fact, on only one encounter, in Owensboro, did [redacted] have no psychotic expressions. So, sometimes [redacted] looked OK, but at most hospitalizations he was obviously overtly delusional.

These electronic medical records are horribly difficult to examine. There are pages and pages of useless boilerplate, and then there will be one little section that contains critical information that is easily overlooked. It took me 3 ½ hours to examine these records and take notes. There is little way for a busy practitioner to see a patient AND thoroughly go examine greater than 200 pages of computer printout at the same visit.

Dr. Patel implies in his letter that he did examine them later. But if he did examine them as he stated he did, why would he disregard the opinions of more than half a dozen mental health personnel, and the family's opinion, and history of delusions? And how could he, in truth, state, "...and seemed to have been stable for a few years", referring to this same time period from 2008-2012 during which time the patient was documented to be frankly delusional?

Regarding medical diagnosis, either not reading medical records or disregarding the opinions of so many colleagues and of the family without explanation is not wise medical diagnosis strategy.

2. Can you form an opinion?

YES

Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

___X___ Yes, I can form an opinion.
_____ No, I cannot form an opinion.
_____ I need more information (specify): _____
_____
_____
_____
_____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

___X___ Below minimum standards
_____ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards
___X__ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards
__X____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.
____ Clearly within minimum standards
___X___ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the

physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

No.

4. Other questions from the Medical Board (ignore if blank): _____

I saw no problems in:
PRESCRIBING
MENTAL OR PHYSICAL CONDITION
MEDICAL NECESSITY
DEPENDENCY
EXCESSIVE FEES
GROSSLY IMPROBABLE CLAIMS
UNETHICAL OR UNPROFESSIONAL CONDUCT
FALSE STATEMENTS
SUBSTANDARD CARE (apart from the concerns mentioned elsewhere in this document.)

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

More attention to history taking should be done in this one case by the doctor, reading all records and taking seriously other professionals opinions as well as the family's, whether they be women or not.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board. YES

Or,

Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger? NO

Not applicable

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

I think this patient should have a second opinion by another psychiatrist soon.

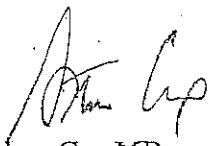
That concludes my comments of my opinions. If failed to observe some part of a record that concerns you, please bring it to my attention.

Thank you for what you do.

Aristotle pointed out in his Nicomacean Ethics. "For this good is the same for the individual and the state, yet the good of the state seems a grander and more perfect thing both to attain and to secure; and glad as one would be to do this service for a single individual, to do it for a people, and for a number of states is nobler and more divine."

Thus, what you and the Board does, and to a tiny degree what I do, is "good". It is an honor to serve the Commonwealth to review these records and to express my clinical opinion, for what it's worth, to assist the KBML in securing our state physicians' practices of medicine.

Respectfully,



4.15.14
Date of Review

Stephen Cox MD
Signature of Expert

Stephen Michael Cox, M.D.
[redacted]

June 22, 2014

KBML Hurstbourne Office Park
310 Whittington Parkway 1B
Louisville KY 40222

RE: Sharad Patel, M.D.

Attn: Investigator Stephen Manley

Dear Investigator Manley:

As I was instructed by the KBML, I reviewed these 14 charts of Dr. Patel's patients, his family member, and Kasper reports of some of these same 14 patients that you sent in a separate file. In that file there were Kasper reports of other Patel patients that were not of the 14 patients I was to review. I returned those Kasper reports un-reviewed. I address here your inquiry.

PRESCRIBING

In my clinical opinion, Dr. Sharad C. Patel **did** engage in conduct which departed from or failed to conform to prevailing medical practice standards within the Commonwealth of Kentucky.

In my clinical opinion, Dr. Sharad C. Patel **did** commit a pattern of acts, during the course of his medical practice, which under the attendant circumstances, would be deemed to be gross negligence.

In my clinical opinion, Dr. Sharad C. Patel's practice of medicine **did** constitute a danger to the health and safety of his patients.

I did not find any instance, in this review of these 14 patients, where Dr. Sharad C. Patel made, or caused to be made, or aided or abetted in the making of a false statement in any document executed in connection with the practice of the medical profession.

In these 14 chart reviews, in my clinical opinion, Dr. Sharad C. Patel did not prescribe or dispense medication with the intent or knowledge that the medicine would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose.

In my clinical opinion, Dr. Sharad C. Patel **did not** prescribe or dispense controlled medication for use by himself; **however, he did prescribe a controlled medication for use of or of his immediate family,** Dimpi Patel (11/6/2013 prescription for Adderall 7.5 mg #90. No refill.). There is no clinical chart apart from three pages listing the prescription dated at the bottom of the page May16, 2014. I think this date was after the KBML investigated Dr. Patel. Beside the fact that there is no adequate medical record for this patient, it is not permitted by the KBML to prescribe controlled substances to one's own kin, at least that is my understanding.

In my clinical opinion, Dr. Sharad C. Patel **did prescribe medicines in other than appropriate amounts** for the disorders that he was treating by, in more than one patient, **authorizing early refills for them on more than one occasion without documenting clinical justification** for the increased level of dosage dispensed.

I **found** that Dr. Sharad C. Patel engaged in conduct which departed from the standards of accepted and prevailing medical practice within Kentucky.

Additional remarks:

Regarding your inquiry into **prescribing patterns** of Dr. Sharad Patel:

Type of controlled substance:
Of the 14 cases reviewed the majority were prescribed narcotics. Other controlled drugs prescribed were amphetamines for attention deficit disorder and benzodiazepines for anxiety.

Quantity prescribed:
Month supplies were usually dispensed. In one patient, and it is unclear from the record, a 90 day supply may have been dispensed.

Frequency:
The doses and frequency of doses were in line with FDA guidelines. One male patient was prescribed the maximum dose of narcotic on his first visit. Several patients were given early refills and no consideration was made in several such cases to delay filling of the next prescription. Many of these patients filled that prescription at a different drug store. A violation of their HB1 drug contract they were supposed to have with Dr. Patel. Sometimes such a contract was on file, other times, one was not on file. Except in one case I saw no documentation that Dr. Patel took action to dismiss a patient from his practice for violating the poly drug store prohibition of HB1. All this changes an "early refill" into possible double dosing, approximately, without documented reasons in the chart that I could find.

Dr. Patel's **duration of treatment with controlled substances** was seemingly to be chronic. My opinion is confined to his narcotic prescriptions. Rightly or wrongly, it appears to me that the overwhelming majority prescribers of Suboxone, and the like, have no real intention of tapering off the patients. It is oft mentioned at the onset of treatment but I have yet to ever see a case where it happened. So, Dr. Patel's appearance of chronic narcotic provision is not unusual; it seems to be the standard of practice of his Kentucky peers in that field.

I **did not** notice any instances of office dispensing of controlled substances.

SUBSTANDARD CARE

In my opinion, Dr. Patel's prescribing deficiencies addressed above **do constitute substandard care**, but I saw nothing else in examination of these 14 charts in other areas. All problems were addressed in the above section.

In review of these 14 records, I found no evidence of failures to concern the KBML in the following areas that you asked me to consider:
MENTAL OR PHYSICAL CONDITION
MEDICAL NECESSITY
DEPENDENCY
EXCESSIVE FEES
GROSSLY IMPROBABLE CLAIMS
UNETHICAL AND PROFESSIONAL CONDUCT
FALSE STATEMENTS

SUMMARY OF EACH OF THE 14 INDIVIDUAL CHARTS:

D P

This is, I assume, a first degree relative of Dr. Patel. Adderall 7.5 mg, a mild dose, was prescribed by Dr. Patel. #90 pills.
There was virtually no chart. No evaluation, no Kasper, no drug urine screen. All the HB 1 regs were essentially violated.
KBML Consultant opinion: Unacceptable clinical practice.

B B-C

Kasper on 4/10/14 shows multiple drug stores being usedfor Dr. Patel's prescriptions without chart comment. There is only one other Kasper on 5/22/14. It is noticeable that the dates of the Kaspers were perhaps subsequent to KBML contacting Dr. Patel. Amphetamines and benzodiazepines were showing up on toxicology tests as early as 6/14/13. Amphetamines and benzodiazepines and (oxycodone/oxy-morphine or buprenorphine) positive on urine tests 8/20/13 and on 10/13/13. The presence of amphetamine was not addresses until April 2014. Benzodiazepines were positive in many drug screens without comment that I could find in the chart. Some progress notes were "cut and paste" fragments that repeated identically, visit to visit, whether they made sense temporally or not (This "cut and paste" is becoming so widespread with the EMR that it is, sadly, the new, current standard of practice, and will not be counted against Dr. Patel in forming my opinion.).
KBML Consultant opinion: Unacceptable clinical practice.

M B

Lacks "S,O,A" in most SOAP progress notes. Very acceptable otherwise. The patient was terminated due to violation of patient HB1 contract.
KBML Consultant opinion: Acceptable clinical practice.

W B

This patient was not on narcotics. Dr. Patel performed and recorded an exemplary initial evaluation H&P. The progress notes in this case were much better than Dr. Patel's usual. In the narcotic cases there was more often than not a lack of any clinical contemporary substance except for vital signs (O) and pill details (P), no S.O.A.P. details otherwise. It appeared that Dr. Patel does a much better job with non-narcotic cases like this one. But then I discovered that in looking at Kaspers, Dr. Patel authorized early refills repeatedly and the patient went to different drug stores to fill such. Early refills are necessary on occasion. Pills can really actually be stolen. Doses sometimes need to be increased for good clinical cause. Documentation of the reason why an early refill was made needs to be logged into the record when possible. Sometimes such legitimate reasons arise when the doctor is away from the office, ill at home, or at night or on the weekend. Occasional slip ups to remember to log it in the chart the next working day are understandable. However, in none of Dr. Patel's 14 charts pulled for this investigation did I see an explanation for an early refill or for increasing dosages. Doing this is important for even non-controlled medicine, and more so for the semi-controlled amphetamines and benzodiazepines, and is extremely important for heavily controlled narcotics like Subutex and buprenorphine which are MUCH more addictive than amphetamines and benzos.
KBML Consultant opinion: Unacceptable clinical practice.

J D

Adequate to superior clinical record except for deficiencies of:
No mention I could find of a Kasper. No drug screen that I could find. No documentation of customary care of the patient Jan-April 2014. Specifically, progress (SOAP) notes from 2/2/14 to 4/28/14 were missing everything except vital signs and pill details.
KBML Consultant opinion: Unacceptable clinical practice.

K D

This patient's record started off superiorly. But then the chart details run afoul of HB1 regulations,; e.g., I could find no drug screens even though the patient is on narcotics. In March to the end of April one year, Dr. Patel authorized early refills with no documented reason for same, except for a patient penned note written after the KBML investigation commenced commending Dr. Patel (I think for the KBML). She was alleging that her pills had been stolen. The patient was filling prescriptions at two different drug stores. A violation that Dr. Patel either ignored or did not notice on his HB1 periodic reviews of Kaspers. Not surprising, as there was a single Kasper in the record and it was dated after, I think, the KBML investigation commenced, 4/29/14.

KBML Consultant opinion: Unacceptable clinical practice.

T D

This patient has a massive chart to review of (I estimate) greater than 500 pages (ugh).

The H&P is good. There is a photo ID. There are toxicology labs. There are HB1 contracts with patient. There are only two Kasper reports I found on 8/6/12 and one on 5/12/14(after the investigation of Dr. Patel started I think). This is a violation of HB1 to run a patient on controlled drugs from 4/2/12 until April 2014 with only one Kasper request. The majority of the progress notes are OK although there were some with only vital signs and pills.

I detected substandard prescribing of narcotics. For example, on a Kasper on Nov13,13 the patient filled a prescription for Suboxone for a dispensed amount sufficient for 38 days according to Kasper (I calculate to Dec 21, 2013). But only 13 days later, on 11/26/13, buprenorphine is prescribed too, which would, by itself, last 8 days per Kasper. This prescription was filled at a different drug store suspiciously. This goes on the rest of the calendar year There is no note explaining this prescribing pattern that I could find, but it is a 500+ page chart and is no particular order. This particular Kasper was from the KBML, not from Dr. Patel's chart copy. It was dated 5/12/14 and I gather that is after the investigation of Dr. Patel was underway.

KBML Consultant opinion: Unacceptable clinical practice.

S G

This was a patient on narcotics for back pain. Overall, Dr. Patel's management here was not up to the minimum standard of care. Deficient in: no H&P, only 1 or two drug screens (one was in chart and I found a second one filed in a different Dr. Patel patient [redacted] chart while reviewing that chart later.). There are only two Kaspers, both are dated after the KBML investigation started, I think 2014, May 9&14. HB1 regs. say Kaspers are to be checked contemporaneously with care, not just after the KBML investigates a complaint. No HB 1 drug contract was found. Progress notes are for the most part incomplete, usually with nothing except vital signs and pill details of name strength directions and quantity dispensed.
KBML Consultant opinion: Unacceptable clinical practice.

L H

I have never operated a Suboxone clinic; but, it was disturbing to me that Dr. Patel's first prescription for this patient was for Suboxone 8 mg three a day #90 according to the Kasper. This 24 mg is the maximum dose. If there was titration done, there is no documentation of such. Another place in his record suggest the direction of use was only 8mg per day. But that would make the dispensed amount a 90 day supply which I think would be an excessive number of pills for a narcotic addict to be given at a single visit. Either way it is improper in my opinion. The inadequate progress notes are merely vital signs and a list of pills.
KBML Consultant opinion: Unacceptable clinical practice.

L W-H

This record has no initial evaluation by Dr. Patel that I could find. There are multiple doctors prescribing controlled drugs and the patient is filling at multiple drug stores. There was an accidental not suicide overdose on narcotics I think before Dr. Patel started treating her. It was on Haloween, 2013. According to Kasper, on Valentines Day 2014 the patient filled a Dr. Patel prescription of a 30 day supply of Suboxone 8/2 to take ii/day. Only 3 days later he prescribed more buprenorphine, 8mg to take one a day another 30 day supply. So, at that point she still possessed about 27 days of her first narcotic prescription AND she has a thirty day bottle of more narcotic at the same time. Why? No notes to explain the dose increase are on file. Also patient changed drug stores to fill the double prescription for her 50% increase in dose without documented rationale. Nor is mention made of the fact that the patient was using multiple drug stores, which Dr. Patel is supposed to look for when reviewing Kasper reports periodically. No urine tox screens were seen as mandated by HB1.
KBML Consultant opinion: Unacceptable clinical practice.

K J

This patient was not a narcotic replacement case. She had post partum bipolar and ADHD. There is a fine H&P, a photo ID, a HB1 contract, and a very good progress note. Some progress notes were deficient as in other charts, consisting of only vital signs and a pills list. There was no Kasper and no labwork. Dr. Patel appears to do much better work when his patient is not a narcotic addict, but a general psychiatric case. But, unfortunately, in this case the lack of proper progress notes and lack of a Kasper is his downfall.
KBML Consultant opinion: Unacceptable clinical practice.

J L

This man was managed for narcotic problems. The chart was all jumbled up and out of order but that does not count in my opinion. The problem here is that there is no HB1 ordered Kasper report request in a patient being prescribed opiates.
KBML Consultant opinion: Unacceptable clinical practice.

L M

All was well with this case except Dr. Patel authorizing early refills with no documented justification. Progress notes were good except for one on 4/28/14 which lacked substance for SOA parts of SOAP. If Dr. Patel had documented a reasonable cause for authorizing early refills, this chart would pass. But he did not.
KBML Consultant opinion: Unacceptable clinical practice.

H W

Good chart except for no drug screens, no concurrent Kasper reports, No HB1 drug contract, poor progress notes – inadequate and too brief , just vital signs and pills.
KBML Consultant opinion: Unacceptable clinical practice.

That concludes my remarks on 14 individual patient chart reviews.
If failed to observe some part of a record that concerns you, please bring it to my attention.

Respectfully,

Stephen Cox MD

Stephen Michael Cox, M.D.
[redacted]

Aug 31, 2014

KBML Hurstbourne Office Park
310 Whittington Parkway 1B
Louisville KY 40222

RE: Sharad Patel, M.D.

Attn: Investigator Stephen Manley

Dear Investigator Manley:

This is my third letter to the Board regarding this physician. You have asked me this time to respond to Dr. Patel's comments related through his counsel Stites & Harbison in a letter dated Aug 5, 2014 to the KBML.

I will say at the beginning that the comments do not change my previously stated opinions which I based upon medical records the KBML sent to me.

Many of the counsel's explanations state facts that are not in the record. An example of this is the lengthily explanation of patient TD's history. Much of that is not in the record. If it were in the record, that might be different or might not. I am not in a position to take into consideration such information not in the record so far as I am to understand. That perogative is, as I understand it, up to the Board of Licensure, not up to me.

Two cases do need specific comment:

Patient WB

I am glad that Dr. Patel's attorney pointed this WB patient out to the KBML. Because of their comments, I requested the file again and I took a second look to see if I needed to correct myself.

Please examine the KASPER report attached which is copied from Dr. Patel's file on WB. It shows that Dr. Patel had this KASPER information when he prepared his justification for his prescribing subsequent to my consultation and to the investigator's feedback to Dr. Patel. The annotations on it are mine to help study it. Unless I am misreading the KASPER analysis shows that lorazepam (which is the "twin sister of Xanax") was filled illegally **too early 19 times** during the span from 6.22.2013 through 4.17.2014.

Sometimes we say that a prescription cannot be filled "because it is 3 days too early" or "is 2 days too early". Pharmacies won't fill prescriptions that they know are too early unless the physician authorizes it. In that sense, this patient filled their prescriptions an astounding **352 days too early** over this span of time. In fact, they filled their prescription less times legally than they filled it illegally. How many of those early refills were filled or not at Dr. Patel's insistence by telephone with the pharmacist I do not know. It is perplexing to me that the pharmacy(ies) filled so many early refills.

Pharmacies only filled prescriptions when due to be filled 21% of the time. According to my calculations from KASPER, they filled prescriptions only 5 times legally but 19 times illegally. 352 days of illegal "too early" refills for a medicine that, according to KASPER records, was to be taken three times a day puts 1,056 pills (puts 3 per day times 352 days) illegally into the hands of the patient which are unaccounted for. It is possible the patient was selling them on the street or taking more than prescribed. As I said in my original note on the case of WB, early refills are sometimes necessary. It should be documented in a chart that this was done and why. **But this level of early refills is egregious in my opinion based upon the records I was given.**
Please, check over my calculations and analysis to be sure I didn't slip up somehow. It seems unbelievable to me that there were such a large number of early refills. **One refill for the controlled drug, lorazepam, was filled on the same day as another refill for lorazepam.**

That brings me to a second point. WB was filling refills at multiple pharmacies, , a breach of HB1, which Dr. Patel has a responsibility to monitor and did not. The duplicate fill on same day at two different pharmacies suggests that the patient was clearly aware they were doing wrong and was attempting to get away with it.

Based upon this deeper look, my prior opinions are unchanged, I think that the degree of Dr. Patel's failure in the case of WB is more grave than I had opined. It would be worse if Dr. Patel actually knew the patient was doing this, but it is still disturbing if he did not know the patient was doing this when HB1 mandates that physicians watch for this kind of illegal action. This is one of those cases where, as they say, "he knew or should have known".

Patient SG

The counsel letter reply defends that, " The patient H&P was done .... and is in the EMR."

I scoured the chart that I was given on SG again and I see nothing of this. There are some self-administered "My Depression Quiz" forms. There is a self-administered intake form with medical and demographic information. I assume that they are not intimating that these scant bits constitute an adequate initial medical-psychiatric evaluation. Based on the file of SG that I have, I stand by my original comment of physician failure.

The changes Dr. Patel relates that he made late in the game and which he says he will do in the future are all nice and good, but numerous medical violations happened in this and other cases. I only render opinions on what took place from analysis of what the records I have be provided say happened. What mitigating circumstances are to be taken into consideration is not in my purview as a consultant. It is the function of the Medical Licensure Board to take what it deems proper into consideration in making their decisions, as I understand it.

Sincerely,

Stephen Cox MD
KBML consultant /Psychiatry

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 1625

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, 1506 BRISTOL COURT, ELIZABETHTOWN, KENTUCKY 42701

COMPLAINT

Comes now the Complainant Randel C. Gibson, D.O., Chair of the Kentucky Board of Medical Licensure's Inquiry Panel B, and on behalf of the Panel which met on November 20, 2014, states for its Complaint against the licensee, SHARAD C. PATEL, M.D, as follows:

1. At all relevant times, Sharad C. Patel, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On March 8, 1999, the licensee filed with the Board an Amended Letter of Agreement, which he executed on March 5, 1999. Condition One (1) of the Amended Letter of Agreement specified: "Physician shall fully maintain a contractual relationship with the Impaired Physician Committee and abide by all conditions placed upon him by the Impaired Physician Committee."
4. On March 16, the licensee verbally notified a Board Investigator that he desired to convert his license to inactive status and that he intended to discontinue his relationship with the Kentucky Physicians Health Foundation ("the Foundation"). In a Memorandum to the Board's Inquiry Panel B, dated March 22, 2000, the investigator notified the Board of this information.

5. In a letter dated March 17, 2000, Burns M. Brady, M.D., Medical Director of the Foundation, confirmed a telephone conversation he had with the licensee. In his letter, a copy of which was received by the Board on March 21, 2000, Dr. Brady stated, "As I understand it, you [the licensee] are not going to renew your Kentucky medical license at this time and would like to discontinue your relationship with [the Foundation]." Seeking confirmation of his understanding, Dr. Brady further stated in same: "I look forward to your response and if I have not heard from you within 14 days of your receipt of this letter, then I will assume this establishes for our records and for the Kentucky Board of Medical Licensure that you are discontinuing your relationship with this organization."

6. Given these circumstances, the Panel required the licensee to enter into an Agreed Order of Surrender, which he did and which was filed on June 9, 2000. He had not practiced medicine in the Commonwealth since that time.

7. At its July 2002 meeting, the Panel considered the licensee's request to resume the active practice of medicine. The Panel deferred any action until the licensee completed a clinical skills assessment at the Center for Personalized Education for Physicians (CPEP).

8. The licensee completed that assessment January 27-28, 2003. The Assessment Report included the following findings:

   A. Medical Knowledge

   During this Assessment, Dr. Patel's medical knowledge was fairly broad but it lacked depth and was not current. He was aware of the general initial psychiatric assessment process including the mental status examination. However, he omitted important historical areas and lacked necessary details and clarity on the mental status exam. He was knowledgeable about substance abuse issues as well as pain management and psychiatric treatment

in workman's compensation patients. He accurately assessed suicidal and homicidal risk. His level of knowledge of the civil commitment process was adequate, although it lacked detail. He demonstrated a general knowledge of anxiety, psychotic, and personality disorders but it lacked depth. Dr. Patel's diagnosis of mood disorders was unacceptable. His knowledge of psychotropic medications including antidepressants, antipsychotics, and mood stabilizers was incomplete and not current. His differential diagnosis did not always reflect the most likely possibilities. Dr. Patel was not well-versed in the DSM IV-R categories of the mood disorders. Dr. Patel's diagnostic and assessment skills lacked sufficient detail and completeness.

B. Clinical Reasoning

Overall, Dr. Patel's clinical reasoning was inconsistent. One consultant thought that, based on the few charts reviewed, Dr. Patel's clinical decision-making was adequate. Another consultant noted that Dr. Patel provided an adequate account of the issues from a drug overdose patient and a workman's compensation injury. Dr. Patel demonstrated flexibility in his ability to modify his management strategies based on changes in the patient's clinical course; however, his approach to pharmacology was more rigid.

Many of Dr. Patel's stated management strategies were reasonable; he did not apply these principles to the actual patient cases reviewed. This included use of mood stabilization in bipolar disorder and use of informed consent. He ordered laboratory tests and developed treatment plans that were not supported by the diagnostic possibilities. Dr. Patel's differential diagnosis did not always reflect the facts of the case. He occasionally assigned a diagnosis without sufficient clinical data, in contrary to the patient's clinical presentation, or without integrating important social issues. His follow-up recommendations did not always correlate with the clinical status and needs of the patient. Dr. Patel did not have an organized theory of psychopathology upon which to guide his prescription for non-pharmacologic-psychiatric treatments.

C. Communication

Dr. Patel's communication skills with the Simulated Patients were adequate but his skills were weak due to the time since he left practice. He demonstrated the core skills needed to be an effective communicator. He asked open-ended questions, listened without interruption, made effective use of summary statements, and had good eye contact. With practice his interactions became more conversational. His initial attempts at rapport were difficult but these improved over the course of the interview. He sometimes confused the patients by changing his line of questioning too quickly and without the use of transition statements. He did not provide patient education. His interactions with the peer consultants were acceptable.

D. Documentation

Dr. Patel's documentation skills were inadequate. His intake assessments were organized. His documentation of the mental status exams was acceptable. He provided a reasonable accounting of the patient's clinical progress. However, there was no documentation of medication side effects, reasons for psychotherapy or cognitive behavior therapy, or explanations for changes in medications. Dr. Patel did not document all patient encounters with an appropriate note. His management strategies were not consistently reflected in the chart. He did not record a formal diagnosis of PTSD in a patient he was treating for this disorder. He did not enumerate manic or depressive symptoms in a bipolar patient. He did not provide a clear plan of action in some cases. Comments about psychosocial issues were brief and general. The notes generated during the CPEP Assessment were unorganized and lacked any detail about his clinical thought processes. His treatment plans were vague.

CPEP recommended that Dr. Patel participate in structured, individualized Education Intervention to address the identified areas of need, and noted that such an intervention would likely require significant time and effort.

9. After reviewing the report, the Panel voted to defer action until Dr. Patel had obtained an Educational Plan from CPEP and presented it to the Panel for review. The licensee obtained an Educational Intervention Education Plan from CPEP in July 2006 and it was considered by the Panel at its October 19, 2006 meeting.

10. The parties entered into an Agreed Order of Indefinite Restriction on November 7, 2006. Conditions 2d and 2e of that Agreed Order provided:

    d. The licensee SHALL fully comply with the directives of Phase I of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Agreed Order of Indefinite Restriction. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase I of the Education Plan;

    e. The licensee SHALL NOT proceed to or perform any act under Phase II of the CPEP Education Plan, unless and until approved to do so by the Panel by Amended Agreed Order of Indefinite Restriction.

11. Both the licensee and CPEP have advised the Panel that, due to circumstances beyond the licensee's control, he has been unable to complete Phase I of the Education Plan, because of CPEP's lack of ability to properly evaluate the licensee's completion of that Phase. CPEP and the licensee have tried to develop an alternative means of evaluating the licensee's completion of Phase I. However, to date, they have been unable to implement an evaluation process which would provide CPEP with the level of assurance necessary to recommend his transition to Phase II of the Education Plan. Part of the difficulty in formulating and implementing an alternative evaluation process has been the perceived requirement to obtain the Panel's approval of a specific alternative Phase I evaluation process before it is implemented. In order to facilitate this process, the Panel has determined to delegate the authority to CPEP to develop and implement an alternative evaluation process for Phase I.

12. In their Point of Care Education and Evaluation Report for July 2009, CPEP reported:

> Dr. Patel successfully completed this simulated patient exercise. CPEP recommends that he progress to Phase II of his Education Plan. Dr. Patel should notify CPEP of his intent to reactivate his Education Plan and engage in educational activities, starting with Phase II.
>
> Dr. Patel will need to identify a qualified preceptor to work with him for the duration of Phase II. Because there has been a lengthy delay for Dr. Patel to begin Phase II of his Plan, it will be important that he participate in the educational activities in a timely manner. Therefore, if he has not already begun a preceptor search, Dr. Patel is encouraged to do so immediately. CPEP recommends that he submit the preceptor candidate's curriculum vitae within 15 days of reactivating his Plan (date to be determined). CPEP also recommends that Dr. Patel carefully review his Plan prior to initiating Phase II.

13. At the Panel's October 15, 2009 meeting, when they took up the licensee's request to modify his Amended Agreed Order of Indefinite Restriction, James. T. Jennings, M.D., Medical Director, Kentucky Physicians' Health Foundation, asked the Panel to consider terminating Condition 2h, based upon the length of the licensee's involvement with the Foundation and the primary focus of the present Amended Agreed Order.

14. Following his statement to CPEP staff that he would also like to pursue the possibility of practicing in an in-patient setting, CPEP conducted an Addendum Assessment on April 8-9, 2010. In their report, CPEP made the following findings and recommendations:

Medical Knowledge:

- Psychopharmacology: especially newer agents:
  - Available dose forms and typical dosing of Depakote;
  - Dosing of Risperdal and Risperdal Consta;
  - Atypical antipsychotics:
    - Blackbox warning: risk of death in elderly patients treated with antipsychotics;
  - Familiarity with the use of drugs used to treat Alzheimer's dementia, such as acetylcholinesterase inhibitors;
  - Drug interactions: Depakote and Lamictal;
  - Risk of polycystic ovarian syndrome with Depakote;
  - Pregnancy categories: nomenclature;
- Bipolar disorder:
  - Treatment of psychotic mania;
  - Treatment of bipolar depression, including:
    - Treatment of refractory bipolar depression;
    - Knowledge of drugs to be avoided because they can destabilize the patient and lead to mania or a mixed state (stimulants, antidepressants);
- Full understanding of the risk factors for completed suicide;
- Obsessive-compulsive disorder:
  - Pharmacologic management: lack of effectiveness of benzodiazepines; options to augment SSRIs in treating OCD;
- Substance abuse:
  - Alcoholism:

        - Role of Antabuse;
        - Current perspectives on controlled drinking;
        - Disadvantages of benzodiazepines in the rehabilitating alcoholic (as opposed to in acute withdrawal);
    - Opioid abuse: advantages and disadvantages of the three main treatment options of Suboxone, methadone, and abstinence;
- Personality disorders:
    - General knowledge;
    - Narcissistic personality D/O: psychodynamic explanation;
    - Sociopathic personality disorder: psychodynamic underpinnings;
    - Borderline personality disorder: see psychotherapy, below;
- Psychotherapy:
    - OCD: fuller understanding of important components of the therapy;
    - Dialectical behavioral therapy for borderline personality disorder and chronic self-harm/mutilation;
- Reasons for self-mutilation in psychiatric patients;
- Procedures for administering involuntary medications;
- Electroconvulsive therapy: body of evidence indicating that ECT can lead to long-term retrograde memory loss;
- Obstructive sleep apnea: as a comorbidity, medical complications and risks.

Clinical Judgment and Reasoning:

- Balance between the role of testing (laboratory and psychological) and clinical assessment and judgment;
- Awareness and recognition of one's idiosyncratic approaches that are not supported by literature, with a goal to examine the evidence in those instances.

Implications for Education and Other Interventions:

Based on the findings of the Second Assessment Addendum, the following educational recommendations should be completed if Dr. Patel includes inpatient care in his scope of practice:

- Point of Care Experience: Dr. Patel should participate in an inpatient clinical experience to provide the necessary supervision required as he addresses the areas of demonstrated need in inpatient psychiatry. The experience would be designed to allow appropriately graduated levels of independence.
    - Dr. Patel should initially have all cases reviewed with a preceptor prior to initiation of treatment;

- He should practice in a setting where he would have the availability of immediate consultation with another attending on the inpatient psychiatric ward.

- Educational Preceptor: Dr. Patel should establish a relationship with an experienced educational preceptor in psychiatry, with experience in inpatient care. This involves regularly scheduled meetings to review cases and documentation, discuss decisions related to those cases, review specific topics, and make plans for future learning.

- Continuing Medical Education and Self-Study: Dr. Patel should engage in continuing medical education courses and self-study which include, but are not limited to, the topics indicated in areas of demonstrated need.

15. At the Board's request, CPEP staff also identified the following learning objectives of Phase II of the original Education Plan that still need to be addressed by the licensee:

LEARNING OBJECTIVES III – IV: INCOMPLETE ("I")

III. To improve clinical decision-making in the following areas:	I
1. Consistent application of medical knowledge;	I
2. Organized, detailed, comprehensive, and integrated approach to diagnostic evaluation that includes differential diagnoses;	I
3. Development of comprehensive and integrative treatment plans for an adequately wide range of psychiatric diagnoses; these plans should include documentation of the patient's progress;	I
4. Consideration of medication management options;	I
5. Application of psychopathology.	I

Preceptor Meetings and Chart Reviews – Not Initiated
For more information, see Education Plan.

IV: To improve patient care documentation, specifically:	I
1. Organized and complete chart components, including flow sheets;	I
2. Consistently organized, detailed and complete notes, that include but not limited to the following elements:	I
a. Presenting complaint;	I
b. Psychiatric history;	I
c. Family and social history;	I
d. Mental status exam;	I

e. Differential and final diagnoses;	I
f. Detailed treatment plans;	I
g. Patient/family education;	I
h. Consultant reports/communications;	I
i. Testing;	I
j. Detailed clinical reasoning;	I
3. Consistent documentation of all patient encounters.	I

Dr. Patel attended the *Patient Care Documentation Seminar (Seminar)* in December 2006. The AMD will monitor Dr. Patel's documentation to determine if he should attend the *Seminar* again, or if his educational needs would be sufficiently addressed if he enrolled in the follow-up component to the December 2006 *Seminar*.

V. To monitor physician-patient communications:	I
1. Effective core communication skills.	I

Dr. Patel completed reading The Medical Interview as recommended in his Education Plan. This objective should be addressed with the Preceptor during Phase II.

VI. To determine a plan to maintain current standards within the field of psychiatry.	I

16. On April 28, 2011, the licensee entered into a Fourth Amended Agreed Order. The relevant term of that order is 2g, which states:

> The licensee SHALL SUCCESSFULLY become re-certified by the American Board of Psychiatry and Neurology within two calendar years of the date of filing of this Fourth Amended Agreed Order.

17. On January 6, 2014, the licensee appeared before the Panel when it reviewed a report of non-compliance, as the licensee had not become recertified by the American Board of Psychiatry and Neurology. The Panel deferred action and gave the licensee two options to address his non-compliance: (1) either complete the appeals process with the American Board of Psychiatry and Neurology for recertification and present their official resolution to the Panel, or (2) submit to a CPEP Post-Education Evaluation and present those results for review by the Panel.

18. As of the Panel meeting on November 20, 2014, the licensee had neither completed the appeals process and presented the official resolution to the Panel nor submitted to a CPEP Post-Education Evaluation and presented those results to the Panel.

19. In February 2014, the Board received a grievance filed by Patient A, who described an incident in which the licensee offered to prescribe additional narcotic drugs if he was provided with a discount on a new Toyota Avalon. Patient A was a salesman for Toyota at the time. Patient A stated that he did assist the licensee in purchasing the Toyota Avalon, and that about a week later the licensee called the patient stating he had damaged the car but did not have insurance on it. Patient A stated that the licensee asked him to change dates on the paperwork and say that the car was damaged in the car lot. Patient A declined the request. Patient A stated that a few weeks later, the licensee called him upset about his bill from Toyota. Patient A explained that the bill was higher due to the licensee's purchase of $4000 worth of additional services and products, and the licensee seemed upset. Patient A stated that about a week later, a police officer approached Patient A at work, interrogating Patient A about stealing the licensee's prescription pad. Patient A's employment was subsequently terminated. Subsequently, Patient A was notified by the licensee's office that they would be increasing the costs of his appointment.

20. During an interview with Board investigator Steve Manley, Patient A stated that the licensee was the only physician he could find to prescribe him Subutex instead

of Suboxone, because Suboxone was out of the patient's financial reach. Patient A did not have health insurance and paid cash for his appointments and medications.

21. On March 28, 2014, Patient A sent a fax to the Board wherein he stated his desire to withdraw the grievance he filed against the licensee. The fax was sent from the licensee's office.

22. On April 1, 2014, the licensee responded in writing to the grievance filed by Patient A. The licensee admitted that he provided the licensee's name to the police in connection with a missing prescription pad. The licensee acknowledged that he later found the "missing" prescription pad under the seat in his car. The licensee stated "As far as the nonsense about buying a car from the complainant and committing fraud as charged by the complainant, is concerned, I have no knowledge of it."

23. In an interview with Board investigator Steve Manley, Kathy McGubbins, sales manager at the Toyota business in Elizabethtown, confirmed that she did terminate Patient A's employment after the police interviewed him regarding the licensee's missing prescription pad. She further confirmed that the licensee did purchase a vehicle from Patient A at invoice price with $4000 worth of additional services and products. She stated that Patient A never had an inappropriate drug test and at no time did she find him to be dishonest, even when it was to his detriment.

24. During an investigation with Board investigator Steve Manley, Officer Elam with the Elizabethtown Police Department confirmed that the licensee contacted the police department and reported that his prescription pads had been stolen and that

he suspected Patient A was the thief. Officer Elam stated that a few days later, the licensee's office employees contacted the police to report that the prescription pads had been located in the licensee's car.

25. Within four weeks of receiving the grievance from Patient A, a second grievance was received from the guardian of Patient B, who was concerned about the diagnosis given to her brother by the licensee. The grievant stated that her brother has previously been diagnosed as schizophrenic by several other psychiatrists and it is documented in his medical history, but the licensee diagnosed him as bipolar.

26. On April 1, 2014, the licensee responded in writing to the grievance submitted by the guardian of Patient B. The licensee defended his diagnosis of Patient B.

27. Based upon these two grievances, a request was made to the Office of the Inspector General, Division of Audits and Investigations ("OIG") to review the licensee's prescribing habits.

28. On or about April 29, 2014, Carrie Gentry, PharmD, RPh, OIG, reviewed and analyzed the license's KASPER records (dated April 18, 2013 to April 18, 2014) and noted several concerns, including:

- 70% of patients received a non-abuse deterrent formulation of buprenorphine;
- 50% of patients receiving buprenorphine also received a benzodiazepine;
- Inappropriate buprenorphine induction/maintenance prescribing based on KBML Opinion relating to the use of Suboxone and Subutex for the treatment of Opiate Dependency
- Patient use of multiple pharmacies
- Patient use of multiple prescribers (including Indiana prescribers)
- Early refills of controlled substances based on day supply
- Prescribing controlled substances for family

Ms. Gentry identified fourteen (14) of the licensee's patients for further investigation by the Board.

29. A Board consultant reviewed the chart regarding the grievance filed by Patient A and found the licensee's treatment and overall care to be below standards of care. The consultant opined that if Patient A's allegations are true, the licensee's conduct would constitute gross ignorance, gross negligence, and/or gross incompetence. The consultant found the following problems with the licensee's care: unethical or unprofessional conduct, false statements, excessive fees, and prescribing. The consultant stated, in part:

> The minimum standards of practice in Kentucky prohibit a physician from making a deal to prescribe excessive narcotics for a discount on a car.
> The minimum standards of practice in Kentucky prohibit a physician from lying to the KBML about an investigation.
>
> Regarding prescribing minimal standard of care, I noticed that Patient A did not fill many days quantity according to KASPER until September 23, 2013. Starting on that date it looks like Patient A started filling 30 day supplies of Subutex (24mg/day) for the first time, whereas, up until September 23, he was filling an average of perhaps 9 days at a time with a high of only 17 days. It was in this Fall of the year that I believed the alleged "more pills for a car deal" was to have occurred. On 10/16/2013, [the licensee] prescribed another 30 day supply unnecessarily a full week before a new prescription was needed. And, the patient for the first time filled his prescription at a different drug store. I suspect the original druggist would not have filled this "too early" prescription.
>
> ...I see no chart evidence of KASPERs being checked on Patient A. The minimum standard of practice in Kentucky is to check KASPERs for patients on Schedule II drugs or stronger.

The Board consultant's report is attached and incorporated herein in its entirety.

30. The Board consultant reviewed Patient B's chart regarding the grievance filed by Patient B's guardian. The consultant found the licensee's diagnosis to be below minimum standards in diagnosis and borderline overall. The consultant stated, in part:

> [The licensee's] next to last sentence in his response is concerning to me though. "...and seemed to have been stable for a few years." [The licensee] has a right as a clinician to come to his own opinion, based on his clinical judgment. However, in the same letter to KBML, he implied to the KBML that he read the "mammoth" "several hundred pages" of medical records. It appears that he did not read that "mammoth filed" of records from the Veterans Hospital. In these records are more than a half a dozen mental health professionals who gave witness to the patient's delusions and strange experiences at most encounters over a few years. In fact, on only one encounter, in Owensboro, did [Patient B] have no psychotic expressions. So, sometimes [Patient B] looked OK, but at most hospitalizations he was obviously overtly delusional.
>
> ...[The licensee] implies in his letter that he did examine [the records] later. But if he did examine them as he stated he did, why would he disregard the opinions of more than half a dozen mental health personnel, and the family's opinion, and history of delusions? And how could he, in truth state, "...and seemed to have been stable for a few years," referring to this same time period from 2008-2012 during which time the patient was documented to be frankly delusional? Regarding medical diagnosis, either not reading medical records or disregarding the opinions of so many colleagues and of the family without explanation is not wise medical diagnosis strategy.

The Board consultant's report is attached and incorporated herein in its entirety.

31. The Board consultant reviewed fourteen (14) of the licensee's patient charts and found the following:

- the licensee did engage in conduct which departed from or failed to conform to prevailing medical practice standards within the Commonwealth of Kentucky;
- the licensee did commit a pattern of acts, during the course of his medical practice, which under the attended circumstances, would be deemed to be gross negligence;
- the licensee's practice of medicine did constitute a danger to the health and safety of his patients;
- the licensee did prescribe a controlled medication for use of or by his immediate family;
- the licensee did prescribe medicines in other than appropriate amounts for the disorders he was treating by, in more than one patient, authorizing early refills for them on more than one occasion without documental clinical justification for the increased level of dosage dispensed.

The Board consultant's report is attached and incorporated herein in its entirety.

32. On or about August 5, 2014, the licensee responded in writing, through counsel, to the Board consultant's findings. The licensee responded in general and specifically to comments by the consultant on each patient, disagreeing with the consultant's findings.

33. The licensee's response was provided to the Board's consultant. On or about August 31, 2014, the Board's consultant stated that "many of the counsel's explanations state facts that are not in the record." With regard to Patient C, the consultant stated, "Based upon this deeper look, my opinions are unchanged. I think that the degree of [the licensee's] failure in the case of Patient C is more grave than I had opined."

34. On or about November 20, 2014 the Board's Inquiry Panel B determined that the licensee's practices place his patients and the public at risk and in danger. As a result, the licensee was suspended from the practice of medicine in the Commonwealth of Kentucky pending resolution of this Complaint.

35. By his conduct, the licensee has violated KRS 311.595(9) [as illustrated by KRS 311.597 (1)(c), (1)(d), (3), and (4)], KRS 311.595(12), and KRS 311.595 (13). Accordingly, legal grounds exist for disciplinary action against his Kentucky medical license.

36. The licensee is directed to respond to the allegations delineated in the Complaint within thirty (30) days of service thereof and is further given notice that:

    (a) His failure to respond may be taken as an admission of the charges;

    (b) He may appear alone or with counsel, may cross-examine all prosecution witnesses and offer evidence in his defense.

37. NOTICE IS HEREBY GIVEN that a hearing on this Complaint is scheduled for March 23-25, 2015, at 9:00 a.m., Eastern Standard Time, at the Kentucky Board of Medical Licensure, Hurstbourne Office Park, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222. Said hearing shall be held pursuant to the Rules and Regulations of the Kentucky Board of Medical Licensure and pursuant to KRS Chapter 13B. This hearing shall proceed as scheduled and the hearing date shall only be modified by leave of the Hearing Officer upon a showing of good cause.

WHEREFORE, Complainant prays that appropriate disciplinary action be taken against the license to practice medicine held by SHARAD C. PATEL, M.D.

This 24th day of November, 2014.

Randel C Gibson DO

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B

CERTIFICATE OF SERVICE

I certify that the original of this Complaint was delivered to Mr. Michael S. Rodman, Executive Director, Kentucky Board of Medical Licensure, 310 Whittington Parkway, Suite 1B, Louisville, Kentucky 40222; a copy was mailed to Thomas J. Hellmann, Esq., 415 West Main Street, P.O. Box 676, Frankfort, Kentucky 40602-0676; and copies were mailed via certified mail return-receipt requested to the licensee, Sharad C. Patel, M.D., 1506 Bristol Court, Elizabethtown, Kentucky, 42701 and his counsel, Marc S. Murphy, 400 West Market Street, Suite 1800, Louisville, Kentucky 40202-3352, on this 24th day of November, 2014.

Sara Farmer

Sara Farmer
Assistant General Counsel
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310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
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KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._none listed____ Patient Name_____[redacted]_____

Expert's Name_____Stephen Cox_____

1. Brief description of symptom, dx and course of treatment: _____

Narrative:

This is an odd complaint. It was submitted in writing with great clarity and passion in February 2014, only to be withdrawn hurriedly on March 28, 2014 without sufficient explanation to make one feel at ease. Seems fishy. Dr. Patel's response to the complaint was dated 3 days after the complaint was withdrawn..

The patient who complained is a heroin narcotic addict and bipolar disorder person who saw Dr. Patel for treatment. He alleged in June 2013 Dr. Patel offered to prescribe higher doses of narcotics in exchange for a financial break on a new car. He said the doctor spent the patient's sessions (paid for by the patient) talking about the car details. In the Fall of 2013, he says Dr. Patel bought the car from patient and the discounts were arranged. Dr. Patel was angry according to the patient when he got his first bill from Toyota, it being higher than he expected. A week later [redacted] said the police came where [redacted] was employed and arrested him with great show for stealing Dr. Patel's prescription pad which resulted in [redacted] being fired. Dr. Patel's office raised [redacted] fees 30% and billed him for fees [redacted] was not in agreement with. Dr. Patel found his missing preseription pads under his car seat that [redacted] was accused of stealing.

[redacted] accused Dr. Patel of not seeing people that he prescribes medication to. He accuses him of hiring people he gives drugs to. He said he manipulates people.

He said he had audio recordings of evidence of Dr. Patel admitting what he has done. He said he could prove Dr. Patel purchased the vehicle and leveraged it against [redacted]

Medical records

A review of [redacted] records shows a neat, well-kept record. There are initial evaluations, progress notes in good order. There is a record of prescriptions written. The progress notes are typical of today's EMR records with copy and paste sentences that repeat verbatim in many progress notes. There are relevant sentences too that indicate doctor's individual treatment at many of these visits, which is a good thing.

The dose of Subutex prescribed for [redacted] heroin addiction was commonly three of the maximum strength doses per day, that is a total of 24mg/day, (max dose permitted = 32mg.).

In the area where [redacted] lives it appears that no doctor except Dr. Patel will prescribe [redacted] his Subutex. Despite this complaint against Dr. Patel, [redacted] virtually has to continue with Dr. Patel, assuming Dr. Patel will allow him to do so.

2. Can you form an opinion?

YES. All of this depends on whether the allegations from [redacted] are true or not. I, for the remainder of this report am assuming the allegations are factual, which may or not be so.

Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

___X___ Yes, I can form an opinion.
_____ No, I cannot form an opinion.
_____ I need more information (specify): _____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

_____ Below minimum standards
__X____ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

___X___ Below minimum standards
_____ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards
__X____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

__X____ Clearly below minimum standards. (If allegations are true)
____ Clearly within minimum standards
_____ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the

physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

Yes, if allegations are true.

4. Other questions from the Medical Board (ignore if blank): _____

I saw no problems in:

- MENTAL OR PHYSICAL CONDITION
- MEDICAL NECESSITY
- DEPENDENCY
- GROSSLY IMPROBABLE CLAIMS
- SUBSTANDARD CARE

Assuming [redacted] allegations are factual I see the following problems in this case:

- UNETHICAL OR UNPROFESSIONAL CONDUCT
- FALSE STATEMENTS
- EXCESSIVE FEES (The 30% increase rate)
- PRESCRIBING

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

The minimum standards of practice in Kentucky prohibit a physician from making a deal to prescribe excessive narcotics for a discount on a car.

The minimum standards of practice in Kentucky prohibit a physician from lying to the KBML about an investigation.

Regarding prescribing minimal standard of care, I noticed that [redacted] did not fill many days quantity according to Kasper until Sept 23,2013.
Starting on that date it looks like [redacted] started filling 30 day supplies of Subutex (24mg/day) for the first time, whereas, up until September 23, he was filling an average of perhaps 9 days at a time with a high of only 17 days. It was in this Fall of the year that I believe the alleged "more pills for a car deal" was to have occurred. On 10/16/2013 Dr. Patel prescribed another 30 day supply unnecessarily a full week before a new prescription was needed. And, the patient for the first time filled his prescription at a different drug store. I suspect the original druggist would not have filled this "too early" prescription.

The minimum standard of practice in Kentucky is to write prescriptions such that patients do not double up on narcotic pills, having twice as many as needed and intended.

I see no chart evidence of Kasper's being checked on [redacted] The minimum standard of practice in Kentucky is to check Kaspers for patients on Schedule II drugs or stronger.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board. NO

Or,

Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger? Yes, if the allegations in the complaint are factual

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

I f the allegations in the complaint are factual, dangerous controlled drugs are at risk of harming patients or street drug users who purchase such pills.

That concludes my comments of my opinions. If failed to observe some part of a record that concerns you, please bring it to my attention.

Thank you for what you do.

Aristotle pointed out in his Nicomacean Ethics. "For this good is the same for the individual and the state, yet the good of the state seems a grander and more perfect thing both to attain and to secure; and glad as one would be to do this service for a single individual, to do it for a people, and for a number of states is nobler and more divine."

Thus, what you and the Board does, and to a tiny degree what I do, is "good". It is an honor to serve the Commonwealth to review these records and to express my clinical opinion, for what it's worth, to assist the KBML in securing our state physicians' practices of medicine.

Respectfully,

4.16.14
Date of Review

Stephen Cox MD
Signature of Expert

KENTUCKY BOARD OF MEDICAL LICENSURE

EXPERT REVIEW WORKSHEET

(Please type)

Case No._none listed____ Patient Name_____[redacted]_____

Expert's Name_____Stephen Cox_____

1. Brief description of symptom, dx and course of treatment: _____

Narrative:

Dear Investigator Lewis

[redacted] was a long distance truck driver. Then a local driver. Then unemployed. He was struck by a motor vehicle while walking to another town to look for work. His leg was fractured. He was taken to the hospital and treated 10/5/09. A consulting psychiatrist who saw him deemed him to be mentally ill as per the VAH impression of diagnosis; but no hallucinations or delusions were manifest at the time.

Before that injury he was treated at VAH in 2008 for psychiatric delusions, but since not deemed dangerous, he was dismissed to mental health outpatient follow-up.

Then he received much diagnostic and treatment work at the VAH in Louisville KY in 2010 and 2012. He carried a diagnosis of psychosis consistently, but the details were debated and uncertain as to the specific diagnosis. Mostly, he seemed thought to be schizophrenic, but bipolar was mentioned every time as a possible diagnosis. Oddly, he was never treated with Lithium or meds like Depakote for bipolar disorder. It seemed that Risperdal suited his symptoms and compliance the best. Geodon failed. He usually quit medicine more than took it when left to his responsibility. Fortunately for him his sister or daughter supervise his medication.

His symptoms over these 4 years, as detailed in the VAH records included recurring delusions of snake(s) in his body that occasionally would appear, headless, once coming out his mouth when he tried to kiss his wife (Freudian for sure!) or as a more modest worm coming out of his face. Additionally, he had grandiose delusions that he had been shot three times when three years old, that he constructed his first aircraft at age 6 years, that he was to work for a

manufacturer like Lockheed as an aircraft engineer, and that his designed plane was used in Vietnam.
He was admitted to one of these hospitalizations after a fight with his son in law and threatening to hit grandson with a bat and choke him.

He was never known to have auditory hallucinations. Schizophrenics quite commonly have voices. Not him.

His mood was, when abnormal, most often angry, typical for bipolar. His mother was said to have the same behaviors.

Some of Dr. Patel's records are puzzling. There is a page of dates and vital signs. It lists dates down the column for visits of:

- 10/9/2013
- 10/15/13
- 2/26/13 {probably 2/26/2014}

I only see one clinical note for this 4 month time span "seen by Linda Pickering seen on 09 October 2013". The same note was "electronically signed by: Dr. Sharad Patel, MD signed on Thursday 27 Feb 2014. I cannot find any notes from Dr. Patel for 10/09/13 or 10/15/13. This one note appears to have been finished at the date of 2/26/13 ("At the present time and over the past 4 months, this patient's mental status has been stable."). So, this only note in the chart for a case that lists three visits; and it seems to have been done very recent to the complaint which was dated almost the same day. There appear to be no doctor notes written earlier than the day before the complaint over the 4 months of care. This is irregular. There should be a progress note for the three visits dated on the days of care. One wonders if Dr. Patel's evaluation was written in response to the complaint.

The sister who filed the complaint dated the following day 2/27/2014 was [redacted] guardian.

The sister, in her complaint, was perturbed that Dr. Patel in his evaluation did not agree with the VAH doctors. Dr. Patel felt that [redacted] was not schizophrenic. (I share that impression myself, favoring bipolar disorder.)

The family is frustrated with Dr. Patel's clinical impression and opinion which they do not agree with whatsoever. These women are astonished and dismayed at being dismissed by Dr. Patel. They do not feel Dr. Patel is listening to them. Dr. Patel implies that at that time there was little reason for concern about the patient returning to work driving trucks. His impression remained these were" tall tales"

not symptoms and signs of illness. He believed the patient was "fully competent" consequently there was no need for continued guardianship. That alarms the family.

Dr. Patel's complaint response letter dismisses the family's history. Dr. Patel believes [redacted] account and explanations. Dr. Patel did a thorough mental status examination which checked out fine.

His next to last sentence in his response is concerning to me though. "...and seemed to have been stable for a few years."

Dr. Patel has a right as a clinician to come to his own opinion, based on his clinical judgment. However, in the same letter to KBML, he implied to the KBML that he read the "mammoth""several hundred pages" of medical records.

It appears that he did not read that "mammoth file"of records from the Veterans Hospital. In these records are more than a half dozen mental health professionals who gave witness to the patient's delusions and strange experiences at most encounters over a few years. In fact, on only one encounter, in Owensboro, did [redacted] have no psychotic expressions. So, sometimes [redacted] looked OK, but at most hospitalizations he was obviously overtly delusional.

These electronic medical records are horribly difficult to examine. There are pages and pages of useless boilerplate, and then there will be one little section that contains critical information that is easily overlooked. It took me 3 ½ hours to examine these records and take notes. There is little way for a busy practitioner to see a patient AND thoroughly go examine greater than 200 pages of computer printout at the same visit.

Dr. Patel implies in his letter that he did examine them later. But if he did examine them as he stated he did, why would he disregard the opinions of more than half a dozen mental health personnel, and the family's opinion, and history of delusions? And how could he, in truth, state, "...and seemed to have been stable for a few years", referring to this same time period from 2008-2012 during which time the patient was documented to be frankly delusional?

Regarding medical diagnosis, either not reading medical records or disregarding the opinions of so many colleagues and of the family without explanation is not wise medical diagnosis strategy.

2. Can you form an opinion?

YES

Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the minimal standards of acceptable and prevailing medical practice (in the medical community at large)?

___X___ Yes, I can form an opinion.
_____ No, I cannot form an opinion.
_____ I need more information (specify): _____
_____
_____
_____
_____

3. What is your opinion? Please use the definitions below as "guidelines" to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

a. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

___X___ Below minimum standards
_____ Within minimum standards

b. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

_____ Below minimum standards
___X__ Within minimum standards

c. Records.

Maintenance of records which should contain, at a minimum, the following: (1) appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty; (2) results of diagnostic tests (when indicated); (3) a working diagnosis; (4) notes on treatment(s) undertaken; (5) a record by date of all prescriptions for drugs, with names of medications, strengths , dosages, quantity, and number of refills; and (6) a record of billings.

_____ Below minimum standards
__X____ Within minimum standards

d. Overall Opinion. Based on the foregoing, what is your overall opinion?

_____ Clearly below minimum standards.
____ Clearly within minimum standards
___X___ Borderline Case

e. Gross Ignorance, Gross Negligence, Gross Incompetence. If you found that this physician did not meet the minimum standards of care in treating a patient(s), did you also conclude that any of these departures from the minimum standards of care were so serious that you consider them to exhibit gross ignorance, gross negligence, and/or gross incompetence on the

physician's part. If "yes," please identify each of these instances, classify it appropriately and explain your reasoning in reaching that conclusion(s).

If "yes," please also indicate whether you found a pattern of gross ignorance, gross negligence and/or gross incompetence in this physician's practice as evidenced by the records reviewed and explain your conclusion(s).

No.

4. Other questions from the Medical Board (ignore if blank): _____

I saw no problems in:
PRESCRIBING
MENTAL OR PHYSICAL CONDITION
MEDICAL NECESSITY
DEPENDENCY
EXCESSIVE FEES
GROSSLY IMPROBABLE CLAIMS
UNETHICAL OR UNPROFESSIONAL CONDUCT
FALSE STATEMENTS
SUBSTANDARD CARE (apart from the concerns mentioned elsewhere in this document.)

5. Explain your opinion. If you opined that practice was below minimum standard for any of the above reasons, state the correct minimal standard of practice (NOTE: It is not sufficient to say "I would have..., or I would have not...", you should be able to testify that "the minimal standard of practice in the medical community at large would be to...") Use extra sheets as necessary to explain your opinion and complete this report.

More attention to history taking should be done in this one case by the doctor, reading all records and taking seriously other professionals opinions as well as the family's, whether they be women or not.

6. If you determine from your review that the physician has failed to meet the standard of acceptable practice in a specific area(s), please answer the following questions as well:

a. Is it your opinion that the standard of practice violations you have identified may be addressed by the Board in an orderly process, extending over some period of time (6 months to 2-3 years) through remedial education and training, and subsequent monitoring by the Board. YES

Or,

Are the violations of such a nature that the Board must act immediately to restrict or suspend the doctor's license to protect patients or the public from imminent danger? NO

Not applicable

b. If you answered that the Board must act immediately to avoid imminent danger, please identify the imminent danger involved and examples of the violations that create such a danger.

I think this patient should have a second opinion by another psychiatrist soon.

That concludes my comments of my opinions. If failed to observe some part of a record that concerns you, please bring it to my attention.

Thank you for what you do.

Aristotle pointed out in his Nicomacean Ethics. "For this good is the same for the individual and the state, yet the good of the state seems a grander and more perfect thing both to attain and to secure; and glad as one would be to do this service for a single individual, to do it for a people, and for a number of states is nobler and more divine."

Thus, what you and the Board does, and to a tiny degree what I do, is "good". It is an honor to serve the Commonwealth to review these records and to express my clinical opinion, for what it's worth, to assist the KBML in securing our state physicians' practices of medicine.

Respectfully,

4.15.14
Date of Review

Stephen Cox MD
Signature of Expert

Stephen Michael Cox, M.D.
[redacted]

June 22, 2014

KBML Hurstbourne Office Park
310 Whittington Parkway 1B
Louisville KY 40222

RE: Sharad Patel, M.D.

Attn: Investigator Stephen Manley

Dear Investigator Manley:

As I was instructed by the KBML, I reviewed these 14 charts of Dr. Patel's patients, his family member, and Kasper reports of some of these same 14 patients that you sent in a separate file. In that file there were Kasper reports of other Patel patients that were not of the 14 patients I was to review. I returned those Kasper reports un-reviewed. I address here your inquiry.

PRESCRIBING

In my clinical opinion, Dr. Sharad C. Patel **did** engage in conduct which departed from or failed to conform to prevailing medical practice standards within the Commonwealth of Kentucky.

In my clinical opinion, Dr. Sharad C. Patel **did** commit a pattern of acts, during the course of his medical practice, which under the attendant circumstances, would be deemed to be gross negligence.

In my clinical opinion, Dr. Sharad C. Patel's practice of medicine **did** constitute a danger to the health and safety of his patients.

I did not find any instance, in this review of these 14 patients, where Dr. Sharad C. Patel made, or caused to be made, or aided or abetted in the making of a false statement in any document executed in connection with the practice of the medical profession.

In these 14 chart reviews, in my clinical opinion, Dr. Sharad C. Patel did not prescribe or dispense medication with the intent or knowledge that the medicine would be used or was likely to be used other than medicinally or other than for an accepted therapeutic purpose.

In my clinical opinion, Dr. Sharad C. Patel **did not** prescribe or dispense controlled medication for use by himself; **however, he did prescribe a controlled medication for use of or of his immediate family,** Dimpi Patel (11/6/2013 prescription for Adderall 7.5 mg #90. No refill.). There is no clinical chart apart from three pages listing the prescription dated at the bottom of the page May16, 2014. I think this date was after the KBML investigated Dr. Patel. Beside the fact that there is no adequate medical record for this patient, it is not permitted by the KBML to prescribe controlled substances to one's own kin, at least that is my understanding.

In my clinical opinion, Dr. Sharad C. Patel **did prescribe medicines in other than appropriate amounts** for the disorders that he was treating by, in more than one patient, **authorizing early refills for them on more than one occasion without documenting clinical justification** for the increased level of dosage dispensed.

I **found** that Dr. Sharad C. Patel engaged in conduct which departed from the standards of accepted and prevailing medical practice within Kentucky.

Additional remarks:

Regarding your inquiry into prescribing patterns of Dr. Sharad Patel:

Type of controlled substance:
Of the 14 cases reviewed the majority were prescribed narcotics. Other controlled drugs prescribed were amphetamines for attention deficit disorder and benzodiazepines for anxiety.

Quantity prescribed:
Month supplies were usually dispensed. In one patient, and it is unclear from the record, a 90 day supply may have been dispensed.

Frequency:
The doses and frequency of doses were in line with FDA guidelines. One male patient was prescribed the maximum dose of narcotic on his first visit. Several patients were given early refills and no consideration was made in several such cases to delay filling of the next prescription. Many of these patients filled that prescription at a different drug store. A violation of their HB1 drug contract they were supposed to have with Dr. Patel. Sometimes such a contract was on file, other times, one was not on file. Except in one case I saw no documentation that Dr. Patel took action to dismiss a patient from his practice for violating the poly drug store prohibition of HB1. All this changes an "early refill" into possible double dosing, approximately, without documented reasons in the chart that I could find.

Dr. Patel's duration of treatment with controlled substances was seemingly to be chronic. My opinion is confined to his narcotic prescriptions. Rightly or wrongly, it appears to me that the overwhelming majority prescribers of Suboxone, and the like, have no real intention of tapering off the patients. It is oft mentioned at the onset of treatment but I have yet to ever see a case where it happened. So, Dr. Patel's appearance of chronic narcotic provision is not unusual; it seems to be the standard of practice of his Kentucky peers in that field.

I did not notice any instances of office dispensing of controlled substances.

SUBSTANDARD CARE

In my opinion, Dr. Patel's prescribing deficiencies addressed above do constitute substandard care, but I saw nothing else in examination of these 14 charts in other areas. All problems were addressed in the above section.

In review of these 14 records, I found no evidence of failures to concern the KBML in the following areas that you asked me to consider:
MENTAL OR PHYSICAL CONDITION
MEDICAL NECESSITY
DEPENDENCY
EXCESSIVE FEES
GROSSLY IMPROBABLE CLAIMS
UNETHICAL AND PROFESSIONAL CONDUCT
FALSE STATEMENTS

SUMMARY OF EACH OF THE 14 INDIVIDUAL CHARTS:

D P

This is, I assume, a first degree relative of Dr. Patel. Adderall 7.5 mg, a mild dose, was prescribed by Dr. Patel. #90 pills.
There was virtually no chart. No evaluation, no Kasper, no drug urine screen. All the HB 1 regs were essentially violated.
KBML Consultant opinion: Unacceptable clinical practice.

B B-C

Kasper on 4/10/14 shows multiple drug stores being usedfor Dr. Patel's prescriptions without chart comment. There is only one other Kasper on 5/22/14. It is noticeable that the dates of the Kaspers were perhaps subsequent to KBML contacting Dr. Patel. Amphetamines and benzodiazepines were showing up on toxicology tests as early as 6/14/13. Amphetamines and benzodiazepines and (oxycodone/oxy-morphine or buprenorphine) positive on urine tests 8/20/13 and on 10/13/13. The presence of amphetamine was not addresses until April 2014. Benzodiazepines were positive in many drug screens without comment that I could find in the chart. Some progress notes were "cut and paste" fragments that repeated identically, visit to visit, whether they made sense temporally or not (This "cut and paste" is becoming so widespread with the EMR that it is, sadly, the new, current standard of practice, and will not be counted against Dr. Patel in forming my opinion.).
KBML Consultant opinion: Unacceptable clinical practice.

M B

Lacks "S,O,A" in most SOAP progress notes. Very acceptable otherwise. The patient was terminated due to violation of patient HB1 contract.
KBML Consultant opinion: Acceptable clinical practice.

W B

This patient was not on narcotics. Dr. Patel performed and recorded an exemplary initial evaluation H&P. The progress notes in this case were much better than Dr. Patel's usual. In the narcotic cases there was more often than not a lack of any clinical contemporary substance except for vital signs (O) and pill details (P), no S.O.A.P. details otherwise. It appeared that Dr. Patel does a much better job with non-narcotic cases like this one. But then I discovered that in looking at Kaspers, Dr. Patel authorized early refills repeatedly and the patient went to different drug stores to fill such. Early refills are necessary on occasion. Pills can really actually be stolen. Doses sometimes need to be increased for good clinical cause. Documentation of the reason why an early refill was made needs to be logged into the record when possible. Sometimes such legitimate reasons arise when the doctor is away from the office, ill at home, or at night or on the weekend. Occasional slip ups to remember to log it in the chart the next working day are understandable. However, in none of Dr. Patel's 14 charts pulled for this investigation did I see an explanation for an early refill or for increasing dosages. Doing this is important for even non-controlled medicine, and more so for the semi-controlled amphetamines and benzodiazepines, and is extremely important for heavily controlled narcotics like Subutex and buprenorphine which are MUCH more addictive than amphetamines and benzos.
KBML Consultant opinion: Unacceptable clinical practice.

J D

Adequate to superior clinical record except for deficiencies of:
No mention I could find of a Kasper. No drug screen that I could find. No documentation of customary care of the patient Jan-April 2014. Specifically, progress (SOAP) notes from 2/2/14 to 4/28/14 were missing everything except vital signs and pill details.
KBML Consultant opinion: Unacceptable clinical practice.

K D

This patient's record started off superiorly. But then the chart details run afoul of HB1 regulations,; e.g., I could find no drug screens even though the patient is on narcotics. In March to the end of April one year, Dr. Patel authorized early refills with no documented reason for same, except for a patient penned note written after the KBML investigation commenced commending Dr. Patel (I think for the KBML). She was alleging that her pills had been stolen. The patient was filling prescriptions at two different drug stores. A violation that Dr. Patel either ignored or did not notice on his HB1 periodic reviews of Kaspers. Not surprising, as there was a single Kasper in the record and it was dated after, I think, the KBML investigation commenced, 4/29/14.

KBML Consultant opinion: Unacceptable clinical practice.

T D

This patient has a massive chart to review of (I estimate) greater than 500 pages (ugh).

The H&P is good. There is a photo ID. There are toxicology labs. There are HB1 contracts with patient. There are only two Kasper reports I found on 8/6/12 and one on 5/12/14(after the investigation of Dr. Patel started I think). This is a violation of HB1 to run a patient on controlled drugs from 4/2/12 until April 2014 with only one Kasper request. The majority of the progress notes are OK although there were some with only vital signs and pills.

I detected substandard prescribing of narcotics. For example, on a Kasper on Nov13,13 the patient filled a prescription for Suboxone for a dispensed amount sufficient for 38 days according to Kasper (I calculate to Dec 21, 2013). But only 13 days later, on 11/26/13, buprenorphine is prescribed too, which would, by itself, last 8 days per Kasper. This prescription was filled at a different drug store suspiciously. This goes on the rest of the calendar year There is no note explaining this prescribing pattern that I could find, but it is a 500+ page chart and is no particular order. This particular Kasper was from the KBML, not from Dr. Patel's chart copy. It was dated 5/12/14 and I gather that is after the investigation of Dr. Patel was underway.

KBML Consultant opinion: Unacceptable clinical practice.

S G

This was a patient on narcotics for back pain. Overall, Dr. Patel's management here was not up to the minimum standard of care. Deficient in: no H&P, only 1 or two drug screens (one was in chart and I found a second one filed in a different Dr. Patel patient [redacted] chart while reviewing that chart later.). There are only two Kaspers, both are dated after the KBML investigation started, I think 2014, May 9&14. HB1 regs. say Kaspers are to be checked contemporaneously with care, not just after the KBML investigates a complaint. No HB 1 drug contract was found. Progress notes are for the most part incomplete, usually with nothing except vital signs and pill details of name strength directions and quantity dispensed.
KBML Consultant opinion: Unacceptable clinical practice.

L H

I have never operated a Suboxone clinic; but, it was disturbing to me that Dr. Patel's first prescription for this patient was for Suboxone 8 mg three a day #90 according to the Kasper. This 24 mg is the maximum dose. If there was titration done, there is no documentation of such. Another place in his record suggest the direction of use was only 8mg per day. But that would make the dispensed amount a 90 day supply which I think would be an excessive number of pills for a narcotic addict to be given at a single visit. Either way it is improper in my opinion. The inadequate progress notes are merely vital signs and a list of pills.
KBML Consultant opinion: Unacceptable clinical practice.

L W-H

This record has no initial evaluation by Dr. Patel that I could find. There are multiple doctors prescribing controlled drugs and the patient is filling at multiple drug stores. There was an accidental not suicide overdose on narcotics I think before Dr. Patel started treating her. It was on Haloween, 2013. According to Kasper, on Valentines Day 2014 the patient filled a Dr. Patel prescription of a 30 day supply of Suboxone 8/2 to take ii/day. Only 3 days later he prescribed more buprenorphine, 8mg to take one a day another 30 day supply. So, at that point she still possessed about 27 days of her first narcotic prescription AND she has a thirty day bottle of more narcotic at the same time. Why? No notes to explain the dose increase are on file. Also patient changed drug stores to fill the double prescription for her 50% increase in dose without documented rationale. Nor is mention made of the fact that the patient was using multiple drug stores, which Dr. Patel is supposed to look for when reviewing Kasper reports periodically. No urine tox screens were seen as mandated by HB1.
KBML Consultant opinion: Unacceptable clinical practice.

K J

This patient was not a narcotic replacement case. She had post partum bipolar and ADHD. There is a fine H&P, a photo ID, a HB1 contract, and a very good progress note. Some progress notes were deficient as in other charts, consisting of only vital signs and a pills list. There was no Kasper and no labwork. Dr. Patel appears to do much better work when his patient is not a narcotic addict, but a general psychiatric case. But, unfortunately, in this case the lack of proper progress notes and lack of a Kasper is his downfall.
KBML Consultant opinion: Unacceptable clinical practice.

J L

This man was managed for narcotic problems. The chart was all jumbled up and out of order but that does not count in my opinion. The problem here is that there is no HB1 ordered Kasper report request in a patient being prescribed opiates.
KBML Consultant opinion: Unacceptable clinical practice.

L M

All was well with this case except Dr. Patel authorizing early refills with no documented justification. Progress notes were good except for one on 4/28/14 which lacked substance for SOA parts of SOAP. If Dr. Patel had documented a reasonable cause for authorizing early refills, this chart would pass. But he did not.
KBML Consultant opinion: Unacceptable clinical practice.

H W

Good chart except for no drug screens, no concurrent Kasper reports, No HB1 drug contract, poor progress notes – inadequate and too brief , just vital signs and pills.
KBML Consultant opinion: Unacceptable clinical practice.

That concludes my remarks on 14 individual patient chart reviews.
If failed to observe some part of a record that concerns you, please bring it to my attention.

Respectfully,

Stephen Cox MD

Stephen Michael Cox, M.D.
[redacted]

Aug 31, 2014

KBML Hurstbourne Office Park
310 Whittington Parkway 1B
Louisville KY 40222

RE: Sharad Patel, M.D.

Attn: Investigator Stephen Manley

Dear Investigator Manley:

This is my third letter to the Board regarding this physician. You have asked me this time to respond to Dr. Patel's comments related through his counsel Stites & Harbison in a letter dated Aug 5, 2014 to the KBML.

I will say at the beginning that the comments do not change my previously stated opinions which I based upon medical records the KBML sent to me.

Many of the counsel's explanations state facts that are not in the record. An example of this is the lengthily explanation of patient TD's history. Much of that is not in the record. If it were in the record, that might be different or might not. I am not in a position to take into consideration such information not in the record so far as I am to understand. That perogative is, as I understand it, up to the Board of Licensure, not up to me.

Two cases do need specific comment:

Patient WB

I am glad that Dr. Patel's attorney pointed this WB patient out to the KBML. Because of their comments, I requested the file again and I took a second look to see if I needed to correct myself.

Please examine the KASPER report attached which is copied from Dr. Patel's file on WB. It shows that Dr. Patel had this KASPER information when he prepared his justification for his prescribing subsequent to my consultation and to the investigator's feedback to Dr. Patel. The annotations on it are mine to help study it. Unless I am misreading the KASPER analysis shows that lorazepam (which is the "twin sister of Xanax") was filled illegally **too early 19 times** during the span from 6.22.2013 through 4.17.2014.

Sometimes we say that a prescription cannot be filled "because it is 3 days too early" or "is 2 days too early". Pharmacies won't fill prescriptions that they know are too early unless the physician authorizes it. In that sense, this patient filled their prescriptions an astounding **352 days too early** over this span of time. In fact, they filled their prescription less times legally than they filled it illegally. How many of those early refills were filled or not at Dr. Patel's insistence by telephone with the pharmacist I do not know. It is perplexing to me that the pharmacy(ies) filled so many early refills.

Pharmacies only filled prescriptions when due to be filled 21% of the time. According to my calculations from KASPER, they filled prescriptions only 5 times legally but 19 times illegally. 352 days of illegal "too early" refills for a medicine that, according to KASPER records, was to be taken three times a day puts 1,056 pills (puts 3 per day times 352 days) illegally into the hands of the patient which are unaccounted for. It is possible the patient was selling them on the street or taking more than prescribed. As I said in my original note on the case of WB, early refills are sometimes necessary. It should be documented in a chart that this was done and why. **But this level of early refills is egregious in my opinion based upon the records I was given.**
Please, check over my calculations and analysis to be sure I didn't slip up somehow. It seems unbelievable to me that there were such a large number of early refills. **One refill for the controlled drug, lorazepam, was filled on the same day as another refill for lorazepam.**

That brings me to a second point. WB was filling refills at multiple pharmacies, , a breach of HB1, which Dr. Patel has a responsibility to monitor and did not. The duplicate fill on same day at two different pharmacies suggests that the patient was clearly aware they were doing wrong and was attempting to get away with it.

Based upon this deeper look, my prior opinions are unchanged, I think that the degree of Dr. Patel's failure in the case of WB is more grave than I had opined. It would be worse if Dr. Patel actually knew the patient was doing this, but it is still disturbing if he did not know the patient was doing this when HB1 mandates that physicians watch for this kind of illegal action. This is one of those cases where, as they say, "he knew or should have known".

Patient SG

The counsel letter reply defends that, " The patient H&P was done .... and is in the EMR."

I scoured the chart that I was given on SG again and I see nothing of this. There are some self-administered "My Depression Quiz" forms. There is a self-administered intake form with medical and demographic information. I assume that they are not intimating that these scant bits constitute an adequate initial medical-psychiatric evaluation. Based on the file of SG that I have, I stand by my original comment of physician failure.

The changes Dr. Patel relates that he made late in the game and which he says he will do in the future are all nice and good, but numerous medical violations happened in this and other cases. I only render opinions on what took place from analysis of what the records I have be provided say happened. What mitigating circumstances are to be taken into consideration is not in my purview as a consultant. It is the function of the Medical Licensure Board to take what it deems proper into consideration in making their decisions, as I understand it.

Sincerely,

Stephen Cox MD
KBML consultant /Psychiatry

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 741

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, 1506 BRISTOL COURT, ELIZABETHTOWN, KENTUCKY 42701

FOURTH AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Sharad C. Patel, M.D., and, based upon the Panel's vote to grant the licensee's request to complete the objectives of the CPEP Education Plan independently, hereby ENTER INTO the following **FOURTH AMENDED AGREED ORDER:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Fourth Amended Agreed Order:

1. At all relevant times, Sharad C. Patel, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On March 8, 1999, the licensee filed with the Board an Amended Letter of Agreement, which he executed on March 5, 1999. Condition 1 of the Amended Letter of Agreement specified: "Physician shall fully maintain a contractual relationship with the Impaired Physician Committee and abide by all conditions placed upon him by the Impaired Physician Committee."
4. On March 16, the licensee verbally notified a Board Investigator that he desired to convert his license to inactive status and that he intended to discontinue his

relationship with the Kentucky Physicians Health Foundation ("the Foundation"). In a Memorandum to the Board's Inquiry Panel B, dated March 22, 2000, the investigator notified the Board of this information.

5. In a letter, dated March 17, 2000, Burns M. Brady, M.D., Foundation Medical Director, confirmed a telephone conversation he had with the licensee. In his letter, a copy of which was received by the Board on March 21, 2000, Dr. Brady stated, "As I understand it, you [the licensee] are not going to renew your Kentucky medical license at this time and would like to discontinue your relationship with [the Foundation]." Seeking confirmation of his understanding, Dr. Brady further stated in same: "I look forward to your response and if I have not heard from you within 14 days of your receipt of this letter, then I will assume this establishes for our records and for the Kentucky Board of Medical Licensure that you are discontinuing your relationship with this organization."
6. Given these circumstances, the Panel required the licensee to enter into an Agreed Order of Surrender, which he did and which was filed on June 9, 2000. He has not practiced medicine in the Commonwealth since that time.
7. At its July 2002 meeting, the Panel considered the licensee's request to resume the active practice of medicine. The Panel deferred any action until the licensee completed a clinical skills assessment at the Center for Personalized Education for Physicians (CPEP).
8. The licensee completed that assessment January 27-28, 2003. The Assessment Report included the following findings:

    A. Medical Knowledge

During this Assessment, Dr. Patel's medical knowledge was fairly broad but it lacked depth and was not current. He was aware of the general initial psychiatric assessment process including the mental status examination. However, he omitted important historical areas and lacked necessary details and clarity on the mental status exam. He was knowledgeable about substance abuse issues as well as pain management and psychiatric treatment in workman's compensation patients. He accurately assessed suicidal and homicidal risk. His level of knowledge of the civil commitment process was adequate, although it lacked detail. He demonstrated a general knowledge of anxiety, psychotic, and personality disorders but it lacked depth. Dr. Patel's diagnosis of mood disorders was unacceptable. His knowledge of psychotropic medications including antidepressants, antipsychotics, and mood stabilizers was incomplete and not current. His differential diagnosis did not always reflect the most likely possibilities. Dr. Patel was not well-versed in the DSM IV-R categories of the mood disorders. Dr. Patel's diagnostic and assessment skills lacked sufficient detail and completeness.

B. Clinical Reasoning

Overall, Dr. Patel's clinical reasoning was inconsistent. One consultant thought that, based on the few charts reviewed, Dr. Patel's clinical decision-making was adequate. Another consultant noted that Dr. Patel provided an adequate account of the issues from a drug overdose patient and a workman's compensation injury. Dr. Patel demonstrated flexibility in his ability to modify his management strategies based on changes in the patient's clinical course; however, his approach to pharmacology was more rigid.
Many of Dr. Patel's stated management strategies were reasonable; he did not apply these principles to the actual patient cases reviewed. This included use of mood stabilization in bipolar disorder and use of informed consent. He ordered laboratory tests and developed treatment plans that were not supported by the diagnostic possibilities. Dr. Patel's differential diagnosis did not always reflect the facts of the case. He occasionally assigned a diagnosis without sufficient clinical data, in contrary to the patient's clinical presentation, or without integrating important social issues. His follow-up recommendations did not always correlate with the clinical status and needs of the patient. Dr. Patel did not have an organized theory of psychopathology upon which to guide his prescription for non-pharmacologic-psychiatric treatments.

C. Communication

Dr. Patel's communication skills with the Simulated Patients were adequate but his skills were weak due to the time since he left practice. He demonstrated the core skills needed to be an effective communicator. He asked open-ended questions, listened without interruption, made effective use of summary statements, and had good eye contact. With practice his interactions became more conversational. His initial attempts at rapport were difficult but these improved over the course of the interview. He sometimes confused the patients by changing his line of questioning too quickly and without the use of transition statements. He did not provide patient education. His interactions with the peer consultants were acceptable.

D. Documentation

Dr. Patel's documentation skills were inadequate. His intake assessments were organized. His documentation of the mental status exams was acceptable. He provided a reasonable accounting of the patient's clinical progress. However, there was no documentation of medication side effects, reasons for psychotherapy or cognitive behavior therapy, or explanations for changes in medications. Dr. Patel did not document all patient encounters with an appropriate note. His management strategies were not consistently reflected in the chart. He did not record a formal diagnosis of PTSD in a patient he was treating for this disorder. He did not enumerate manic or depressive symptoms in a bipolar patient. He did not provide a clear plan of action in some cases. Comments about psychosocial issues were brief and general. The notes generated during the CPEP Assessment were unorganized and lacked any detail about his clinical thought processes. His treatment plans were vague.

CPEP recommended that Dr. Patel participate in structured, individualized Education Intervention to address the identified areas of need, and noted that such an intervention would likely require significant time and effort.

9. After reviewing the report, the Panel voted to defer action until Dr. Patel had obtained an Educational Plan from CPEP and presented it to the Panel for review. The licensee obtained an Educational Intervention Education Plan from CPEP in July 2006 and it was considered by the Panel at its October 19, 2006 meeting.

10. The parties entered into an Agreed Order of Indefinite Restriction on November 7, 2006. Conditions 2d and 2e of that Agreed Order provided,

> d. The licensee SHALL FULLY comply with the directives of Phase I of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Agreed Order of Indefinite Restriction. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase I of the Education Plan;
> e. The licensee SHALL NOT proceed to or perform any act under Phase II of the CPEP Education Plan, unless and until approved to do so by the Panel by Amended Agreed Order of Indefinite Restriction.

11. Both the licensee and CPEP have advised the Panel that, due to circumstances beyond the licensee's control, he has been unable to complete Phase I of the Education Plan, because of CPEP's lack of ability to properly evaluate the licensee's completion of that Phase. CPEP and the licensee have tried to develop an alternative means of evaluating the licensee's completion of Phase I. However, to date, they have been unable to implement an evaluation process which would provide CPEP with the level of assurance necessary to recommend his transition to Phase II of the Education Plan. Part of the difficulty in formulating and implementing an alternative evaluation process has been the perceived requirement to obtain the Panel's approval of a specific alternative Phase I evaluation process before it is implemented. In order to facilitate this process, the Panel has determined to delegate the authority to CPEP to develop and implement an alternative evaluation process for Phase I.

12. In their Point of Care Education and Evaluation Report for July 2009, CPEP reported,

Dr. Patel successfully completed this simulated patient exercise. CPEP recommends that he progress to Phase II of his Education Plan. Dr. Patel should notify CPEP of his intent to reactivate his Education Plan and engage in educational activities, starting with Phase II.
Dr. Patel will need to identify a qualified preceptor to work with him for the duration of Phase II. Because there has been a lengthy delay for Dr. Patel to begin Phase II of his Plan, it will be important that he participate in the educational activities in a timely manner. Therefore, if he has not already begun a preceptor search, Dr. Patel is encouraged to do so immediately. CPEP recommends that he submit the preceptor candidate's curriculum vitae within 15 days of reactivating his Plan (date to be determined). CPEP also recommends that Dr. Patel carefully review his Plan prior to initiating Phase II.

13. At the Panel's October 15, 2009 meeting, when they took up the licensee's request to modify his Amended Agreed Order of Indefinite Restriction, James. T. Jennings, M.D., Medical Director, Kentucky Physicians' Health Foundation, asked the Panel to consider terminating Condition 2h, based upon the length of the licensee's involvement with the Foundation and the primary focus of the present Amended Agreed Order.

14. Following his statement to CPEP staff that he would also like to pursue the possibility of practicing in an in-patient setting, CPEP conducted an Addendum Assessment on April 8-9, 2010. In their report, CPEP made the following findings and recommendations:

Medical Knowledge:

- Psychopharmacology: especially newer agents:
  - Available does forms and typical dosing of Depakote;
  - Dosing of Risperdal and Risperdal Consta;
  - Atypical antipsychotics:
    - Blackbox warning: risk of death in elderly patients treated with antipsychotics;
  - Familiarity with the use of drugs used to treat Alzheimer's dementia, such as acetylcholinesterase inhibitors;
  - Drug interactions: Depakote and Lamictal;
  - Risk of polycystic ovarian syndrome with Depakote;
  - Pregnancy categories: nomenclature;
- Bipolar disorder:

    - Treatment of psychotic mania;
    - Treatment of bipolar depression, including:
        - Treatment of refractory bipolar depression;
        - Knowledge of drugs to be avoided because they can destabilize the patient and lead to mania or a mixed state (stimulants, antidepressants);
- Full understanding of the risk factors for completed suicide;
- Obsessive-compulsive disorder:
    - Pharmacologic management: lack of effectiveness of benzodiazepines; options to augment SSRIs in treating OCD;
- Substance abuse:
    - Alcoholism:
        - Role of Antabuse;
        - Current perspectives on controlled drinking;
        - Disadvantages of benzodiazepines in the rehabilitating alcoholic (as opposed to in acute withdrawal);
    - Opioid abuse: advantages and disadvantages of the three main treatment options of Suboxone, methadone, and abstinence;
- Personality disorders:
    - General knowledge;
    - Narcissistic personality D/O: psychodynamic explanation;
    - Sociopathic personality disorder: psychodynamic underpinnings;
    - Borderline personality disorder: see psychotherapy, below;
- Psychotherapy:
    - OCD: fuller understanding of important components of the therapy;
    - Dialectical behavioral therapy for borderline personality disorder and chronic self-harm/mutilation;
- Reasons for self-mutilation in psychiatric patients;
- Procedures for administering involuntary medications;
- Electroconvulsive therapy: body of evidence indicating that ECT can lead to long-term retrograde memory loss;
- Obstructive sleep apnea: as a comorbidity, medical complications and risks.

Clinical Judgment and Reasoning:

- Balance between the role of testing (laboratory and psychological) and clinical assessment and judgment;
- Awareness and recognition of one's idiosyncratic approaches that are not supported by literature, with a goal to examine the evidence in those instances.

III. Implications for Education and Other Interventions

Based on the findings of the Second Assessment Addendum, the following educational recommendations should be completed if Dr. Patel includes inpatient care in his scope of practice:

- Point of Care Experience: Dr. Patel should participate in an inpatient clinical experience to provide the necessary supervision required as he addresses the areas of demonstrated need in inpatient psychiatry. The experience would be designed to allow appropriately graduated levels of independence.
  - Dr. Patel should initially have all cases reviewed with a preceptor prior to initiation of treatment;
  - He should practice in a setting where he would have the availability of immediate consultation with another attending on the inpatient psychiatric ward.

- Educational Preceptor: Dr. Patel should establish a relationship with an experienced educational preceptor in psychiatry, with experience in inpatient care. This involves regularly scheduled meetings to review cases and documentation, discuss decisions related to those cases, review specific topics, and make plans for future learning.

- Continuing Medical Education and Self-Study: Dr. Patel should engage in continuing medical education courses and self-study which include, but are not limited to, the topics indicated in areas of demonstrated need.

15. At the Board's request, CPEP staff also identified the following learning objectives of Phase II of the original Education Plan that still need to be addressed by the licensee:

LEARNING OBJECTIVES III – IV: INCOMPLETE ("I")

III. To improve clinical decision-making in the following areas:	I
1. Consistent application of medical knowledge;	I
2. Organized, detailed, comprehensive, and integrated approach to diagnostic evaluation that includes differential diagnoses;	I
3. Development of comprehensive and integrative treatment plans for an adequately wide range of psychiatric diagnoses; these plans should include documentation of the patient's progress;	I
4. Consideration of medication management options;	I

5. Application of psychopathology.	I

Preceptor Meetings and Chart Reviews – Not Initiated
For more information, see Education Plan.

IV: To improve patient care documentation, specifically:	I
1. Organized and complete chart components, including flow sheets;	I
2. Consistently organized, detailed and complete notes, that include but not limited to the following elements:	I
a. Presenting complaint;	I
b. Psychiatric history;	I
c. Family and social history;	I
d. Mental status exam;	I
e. Differential and final diagnoses;	I
f. Detailed treatment plans;	I
g. Patient/family education;	I
h. Consultant reports/communications;	I
i. Testing;	I
j. Detailed clinical reasoning;	I
3. Consistent documentation of all patient encounters.	I

Dr. Patel attended the *Patient Care Documentation Seminar (Seminar)* in December 2006, the AMD will monitor Dr. Patel's documentation to determine if he should attend the *Seminar* again, or if his educational needs would be sufficiently addressed if he enrolled in the follow-up component to the December 2006 *Seminar.*

V. To monitor physician-patient communications:	I
1. Effective core communication skills.	I

Dr. Patel completed reading The Medical Interview as recommended in his Education Plan. This objective should be addressed with the Preceptor during Phase II.

VI. To determine a plan to maintain current standards within the field of psychiatry.	I

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Fourth Amended Agreed Order:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, there were legal grounds for the Board to impose disciplinary sanctions against his license pursuant to KRS 311.595(13).

The Board did so by requiring the licensee to enter into the Agreed Order of Surrender. The legal grounds supporting the Agreed Order of Surrender extend to this Fourth Amended Agreed Order. Accordingly, there is a legal basis for this Fourth Amended Agreed Order.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully address legal issues, such as the licensee's return to active practice following a period of surrender, by entering into an agreed resolution such as this Fourth Amended Agreed Order.

FOURTH AMENDED AGREED ORDER

Based upon the Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the Panel's vote to grant the licensee's request to permit him to complete the objectives of the CPEP Education Plan independently, the parties hereby ENTER INTO the following **FOURTH AMENDED AGREED ORDER:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Sharad C. Patel, M.D., remains RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, with that period continuing immediately upon the filing of this Fourth Amended Agreed Order and continuing until further Order of the Panel;
2. During the effective period of this Fourth Amended Agreed Order, the licensee's Kentucky medical license SHALL BE RESTRICTED/LIMITED by the following terms and conditions:
    a. The licensee may resume the practice of medicine, but only as specified in the following terms and conditions;

b. The licensee SHALL NOT perform any act which would constitute the "practice of medicine," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities – unless and until the Panel or its Chair has approved, in writing, a preceptor to work with the licensee in fulfilling the objectives of the CPEP Education Plan. The decision whether to approve a particular preceptor lies in the sole discretion of the Panel or its Chair. The Panel has approved Stephen B. Lamb, M.D., Lexington, Kentucky, as the licensee's preceptor.

c. The licensee shall not change preceptors without first obtaining written approval by the Panel or its Chair for such change. The parties agree that the Panel or its Chair may require additional conditions and/or restrictions as a condition of it granting approval for a new preceptor.

d. The licensee SHALL provide any approved Preceptor with a copy of this Fourth Amended Agreed Order before beginning a professional relationship with the Preceptor.

e. If the licensee does not identify a preceptor that is approved by the Panel Chair within three (3) months of the date of filing of this Fourth Amended Agreed Order, this case will be re-presented to the Panel for further action and direction.

f. During the periods that the licensee is practicing with an approved preceptor, the licensee SHALL meet with the approved preceptor at least

once every two weeks to address his completion of the objectives of the CPEP Education Plan. The licensee SHALL take all necessary steps to ensure that the approved preceptor provides the Board's staff with written reports, once every three months, detailing the licensee's completion of the objectives of the CPEP Education Plan and his competence to practice his specialty safely and competently.

g. The licensee SHALL SUCCESSFULLY become re-certified by the American Board of Psychiatry and Neurology within two calendar years of the date of filing of this Fourth Amended Agreed Order.

h. The licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. Any such medical treatment and prescribing shall be reported directly to the Board in writing by the treating physician within ten (10) days after the date of treatment. The licensee must inform the treating physician of this responsibility and ensure timely compliance. Failure to inform the treating physician of this responsibility shall be considered a violation of this Fourth Amended Agreed Order;

i. The licensee shall be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, the purpose being to ensure that the licensee remains drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug analyses and reports will be borne by licensee, which costs shall be paid

under the terms fixed by the Board's agent for testing. Failure to make timely payment of such costs, to provide a specimen upon request, or to remain alcohol and/or drug-free shall be considered a violation of this Fourth Amended Agreed Order;

j. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Fourth Amended Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Fourth Amended Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Fourth Amended Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Fourth Amended Agreed Order.

4. The licensee understands and agrees that any violation of the terms of this Fourth Amended Agreed Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13).

SO AGREED on this 26 day of April, 2010.

FOR THE LICENSEE:

SHARAD C. PATEL, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY PANEL B

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 741

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, 1506 BRISTOL COURT, ELIZABETHTOWN, KENTUCKY 42701

THIRD AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Sharad C. Patel, M.D., and, in order to clarify that the licensee is not required to have complete supervision during Phase II of his Education Plan, hereby ENTER INTO the following **THIRD AMENDED AGREED ORDER:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Third Amended Agreed Order:

1. At all relevant times, Sharad C. Patel, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On March 8, 1999, the licensee filed with the Board an Amended Letter of Agreement, which he executed on March 5, 1999. Condition 1 of the Amended Letter of Agreement specified: "Physician shall fully maintain a contractual relationship with the Impaired Physician Committee and abide by all conditions placed upon him by the Impaired Physician Committee."
4. On March 16, the licensee verbally notified a Board Investigator that he desired to convert his license to inactive status and that he intended to discontinue his

relationship with the Kentucky Physicians Health Foundation ("the Foundation"). In a Memorandum to the Board's Inquiry Panel B, dated March 22, 2000, the investigator notified the Board of this information.

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6. Given these circumstances, the Panel required the licensee to enter into an Agreed Order of Surrender, which he did and which was filed on June 9, 2000. He has not practiced medicine in the Commonwealth since that time.
7. At its July 2002 meeting, the Panel considered the licensee's request to resume the active practice of medicine. The Panel deferred any action until the licensee completed a clinical skills assessment at the Center for Personalized Education for Physicians (CPEP).
8. The licensee completed that assessment January 27-28, 2003. The Assessment Report included the following findings:

    A. Medical Knowledge

During this Assessment, Dr. Patel's medical knowledge was fairly broad but it lacked depth and was not current. He was aware of the general initial psychiatric assessment process including the mental status examination. However, he omitted important historical areas and lacked necessary details and clarity on the mental status exam. He was knowledgeable about substance abuse issues as well as pain management and psychiatric treatment in workman's compensation patients. He accurately assessed suicidal and homicidal risk. His level of knowledge of the civil commitment process was adequate, although it lacked detail. He demonstrated a general knowledge of anxiety, psychotic, and personality disorders but it lacked depth. Dr. Patel's diagnosis of mood disorders was unacceptable. His knowledge of psychotropic medications including antidepressants, antipsychotics, and mood stabilizers was incomplete and not current. His differential diagnosis did not always reflect the most likely possibilities. Dr. Patel was not well-versed in the DSM IV-R categories of the mood disorders. Dr. Patel's diagnostic and assessment skills lacked sufficient detail and completeness.

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Many of Dr. Patel's stated management strategies were reasonable; he did not apply these principles to the actual patient cases reviewed. This included use of mood stabilization in bipolar disorder and use of informed consent. He ordered laboratory tests and developed treatment plans that were not supported by the diagnostic possibilities. Dr. Patel's differential diagnosis did not always reflect the facts of the case. He occasionally assigned a diagnosis without sufficient clinical data, in contrary to the patient's clinical presentation, or without integrating important social issues. His follow-up recommendations did not always correlate with the clinical status and needs of the patient. Dr. Patel did not have an organized theory of psychopathology upon which to guide his prescription for non-pharmacologic-psychiatric treatments.

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9. After reviewing the report, the Panel voted to defer action until Dr. Patel had obtained an Educational Plan from CPEP and presented it to the Panel for review. The licensee obtained an Educational Intervention Education Plan from CPEP in July 2006 and it was considered by the Panel at its October 19, 2006 meeting.

10. The parties entered into an Agreed Order of Indefinite Restriction on November 7, 2006. Conditions 2d and 2e of that Agreed Order provided,

> d. The licensee SHALL FULLY comply with the directives of Phase I of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Agreed Order of Indefinite Restriction. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase I of the Education Plan;
> e. The licensee SHALL NOT proceed to or perform any act under Phase II of the CPEP Education Plan, unless and until approved to do so by the Panel by Amended Agreed Order of Indefinite Restriction.

11. Both the licensee and CPEP have advised the Panel that, due to circumstances beyond the licensee's control, he has been unable to complete Phase I of the Education Plan, because of CPEP's lack of ability to properly evaluate the licensee's completion of that Phase. CPEP and the licensee have tried to develop an alternative means of evaluating the licensee's completion of Phase I. However, to date, they have been unable to implement an evaluation process which would provide CPEP with the level of assurance necessary to recommend his transition to Phase II of the Education Plan. Part of the difficulty in formulating and implementing an alternative evaluation process has been the perceived requirement to obtain the Panel's approval of a specific alternative Phase I evaluation process before it is implemented. In order to facilitate this process, the Panel has determined to delegate the authority to CPEP to develop and implement an alternative evaluation process for Phase I.

12. In their Point of Care Education and Evaluation Report for July 2009, CPEP reported,

Dr. Patel successfully completed this simulated patient exercise. CPEP recommends that he progress to Phase II of his Education Plan. Dr. Patel should notify CPEP of his intent to reactivate his Education Plan and engage in educational activities, starting with Phase II.
Dr. Patel will need to identify a qualified preceptor to work with him for the duration of Phase II. Because there has been a lengthy delay for Dr. Patel to begin Phase II of his Plan, it will be important that he participate in the educational activities in a timely manner. Therefore, if he has not already begun a preceptor search, Dr. Patel is encouraged to do so immediately. CPEP recommends that he submit the preceptor candidate's curriculum vitae within 15 days of reactivating his Plan (date to be determined). CPEP also recommends that Dr. Patel carefully review his Plan prior to initiating Phase II.

13. At the Panel's October 15, 2009 meeting, when they took up the licensee's request to modify his Amended Agreed Order of Indefinite Restriction, James. T. Jennings, M.D., Medical Director, Kentucky Physicians' Health Foundation, asked the Panel to consider terminating Condition 2h, based upon the length of the licensee's involvement with the Foundation and the primary focus of the present Amended Agreed Order.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Third Amended Agreed Order:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, there were legal grounds for the Board to impose disciplinary sanctions against his license pursuant to KRS 311.595(13). The Board did so by requiring the licensee to enter into the Agreed Order of Surrender. The legal grounds supporting the Agreed Order of Surrender extend to this Third Amended Agreed Order. Accordingly, there is a legal basis for this Third Amended Agreed Order.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully address legal issues, such as the licensee's return to active practice following a period of surrender, by entering into an agreed resolution such as this Third Amended Agreed Order.

THIRD AMENDED AGREED ORDER

Based upon the Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the Panel's vote to grant the licensee's request to modify the Amended Agreed Order of Indefinite Restriction the parties hereby ENTER INTO the following **THIRD AMENDED AGREED ORDER:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Sharad C. Patel, M.D., remains SUBJECT TO THE FOLLOWING CONDITIONS FOR AN INDEFINITE PERIOD OF TIME, with that period continuing immediately upon the filing of this Third Amended Agreed Order and continuing until further Order of the Panel;
2. During the effective period of this Agreed Order, the licensee's Kentucky medical license SHALL BE SUBJECT TO the following terms and conditions:
    a. The licensee may resume the practice of medicine, but only as specified in the following terms and conditions;
    b. The licensee MAY PROCEED WITH AND SHALL FULLY comply with the directives of Phase II of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Second Amended Agreed Order. The licensee may only perform those acts and procedures specifically detailed in Phase II of the Education Plan;

c. The licensee SHALL successfully complete Phase II of the CPEP Education Plan, at his expense and at the direction of CPEP staff;

d. The licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. Any such medical treatment and prescribing shall be reported directly to the Board in writing by the treating physician within ten (10) days after the date of treatment. The licensee must inform the treating physician of this responsibility and ensure timely compliance. Failure to inform the treating physician of this responsibility shall be considered a violation of this Third Amended Agreed Order;

e. The licensee shall be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, the purpose being to ensure that the licensee remains drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug analyses and reports will be borne by licensee, which costs shall be paid under the terms fixed by the Board's agent for testing. Failure to make timely payment of such costs, to provide a specimen upon request, or to remain alcohol and/or drug-free shall be considered a violation of this Third Amended Agreed Order;

f. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Third Amended Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Third Amended Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Third Amended Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Third Amended Agreed Order.

4. The licensee understands and agrees that any violation of the terms of this Third Amended Agreed Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13).

SO AGREED on this 10 day of December, 2009.

FOR THE LICENSEE:

SHARAD C. PATEL, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY B

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
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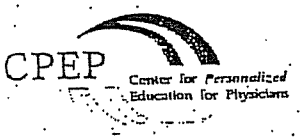

EDUCATIONAL INTERVENTION

EDUCATION PLAN

Developed July 2006

for

Shared Patel , M.D.

I. INTRODUCTION

This Education Plan was developed based upon areas of need identified in CPEP's Assessment of Shared Patel, M.D., conducted in January 2003 and Assessment Addendum (Addendum) in March 2006, data gathered by CPEP and information obtained from the Kentucky Board of Medical Licensure (Board). The areas of educational need identified in the Assessment and the Addendum have been addressed in the objectives of this Education Plan (Plan). Progress Reports will be generated approximately every trimester and provided to the participant and to other entities for which we have authorization.

PURPOSE

The purpose of this Education Plan is to provide a framework in which Dr. Patel can address educational needs that will ultimately improve his delivery of patient care. Plans are created with the understanding that as the physician's capabilities and/or needs change within the parameters of the practice for which this Plan was developed, the educational focus areas may change accordingly.

The goal of CPEP and this Plan is to provide the participant with the tools and support for a meaningful educational experience that includes:

- Addressing individual, identified educational needs;
- Encouraging life-long, independent learning;
- Providing long-term educational benefits that will enhance quality patient care;
- Achieving successful completion of the Plan and the Post-Education Evaluation within the estimated timeframes defined in the Plan.

Participant strategies to support successful completion of the Educational Intervention include the following:

- Being an active partner in learning;
- Actively integrating feedback and new knowledge into daily practice;
- Submitting educational materials and charts as requested in the Plan;
- Adhering to timeframes and due dates as outlined in the Plan;
- Participating in regularly scheduled communications with CPEP.

PHYSICIAN BACKGROUND

Dr. Patel ceased practicing psychiatric medicine in March 2000. He participated in the Assessment process in January 2003. In December 2005, Dr. Patel contacted CPEP to enroll in an Educational Intervention. Since it had been three years since Dr. Patel 's initial CPEP Assessment, CPEP required Dr. Patel to undergo an Assessment Addendum in order to evaluate his current educational needs. The findings of this Addendum were considered in conjunction with the findings of the January 2003 Assessment in the development of this Plan.

II. PRACTICE PROFILE

Dr. Patel provided the following practice profile information to CPEP in July 2006. His perspective practice is yet to be determined, however he reported to CPEP that he will practice adult outpatient psychiatry only. Updates will be obtained from Dr. Patel and reflected in each Progress Report.

Specialty

Psychiatry

Licensure

Licensing State	Status
Kentucky	Inactive

Practice

Years/Description/Location

1980-85; Clinical Director, Comp Care Center; Elizabethtown, KY
1980-1994; 1995-2000 Private practice; Elizabethtown, KY

Active Hospital Privileges

Name/Location	# of Beds	Trauma Level	ICU
TBD			

Current Practice Profile

Volume of patients per day: TBD
Number of days worked per week: TBD
Number of patients admitted per month: TBD
Census of inpatients maintained per month: TBD
Number of days on-call per month: TBD

Commonly Encountered Diagnoses

TBD

Continuing Education

Dr. Patel has not participated in formal continuing medical education in the last five years.

III. REQUIREMENTS

PRACTICE SUPERVISOR AND EDUCATIONAL PRECEPTOR

To participate in the Educational Intervention, Dr. Patel will need to identify a board-certified psychiatrist for the roles of the Supervisor and Preceptor. The Supervisor and Preceptor can be the same individual. The Supervisor should ensure that current evidence-based medical knowledge, skills, and information are addressed. Dr. Patel will provide a copy of the Plan to the proposed Supervisor and/or Preceptor and submit the proposed Supervisor/Preceptor name(s) and resume(s) to CPEP for approval no later than

30 days following the implementation of this Plan. The complete Supervisor and Preceptor Job Descriptions are included with this Plan.

Note:

- CPEP must approve the Supervisor prior to initiating Phase I.
- The Preceptor must be approved prior to initiating Preceptor meetings to ensure that the meetings are applicable to the Plan.

MEDICAL LICENSE

Dr. Patel will need a medical license in order to participate in and complete this Plan. Some educational activities may be completed without a license.

IV. EDUCATIONAL INTERVENTION

This Plan was designed to address adult psychiatric outpatient care. If Dr. Patel 's goals for his anticipated practice change, CPEP may not be able to provide a learning experience to address such changes within the framework of this Plan. Should Dr. Patel independently address issues outside of the Plan, CPEP would be unable to monitor or comment on the experience. It may be possible for CPEP to provide additional assessment that would serve as a foundation for a Supplemental Education Plan.

PHASE I

Phase I is estimated to last between one and two months.

Because of a six-year absence, CPEP recommends that Dr. Patel only see patients with 100% supervision during Phase I. The Supervisor will be present for the entirety of all patient encounters during this period. The volume of daily patient encounters should be restricted so that appropriate and thorough discussion and review occurs immediately after each patient encounter. CPEP recommends a maximum daily patient volume of four.

PERFORMANCE OBJECTIVES

A. Observation of Patient Encounters.

During this experience, Dr. Patel will:

1) Observe the Supervisor for a minimum of 35 encounters in the outpatient setting. For each of the following presenting complaints, he will observe a minimum of two patients: dementia; anxiety; mood disorder; and psychotic and personality disorders. Other patients observed should comprise a variety of diagnoses similar to those Dr. Patel anticipates encountering in his practice. *At the discretion of his Supervisor and the CPEP Associate Medical Director, Dr. Patel may be required to observe more than 35 patient encounters;*

2) Review each case with the Supervisor after each patient encounter. As much as patient diagnoses permit, discussions should focus on content areas identified in Objective I below;
3) Using the Supervised Experience Education Log provided by CPEP, document the diagnosis, treatment, plan, and date of each case, and submit the log to CPEP. The Supervisor will sign the log prior to submission;

B. Supervised Patient Encounters

With the Supervisor in attendance and with direct Supervisor oversight, Dr. Patel will:

1) Interview and examine no fewer than 40 patients in the outpatient setting. For each of the following presenting complaints, he will see a minimum of two patients: dementia; anxiety; mood disorder; and psychotic and personality disorders. Other patients observed should comprise a variety of diagnoses similar to those Dr. Patel anticipates encountering in his practice. *At the discretion of his Supervisor and the CPEP Associate Medical Director, Dr. Patel may be required to see more than 40 patient encounters;*
2) Review his evaluation and plan for patients with the Supervisor prior to completing the patient encounter. As much as patient diagnoses permit, discussions should focus on content areas identified in Objective II below;
3) Write or dictate a simulated note as if he were the primary physician;
4) Have each simulated note reviewed for completeness and overall quality by the Supervisor after each patient encounter. As indicated, discussion regarding documentation should focus on content areas identified in Objective III below;
5) Using the Supervised Experience Log provided by CPEP, document the diagnosis, treatment, plan, and date of each case, and submit the log to CPEP. The Supervisor will sign the log prior to submission.

EVALUATION METHODS

1) As Dr. Patel nears completion of Part A of Phase I, he or his Supervisor should contact CPEP to schedule a telephone conference between the Supervisor and the Associate Medical Director;
2) Upon completion of all Parts of Phase I, the Supervisor and the Associate Medical Director will determine Dr. Patel 's readiness to advance to Phase II. He or his Supervisor should contact CPEP to schedule a telephone conference between the Supervisor and the Associate Medical Director.

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PHASE II

Dr. Patel will transition to a practice-based educational experience after successful completion of Phase I. On-site supervision is no longer required. This experience is estimated to last 10 months. If practicing in Phase I at the Supervisor's practice, Dr. Patel may now transition to independent practice. Dr. Patel will work with the Preceptor to continue addressing the needs identified in the Learning Objectives listed below. If the Preceptor candidate has not been approved at the completion of Phase I, Dr. Patel should continue with self-study activities. Preceptor meetings should be scheduled once CPEP has notified Dr. Patel that the Preceptor candidate has been approved.

LEARNING OBJECTIVES

I. **To improve psychiatric evidence-based medical knowledge, including but not limited to the following:**
   1) Elements of a comprehensive and detailed initial psychiatric assessment, including but not limited to, patient history, family history, and mental status exam;
   2) Algorithms for formulating differential diagnoses;
   3) Symptoms associated with and current management approaches for common psychiatric disorders, including but not limited to the following disorders:
      a) anxiety;
      b) mood (including bipolar disorder);
      c) psychotic;
      d) personality;
      e) post-traumatic stress;
      f) obsessive-compulsive;
      g) dementia;
   4) Non-pharmacologic therapy, including but not limited to, cognitive behavioral therapy;
   5) Legal dimensions of psychiatric practice;
   6) Indicators of substance abuse;
   7) Ability to discern the severity of disorders for appropriate management;
   8) Appropriate testing that is consistent with and supported by the patient's symptoms;
   9) Ability to identify changes in patient behavior and manage accordingly.

II. **To improve knowledge of current pharmacologic therapy that includes but is not limited to the following, especially as related to the disorders identified above:**
   1) Side effects;
   2) Drug-drug interactions;
   3) Dosing.

III. **To improve clinical decision-making in the following areas:**
1) Consistent application of medical knowledge;
2) Organized, detailed, comprehensive, and integrated approach to diagnostic evaluation that includes differential diagnoses;
3) Development of comprehensive and integrative treatment plans for an adequately wide range of psychiatric diagnoses; these plans should include documentation of the patient's progress;
4) Consideration of medication management options;
5) Application of psychopathology.

IV. **To improve patient care documentation, specifically:**
1) Organized and complete chart components, including flow sheets;
2) Consistently organized, detailed and complete notes, that include but not limited to the following elements:
   a) Presenting complaint;
   b) Psychiatric history;
   c) Family and social history;
   d) Mental status exam;
   e) Differential and final diagnoses;
   f) Detailed treatment plans;
   g) Patient/family education;
   h) Consultant reports/communications;
   i) Testing;
   j) Detailed clinical reasoning;
3) Consistent documentation of all patient encounters.

V. **To monitor physician-patient communication:**
1) Effective core communication skills.

VI. **To determine a plan to maintain current standards within the field of psychiatry.**

VI. PERFORMANCE OBJECTIVES and EVALUATION METHODS

Refer to Appendix A for further directions.

PERFORMANCE OBJECTIVES

Dr. Patel will complete the following specified Objectives:

A. Knowledge (Learning Objective I)
1) For each Objective I content area, including subtopics:
   a) Review two current, reputable medical references explicitly relevant to the content area. If assigned a specific guideline for a content area (see below), it can be utilized as one of the references;

b) Submit a brief paragraph, outline or algorithm explaining the applicability of knowledge gained from his reading to his current practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale. Include reference titles and dates of publication;

2) Subscribe to *Focus: The Journal of Lifelong Learning in Psychiatry and the Focus Self Assessment Examination*. The subscription should include the "Influential Papers." Dr. Patel should participate in ongoing reading and assessment. More information can be found at the following web site: http://www.psych.org/edu/cme/selfassess_exam/saexam.cfm. If Dr. Patel identifies an alternative course, the Associate Medical Director must approve the course;

3) Review guidelines/references relevant to diagnosis and treatment of common psychiatric disorders. CPEP recommends the following Internet sites as resources: http://www.guideline.gov and http://www.psych.org;

4) Dr. Patel will participate in Grand Rounds as scheduled at a nearby facility if available.

B. Clinical Decision Making

1) Obtain and utilize the most current publication of the DSM IV-R to assist in developing a more structured and comprehensive approach to the differential diagnosis of patient complaints.

C. Communication

1) Read The Medical Interview by John L., M.D. Coulehan, Marian R., M.D. Block;

2) CPEP will determine if Dr. Patel would benefit from further educational intervention;

3) Discuss with the Supervisor and Preceptor during Phase I and II.

D. Documentation

1) Independently review documentation and medical record keeping;

2) Attend a documentation seminar, with a follow-up component. The follow-up component must consist of at least two chart reviews, preferably three. A course brochure should be submitted for the Associate Medical Director's approval within 30 days of signing the Plan. A certificate of attendance should be submitted to CPEP upon completion;

3) Integrate feedback from the CPEP Associate Medical Director and the Preceptor promptly.

E. Preceptor Meetings and Chart Reviews

1) Address the Objective I content areas with the Preceptor through didactic exercises, as well as case-based and hypothetical discussions;

2) Meet with the Preceptor weekly for a period of time to be determined by the Associate Medical Director and then twice monthly for the duration of the Plan;
3) Provide 16 redacted charts per month (four charts per weekly session and eight charts per twice monthly sessions), for the duration of Phase II for review with the Preceptor. Dr. Patel will submit these charts to the Preceptor prior to their scheduled meeting to allow the Preceptor time for review. As much as possible, the charts selected should be relevant to the content areas of the Plan;
4) Charts should generate discussions addressing medical knowledge, application of medical knowledge to patient care, clinical judgment, and documentation;
5) Submit to CPEP, every other month, four of the 16 redacted charts used in the Preceptor meetings for review by the Associate Medical Director;
6) Discuss his plan for ongoing professional development with the Preceptor.

F. Submission Requirements:
See Appendix A for timelines.
1) Maintain an Education and/or Supervisor Log, documenting all educational activities, including topics discussed with the Preceptor, and submit to CPEP;
2) Submit practice application materials for Objective I to CPEP;
3) Submit title, resource and date of publication, or first page of article, for all assigned guidelines for Objective I to CPEP;
4) Submit a certificate of completion and/or monthly participation in *Focus: The Journal of Lifelong Learning in Psychiatry and the Focus Self Assessment Examination*, or other approved course;
5) Develop a plan for ongoing professional development in psychiatry and submit it to CPEP.

EVALUATION METHODS

A. The Preceptor will:
1) Provide feedback to Dr. Patel on medical knowledge, application of knowledge, clinical judgment, communication and documentation at the time of their meetings;
2) Provide monthly written and scheduled verbal feedback on Dr. Patel 's progress for the duration of the Plan, or as applicable.

B. The Associate Medical Director will:
1) Review and approve the required submissions to CPEP, and provide feedback to Dr. Patel , with regard to medical knowledge, application of medical knowledge, clinical judgment, documentation, and other identified areas, during regularly scheduled telephone conversations;
2) Monitor Dr. Patel 's documentation and overall progress;

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3) Review and approve Dr. Patel 's plan for ongoing professional development;
4) Provide a written progress report approximately every trimester.

ESTIMATED DURATION

The duration of the Education Plan can only be estimated. CPEP anticipates that this Educational Intervention will last approximately 12 months. It may be extended or shortened at the discretion of CPEP depending on progress towards meeting the stated educational goals. If new education needs are uncovered during the course of this Plan, these will be addressed accordingly.

REASSESSMENT

Dr. Patel will return to CPEP within two to six months following the completion of the Education Plan for a Post-Education Evaluation that addresses the content of the Plan.

DISCLAIMER

CPEP reserves the right to change the content and/or duration of the Education Plan.

SIGNATURES

Shared Patel , M.D. — Date: 8/13/06

Nancy Wilson-Ashbach, M.D.
Associate Medical Director — Date

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Supervisor/Preceptor candidates.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 741

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, 1506 BRISTOL COURT, ELIZABETHTOWN, KENTUCKY 42701

SECOND AMENDED AGREED ORDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Sharad C. Patel, M.D., and, based upon the Panel's vote to grant the licensee's request to modify his Amended Agreed Order of Indefinite Restriction, hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Second Amended Agreed Order:

1. At all relevant times, Sharad C. Patel, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On March 8, 1999, the licensee filed with the Board an Amended Letter of Agreement, which he executed on March 5, 1999. Condition 1 of the Amended Letter of Agreement specified: "Physician shall fully maintain a contractual relationship with the Impaired Physician Committee and abide by all conditions placed upon him by the Impaired Physician Committee."
4. On March 16, the licensee verbally notified a Board Investigator that he desired to convert his license to inactive status and that he intended to discontinue his

relationship with the Kentucky Physicians Health Foundation ("the Foundation"). In a Memorandum to the Board's Inquiry Panel B, dated March 22, 2000, the investigator notified the Board of this information.

5. In a letter, dated March 17, 2000, Burns M. Brady, M.D., Foundation Medical Director, confirmed a telephone conversation he had with the licensee. In his letter, a copy of which was received by the Board on March 21, 2000, Dr. Brady stated, "As I understand it, you [the licensee] are not going to renew your Kentucky medical license at this time and would like to discontinue your relationship with [the Foundation]." Seeking confirmation of his understanding, Dr. Brady further stated in same: "I look forward to your response and if I have not heard from you within 14 days of your receipt of this letter, then I will assume this establishes for our records and for the Kentucky Board of Medical Licensure that you are discontinuing your relationship with this organization."
6. Given these circumstances, the Panel required the licensee to enter into an Agreed Order of Surrender, which he did and which was filed on June 9, 2000. He has not practiced medicine in the Commonwealth since that time.
7. At its July 2002 meeting, the Panel considered the licensee's request to resume the active practice of medicine. The Panel deferred any action until the licensee completed a clinical skills assessment at the Center for Personalized Education for Physicians (CPEP).
8. The licensee completed that assessment January 27-28, 2003. The Assessment Report included the following findings:

    A. Medical Knowledge

During this Assessment, Dr. Patel's medical knowledge was fairly broad but it lacked depth and was not current. He was aware of the general initial psychiatric assessment process including the mental status examination. However, he omitted important historical areas and lacked necessary details and clarity on the mental status exam. He was knowledgeable about substance abuse issues as well as pain management and psychiatric treatment in workman's compensation patients. He accurately assessed suicidal and homicidal risk. His level of knowledge of the civil commitment process was adequate, although it lacked detail. He demonstrated a general knowledge of anxiety, psychotic, and personality disorders but it lacked depth. Dr. Patel's diagnosis of mood disorders was unacceptable. His knowledge of psychotropic medications including antidepressants, antipsychotics, and mood stabilizers was incomplete and not current. His differential diagnosis did not always reflect the most likely possibilities. Dr. Patel was not well-versed in the DSM IV-R categories of the mood disorders. Dr. Patel's diagnostic and assessment skills lacked sufficient detail and completeness.

B. Clinical Reasoning

Overall, Dr. Patel's clinical reasoning was inconsistent. One consultant thought that, based on the few charts reviewed, Dr. Patel's clinical decision-making was adequate. Another consultant noted that Dr. Patel provided an adequate account of the issues from a drug overdose patient and a workman's compensation injury. Dr. Patel demonstrated flexibility in his ability to modify his management strategies based on changes in the patient's clinical course; however, his approach to pharmacology was more rigid.
Many of Dr. Patel's stated management strategies were reasonable; he did not apply these principles to the actual patient cases reviewed. This included use of mood stabilization in bipolar disorder and use of informed consent. He ordered laboratory tests and developed treatment plans that were not supported by the diagnostic possibilities. Dr. Patel's differential diagnosis did not always reflect the facts of the case. He occasionally assigned a diagnosis without sufficient clinical data, in contrary to the patient's clinical presentation, or without integrating important social issues. His follow-up recommendations did not always correlate with the clinical status and needs of the patient. Dr. Patel did not have an organized theory of psychopathology upon which to guide his prescription for non-pharmacologic-psychiatric treatments.

C. Communication

Dr. Patel's communication skills with the Simulated Patients were adequate but his skills were weak due to the time since he left practice. He demonstrated the core skills needed to be an effective communicator. He asked open-ended questions, listened without interruption, made effective use of summary statements, and had good eye contact. With practice his interactions became more conversational. His initial attempts at rapport were difficult but these improved over the course of the interview. He sometimes confused the patients by changing his line of questioning too quickly and without the use of transition statements. He did not provide patient education. His interactions with the peer consultants were acceptable.

D. Documentation

Dr. Patel's documentation skills were inadequate. His intake assessments were organized. His documentation of the mental status exams was acceptable. He provided a reasonable accounting of the patient's clinical progress. However, there was no documentation of medication side effects, reasons for psychotherapy or cognitive behavior therapy, or explanations for changes in medications. Dr. Patel did not document all patient encounters with an appropriate note. His management strategies were not consistently reflected in the chart. He did not record a formal diagnosis of PTSD in a patient he was treating for this disorder. He did not enumerate manic or depressive symptoms in a bipolar patient. He did not provide a clear plan of action in some cases. Comments about psychosocial issues were brief and general. The notes generated during the CPEP Assessment were unorganized and lacked any detail about his clinical thought processes. His treatment plans were vague.

CPEP recommended that Dr. Patel participate in structured, individualized Education Intervention to address the identified areas of need, and noted that such an intervention would likely require significant time and effort.

9. After reviewing the report, the Panel voted to defer action until Dr. Patel had obtained an Educational Plan from CPEP and presented it to the Panel for review. The licensee obtained an Educational Intervention Education Plan from CPEP in July 2006 and it was considered by the Panel at its October 19, 2006 meeting.

10. The parties entered into an Agreed Order of Indefinite Restriction on November 7, 2006. Conditions 2d and 2e of that Agreed Order provided,

> d. The licensee SHALL FULLY comply with the directives of Phase I of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Agreed Order of Indefinite Restriction. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase I of the Education Plan;
> e. The licensee SHALL NOT proceed to or perform any act under Phase II of the CPEP Education Plan, unless and until approved to do so by the Panel by Amended Agreed Order of Indefinite Restriction.

11. Both the licensee and CPEP have advised the Panel that, due to circumstances beyond the licensee's control, he has been unable to complete Phase I of the Education Plan, because of CPEP's lack of ability to properly evaluate the licensee's completion of that Phase. CPEP and the licensee have tried to develop an alternative means of evaluating the licensee's completion of Phase I. However, to date, they have been unable to implement an evaluation process which would provide CPEP with the level of assurance necessary to recommend his transition to Phase II of the Education Plan. Part of the difficulty in formulating and implementing an alternative evaluation process has been the perceived requirement to obtain the Panel's approval of a specific alternative Phase I evaluation process before it is implemented. In order to facilitate this process, the Panel has determined to delegate the authority to CPEP to develop and implement an alternative evaluation process for Phase I.

12. In their Point of Care Education and Evaluation Report for July 2009, CPEP reported,

Dr. Patel successfully completed this simulated patient exercise. CPEP recommends that he progress to Phase II of his Education Plan. Dr. Patel should notify CPEP of his intent to reactivate his Education Plan and engage in educational activities, starting with Phase II.
Dr. Patel will need to identify a qualified preceptor to work with him for the duration of Phase II. Because there has been a lengthy delay for Dr. Patel to begin Phase II of his Plan, it will be important that he participate in the educational activities in a timely manner. Therefore, if he has not already begun a preceptor search, Dr. Patel is encouraged to do so immediately. CPEP recommends that he submit the preceptor candidate's curriculum vitae within 15 days of reactivating his Plan (date to be determined). CPEP also recommends that Dr. Patel carefully review his Plan prior to initiating Phase II.

13. At the Panel's October 15, 2009 meeting, when they took up the licensee's request to modify his Amended Agreed Order of Indefinite Restriction, James. T. Jennings, M.D., Medical Director, Kentucky Physicians' Health Foundation, asked the Panel to consider terminating Condition 2h, based upon the length of the licensee's involvement with the Foundation and the primary focus of the present Amended Agreed Order.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Second Amended Agreed Order:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, there were legal grounds for the Board to impose disciplinary sanctions against his license pursuant to KRS 311.595(13). The Board did so by requiring the licensee to enter into the Agreed Order of Surrender. The legal grounds supporting the Agreed Order of Surrender extend to this Second Amended Agreed Order. Accordingly, there is a legal basis for this Second Amended Agreed Order.

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully address legal issues, such as the licensee's return to active practice following a period of surrender, by entering into an agreed resolution such as this Second Amended Agreed Order.

SECOND AMENDED AGREED ORDER

Based upon the Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the Panel's vote to grant the licensee's request to modify the Amended Agreed Order of Indefinite Restriction the parties hereby ENTER INTO the following **SECOND AMENDED AGREED ORDER:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Sharad C. Patel, M.D., remains RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, with that period continuing immediately upon the filing of this Second Amended Agreed Order and continuing until further Order of the Panel;
2. During the effective period of this Agreed Order, the licensee's Kentucky medical license SHALL BE RESTRICTED/LIMITED by the following terms and conditions:
    a. The licensee may resume the practice of medicine, but only as specified in the following terms and conditions;
    b. The licensee SHALL ONLY see and treat patients while under the complete and direct supervision and direction of a Board-certified Supervising Physician, who has been approved in advance and in writing by CPEP's Medical Director;

c. The licensee SHALL NOT see patients or provide medical or psychiatric treatment to any individual outside of the direct supervision and direction of the approved Supervising Physician, unless and until approved to do so by the Panel;

d. The licensee MAY PROCEED WITH AND SHALL FULLY comply with the directives of Phase II of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Second Amended Agreed Order. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase II of the Education Plan;

e. The licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. Any such medical treatment and prescribing shall be reported directly to the Board in writing by the treating physician within ten (10) days after the date of treatment. The licensee must inform the treating physician of this responsibility and ensure timely compliance. Failure to inform the treating physician of this responsibility shall be considered a violation of this Second Amended Agreed Order;

f. The licensee shall be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, the purpose being to ensure that the licensee remains drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug

analyses and reports will be borne by licensee, which costs shall be paid under the terms fixed by the Board's agent for testing. Failure to make timely payment of such costs, to provide a specimen upon request, or to remain alcohol and/or drug-free shall be considered a violation of this Second Amended Agreed Order;

g. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Second Amended Agreed Order, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Second Amended Agreed Order, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Second Amended Agreed Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Second Amended Agreed Order.

4. The licensee understands and agrees that any violation of the terms of this Second Amended Agreed Order would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13).

SO AGREED on this 22nd day of November, 2009.

FOR THE LICENSEE:

SHARAD C. PATEL, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY B

C. LLOYD VEST II
General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-7150

CPEP Center for Personalized Education for Physicians

EDUCATIONAL INTERVENTION

EDUCATION PLAN

Developed July 2006

for

Shared Patel , M.D.

I. INTRODUCTION

This Education Plan was developed based upon areas of need identified in CPEP's Assessment of Shared Patel, M.D., conducted in January 2003 and Assessment Addendum (Addendum) in March 2006, data gathered by CPEP and information obtained from the Kentucky Board of Medical Licensure (Board). The areas of educational need identified in the Assessment and the Addendum have been addressed in the objectives of this Education Plan (Plan). Progress Reports will be generated approximately every trimester and provided to the participant and to other entities for which we have authorization.

PURPOSE

The purpose of this Education Plan is to provide a framework in which Dr. Patel can address educational needs that will ultimately improve his delivery of patient care. Plans are created with the understanding that as the physician's capabilities and/or needs change within the parameters of the practice for which this Plan was developed, the educational focus areas may change accordingly.

The goal of CPEP and this Plan is to provide the participant with the tools and support for a meaningful educational experience that includes:

- Addressing individual, identified educational needs;
- Encouraging life-long, independent learning;
- Providing long-term educational benefits that will enhance quality patient care;
- Achieving successful completion of the Plan and the Post-Education Evaluation within the estimated timeframes defined in the Plan.

Participant strategies to support successful completion of the Educational Intervention include the following:

- Being an active partner in learning;
- Actively integrating feedback and new knowledge into daily practice;
- Submitting educational materials and charts as requested in the Plan;
- Adhering to timeframes and due dates as outlined in the Plan;
- Participating in regularly scheduled communications with CPEP.

PHYSICIAN BACKGROUND

Dr. Patel ceased practicing psychiatric medicine in March 2000. He participated in the Assessment process in January 2003. In December 2005, Dr. Patel contacted CPEP to enroll in an Educational Intervention. Since it had been three years since Dr. Patel 's initial CPEP Assessment, CPEP required Dr. Patel to undergo an Assessment Addendum in order to evaluate his current educational needs. The findings of this Addendum were considered in conjunction with the findings of the January 2003 Assessment in the development of this Plan.

II. PRACTICE PROFILE

Dr. Patel provided the following practice profile information to CPEP in July 2006. His perspective practice is yet to be determined, however he reported to CPEP that he will practice adult outpatient psychiatry only. Updates will be obtained from Dr. Patel and reflected in each Progress Report.

Specialty

Psychiatry

Licensure

Licensing State	Status
Kentucky	Inactive

Practice

Years/Description/Location

1980-85; Clinical Director, Comp Care Center; Elizabethtown, KY
1980-1994; 1995-2000 Private practice; Elizabethtown, KY

Active Hospital Privileges

Name/Location	# of Beds	Trauma Level	ICU
TBD			

Current Practice Profile

Volume of patients per day: TBD
Number of days worked per week: TBD
Number of patients admitted per month: TBD
Census of inpatients maintained per month: TBD
Number of days on-call per month: TBD

Commonly Encountered Diagnoses

TBD

Continuing Education

Dr. Patel has not participated in formal continuing medical education in the last five years.

III. REQUIREMENTS

PRACTICE SUPERVISOR AND EDUCATIONAL PRECEPTOR

To participate in the Educational Intervention, Dr. Patel will need to identify a board-certified psychiatrist for the roles of the Supervisor and Preceptor. The Supervisor and Preceptor can be the same individual. The Supervisor should ensure that current evidence-based medical knowledge, skills, and information are addressed. Dr. Patel will provide a copy of the Plan to the proposed Supervisor and/or Preceptor and submit the proposed Supervisor/Preceptor name(s) and resume(s) to CPEP for approval no later than

30 days following the implementation of this Plan. The complete Supervisor and Preceptor Job Descriptions are included with this Plan.

Note:

- CPEP must approve the Supervisor prior to initiating Phase I.
- The Preceptor must be approved prior to initiating Preceptor meetings to ensure that the meetings are applicable to the Plan.

MEDICAL LICENSE

Dr. Patel will need a medical license in order to participate in and complete this Plan. Some educational activities may be completed without a license.

IV. EDUCATIONAL INTERVENTION

This Plan was designed to address adult psychiatric outpatient care. If Dr. Patel 's goals for his anticipated practice change, CPEP may not be able to provide a learning experience to address such changes within the framework of this Plan. Should Dr. Patel independently address issues outside of the Plan, CPEP would be unable to monitor or comment on the experience. It may be possible for CPEP to provide additional assessment that would serve as a foundation for a Supplemental Education Plan.

PHASE I

Phase I is estimated to last between one and two months.

Because of a six-year absence, CPEP recommends that Dr. Patel only see patients with 100% supervision during Phase I. The Supervisor will be present for the entirety of all patient encounters during this period. The volume of daily patient encounters should be restricted so that appropriate and thorough discussion and review occurs immediately after each patient encounter. CPEP recommends a maximum daily patient volume of four.

PERFORMANCE OBJECTIVES

A. Observation of Patient Encounters.

During this experience, Dr. Patel will:

1) Observe the Supervisor for a minimum of 35 encounters in the outpatient setting. For each of the following presenting complaints, he will observe a minimum of two patients: dementia; anxiety; mood disorder; and psychotic and personality disorders. Other patients observed should comprise a variety of diagnoses similar to those Dr. Patel anticipates encountering in his practice. *At the discretion of his Supervisor and the CPEP Associate Medical Director, Dr. Patel may be required to observe more than 35 patient encounters;*

2) Review each case with the Supervisor after each patient encounter. As much as patient diagnoses permit, discussions should focus on content areas identified in Objective I below;
3) Using the Supervised Experience Education Log provided by CPEP, document the diagnosis, treatment, plan, and date of each case, and submit the log to CPEP. The Supervisor will sign the log prior to submission;

B. Supervised Patient Encounters

*With the Supervisor in attendance and with **direct** Supervisor oversight, Dr. Patel will:*

1) Interview and examine no fewer than 40 patients in the outpatient setting. For each of the following presenting complaints, he will see a minimum of two patients: dementia; anxiety; mood disorder; and psychotic and personality disorders. Other patients observed should comprise a variety of diagnoses similar to those Dr. Patel anticipates encountering in his practice. *At the discretion of his Supervisor and the CPEP Associate Medical Director, Dr. Patel may be required to see more than 40 patient encounters;*
2) Review his evaluation and plan for patients with the Supervisor prior to completing the patient encounter. As much as patient diagnoses permit, discussions should focus on content areas identified in Objective II below;
3) Write or dictate a simulated note as if he were the primary physician;
4) Have each simulated note reviewed for completeness and overall quality by the Supervisor after each patient encounter. As indicated, discussion regarding documentation should focus on content areas identified in Objective III below;
5) Using the Supervised Experience Log provided by CPEP, document the diagnosis, treatment, plan, and date of each case, and submit the log to CPEP. The Supervisor will sign the log prior to submission.

EVALUATION METHODS

1) As Dr. Patel nears completion of Part A of Phase I, he or his Supervisor should contact CPEP to schedule a telephone conference between the Supervisor and the Associate Medical Director;
2) Upon completion of all Parts of Phase I, the Supervisor and the Associate Medical Director will determine Dr. Patel 's readiness to advance to Phase II. He or his Supervisor should contact CPEP to schedule a telephone conference between the Supervisor and the Associate Medical Director.

PHASE II

Dr. Patel will transition to a practice-based educational experience after successful completion of Phase I. On-site supervision is no longer required. This experience is estimated to last 10 months. If practicing in Phase I at the Supervisor's practice, Dr. Patel may now transition to independent practice. Dr. Patel will work with the Preceptor to continue addressing the needs identified in the Learning Objectives listed below. If the Preceptor candidate has not been approved at the completion of Phase I, Dr. Patel should continue with self-study activities. Preceptor meetings should be scheduled once CPEP has notified Dr. Patel that the Preceptor candidate has been approved.

LEARNING OBJECTIVES

I. **To improve psychiatric evidence-based medical knowledge, including but not limited to the following:**
   1) Elements of a comprehensive and detailed initial psychiatric assessment, including but not limited to, patient history, family history, and mental status exam;
   2) Algorithms for formulating differential diagnoses;
   3) Symptoms associated with and current management approaches for common psychiatric disorders, including but not limited to the following disorders:
      a) anxiety;
      b) mood (including bipolar disorder);
      c) psychotic;
      d) personality;
      e) post-traumatic stress;
      f) obsessive-compulsive;
      g) dementia;
   4) Non-pharmacologic therapy, including but not limited to, cognitive behavioral therapy;
   5) Legal dimensions of psychiatric practice;
   6) Indicators of substance abuse;
   7) Ability to discern the severity of disorders for appropriate management;
   8) Appropriate testing that is consistent with and supported by the patient's symptoms;
   9) Ability to identify changes in patient behavior and manage accordingly.

II. **To improve knowledge of current pharmacologic therapy that includes but is not limited to the following, especially as related to the disorders identified above:**
   1) Side effects;
   2) Drug-drug interactions;
   3) Dosing.

III. **To improve clinical decision-making in the following areas:**
1) Consistent application of medical knowledge;
2) Organized, detailed, comprehensive, and integrated approach to diagnostic evaluation that includes differential diagnoses;
3) Development of comprehensive and integrative treatment plans for an adequately wide range of psychiatric diagnoses; these plans should include documentation of the patient's progress;
4) Consideration of medication management options;
5) Application of psychopathology.

IV. **To improve patient care documentation, specifically:**
1) Organized and complete chart components, including flow sheets;
2) Consistently organized, detailed and complete notes, that include but not limited to the following elements:
   a) Presenting complaint;
   b) Psychiatric history;
   c) Family and social history;
   d) Mental status exam;
   e) Differential and final diagnoses;
   f) Detailed treatment plans;
   g) Patient/family education;
   h) Consultant reports/communications;
   i) Testing;
   j) Detailed clinical reasoning;
3) Consistent documentation of all patient encounters.

V. **To monitor physician-patient communication:**
1) Effective core communication skills.

VI. **To determine a plan to maintain current standards within the field of psychiatry.**

VI. PERFORMANCE OBJECTIVES and EVALUATION METHODS

Refer to Appendix A for further directions.

PERFORMANCE OBJECTIVES

Dr. Patel will complete the following specified Objectives:

A. Knowledge (Learning Objective I)
1) For each Objective I content area, including subtopics:
   a) Review two current, reputable medical references explicitly relevant to the content area. If assigned a specific guideline for a content area (see below), it can be utilized as one of the references;

b) Submit a brief paragraph, outline or algorithm explaining the applicability of knowledge gained from his reading to his current practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale. Include reference titles and dates of publication;

2) Subscribe to *Focus: The Journal of Lifelong Learning in Psychiatry and the Focus Self Assessment Examination*. The subscription should include the "Influential Papers." Dr. Patel should participate in ongoing reading and assessment. More information can be found at the following web site: http://www.psych.org/edu/cme/selfassess_exam/saexam.cfm. If Dr. Patel identifies an alternative course, the Associate Medical Director must approve the course;

3) Review guidelines/references relevant to diagnosis and treatment of common psychiatric disorders. CPEP recommends the following Internet sites as resources: http://www.guideline.gov and http://www.psych.org;

4) Dr. Patel will participate in Grand Rounds as scheduled at a nearby facility if available.

B. Clinical Decision Making

1). Obtain and utilize the most current publication of the DSM IV-R to assist in developing a more structured and comprehensive approach to the differential diagnosis of patient complaints.

C. Communication

1). Read The Medical Interview by John L., M.D. Coulehan, Marian R., M.D. Block;

2) CPEP will determine if Dr. Patel would benefit from further educational intervention;

3) Discuss with the Supervisor and Preceptor during Phase I and II.

D. Documentation

1) Independently review documentation and medical record keeping;

2) Attend a documentation seminar, with a follow-up component. The follow-up component must consist of at least two chart reviews, preferably three. A course brochure should be submitted for the Associate Medical Director's approval within 30 days of signing the Plan. A certificate of attendance should be submitted to CPEP upon completion;

3) Integrate feedback from the CPEP Associate Medical Director and the Preceptor promptly.

E. Preceptor Meetings and Chart Reviews

1) Address the Objective I content areas with the Preceptor through didactic exercises, as well as case-based and hypothetical discussions;

2) Meet with the Preceptor weekly for a period of time to be determined by the Associate Medical Director and then twice monthly for the duration of the Plan;
3) Provide 16 redacted charts per month (four charts per weekly session and eight charts per twice monthly sessions), for the duration of Phase II for review with the Preceptor. Dr. Patel will submit these charts to the Preceptor prior to their scheduled meeting to allow the Preceptor time for review. As much as possible, the charts selected should be relevant to the content areas of the Plan;
4) Charts should generate discussions addressing medical knowledge, application of medical knowledge to patient care, clinical judgment, and documentation;
5) Submit to CPEP, every other month, four of the 16 redacted charts used in the Preceptor meetings for review by the Associate Medical Director;
6) Discuss his plan for ongoing professional development with the Preceptor.

F. Submission Requirements:
See Appendix A for timelines.
1) Maintain an Education and/or Supervisor Log, documenting all educational activities, including topics discussed with the Preceptor, and submit to CPEP;
2) Submit practice application materials for Objective I to CPEP;
3) Submit title, resource and date of publication, or first page of article, for all assigned guidelines for Objective I to CPEP;
4) Submit a certificate of completion and/or monthly participation in *Focus: The Journal of Lifelong Learning in Psychiatry and the Focus Self Assessment Examination,* or other approved course;
5) Develop a plan for ongoing professional development in psychiatry and submit it to CPEP.

EVALUATION METHODS

A. The Preceptor will:
1) Provide feedback to Dr. Patel on medical knowledge, application of knowledge, clinical judgment, communication and documentation at the time of their meetings;
2) Provide monthly written and scheduled verbal feedback on Dr. Patel 's progress for the duration of the Plan, or as applicable.

B. The Associate Medical Director will:
1) Review and approve the required submissions to CPEP, and provide feedback to Dr. Patel , with regard to medical knowledge, application of medical knowledge, clinical judgment, documentation, and other identified areas, during regularly scheduled telephone conversations;
2) Monitor Dr. Patel 's documentation and overall progress;

Educational Intervention
Education Plan
Shared Patel, M.D.

3) Review and approve Dr. Patel 's plan for ongoing professional development;
4) Provide a written progress report approximately every trimester.

ESTIMATED DURATION

The duration of the Education Plan can only be estimated. CPEP anticipates that this Educational Intervention will last approximately 12 months. It may be extended or shortened at the discretion of CPEP depending on progress towards meeting the stated educational goals. If new education needs are uncovered during the course of this Plan, these will be addressed accordingly.

REASSESSMENT

Dr. Patel will return to CPEP within two to six months following the completion of the Education Plan for a Post-Education Evaluation that addresses the content of the Plan.

DISCLAIMER

CPEP reserves the right to change the content and/or duration of the Education Plan.

SIGNATURES

Shared Patel , M.D.

8/3/06
Date

Nancy Wilson-Ashbach, M.D.
Associate Medical Director

Date

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Supervisor/Preceptor candidates.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 741

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, 1506 BRISTOL COURT, ELIZABETHTOWN, KENTUCKY 42701

AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Sharad C. Patel, M.D., and, based upon the Panel's vote to authorize CPEP to develop and implement an alternative evaluation process for Phase I of the Educational Intervention without further Panel approval, hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Amended Agreed Order of Indefinite Restriction:

1. At all relevant times, Sharad C. Patel, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On March 8, 1999, the licensee filed with the Board an Amended Letter of Agreement, which he executed on March 5, 1999. Condition 1 of the Amended Letter of Agreement specified: "Physician shall fully maintain a contractual relationship with the Impaired Physician Committee and abide by all conditions placed upon him by the Impaired Physician Committee."

4. On March 16, the licensee verbally notified a Board Investigator that he desired to convert his license to inactive status and that he intended to discontinue his relationship with the Kentucky Physicians Health Foundation ("the Foundation"). In a Memorandum to the Board's Inquiry Panel B, dated March 22, 2000, the investigator notified the Board of this information.

5. In a letter, dated March 17, 2000, Burns M. Brady, M.D., Foundation Medical Director, confirmed a telephone conversation he had with the licensee. In his letter, a copy of which was received by the Board on March 21, 2000, Dr. Brady stated, "As I understand it, you [the licensee] are not going to renew your Kentucky medical license at this time and would like to discontinue your relationship with [the Foundation]." Seeking confirmation of his understanding, Dr. Brady further stated in same: "I look forward to your response and if I have not heard from you within 14 days of your receipt of this letter, then I will assume this establishes for our records and for the Kentucky Board of Medical Licensure that you are discontinuing your relationship with this organization."

6. Given these circumstances, the Panel required the licensee to enter into an Agreed Order of Surrender, which he did and which was filed on June 9, 2000. He has not practiced medicine in the Commonwealth since that time.

7. At its July 2002 meeting, the Panel considered the licensee's request to resume the active practice of medicine. The Panel deferred any action until the licensee completed a clinical skills assessment at the Center for Personalized Education for Physicians (CPEP).

8. The licensee completed that assessment January 27-28, 2003. The Assessment Report included the following findings:

A. Medical Knowledge

During this Assessment, Dr. Patel's medical knowledge was fairly broad but it lacked depth and was not current. He was aware of the general initial psychiatric assessment process including the mental status examination. However, he omitted important historical areas and lacked necessary details and clarity on the mental status exam. He was knowledgeable about substance abuse issues as well as pain management and psychiatric treatment in workman's compensation patients. He accurately assessed suicidal and homicidal risk. His level of knowledge of the civil commitment process was adequate, although it lacked detail. He demonstrated a general knowledge of anxiety, psychotic, and personality disorders but it lacked depth. Dr. Patel's diagnosis of mood disorders was unacceptable. His knowledge of psychotropic medications including antidepressants, antipsychotics, and mood stabilizers was incomplete and not current. His differential diagnosis did not always reflect the most likely possibilities. Dr. Patel was not well-versed in the DSM IV-R categories of the mood disorders. Dr. Patel's diagnostic and assessment skills lacked sufficient detail and completeness.

B. Clinical Reasoning

Overall, Dr. Patel's clinical reasoning was inconsistent. One consultant thought that, based on the few charts reviewed, Dr. Patel's clinical decision-making was adequate. Another consultant noted that Dr. Patel provided an adequate account of the issues from a drug overdose patient and a workman's compensation injury. Dr. Patel demonstrated flexibility in his ability to modify his management strategies based on changes in the patient's clinical course; however, his approach to pharmacology was more rigid.
Many of Dr. Patel's stated management strategies were reasonable; he did not apply these principles to the actual patient cases reviewed. This included use of mood stabilization in bipolar disorder and use of informed consent. He ordered laboratory tests and developed treatment plans that were not supported by the diagnostic possibilities. Dr. Patel's differential diagnosis did not always reflect the facts of the case. He occasionally assigned a diagnosis without sufficient clinical data, in contrary to the patient's clinical presentation, or without integrating important social issues. His follow-up recommendations did not always correlate with the clinical status and needs of the patient. Dr. Patel did not have an organized theory of psychopathology upon which to guide his prescription for non-pharmacologic-psychiatric treatments.

C. Communication

Dr. Patel's communication skills with the Simulated Patients were adequate but his skills were weak due to the time since he left practice. He demonstrated the core skills needed to be an effective communicator. He asked open-ended questions, listened without interruption, made effective use of summary statements, and had good eye contact. With practice his interactions became more conversational. His initial attempts at rapport were difficult but these improved over the course of the interview. He sometimes confused the patients by changing his line of questioning too quickly and without the use of transition statements. He did not provide patient education. His interactions with the peer consultants were acceptable.

D. Documentation

Dr. Patel's documentation skills were inadequate. His intake assessments were organized. His documentation of the mental status exams was acceptable. He provided a reasonable accounting of the patient's clinical progress. However, there was no documentation of medication side effects, reasons for psychotherapy or cognitive behavior therapy, or explanations for changes in medications. Dr. Patel did not document all patient encounters with an appropriate note. His management strategies were not consistently reflected in the chart. He did not record a formal diagnosis of PTSD in a patient he was treating for this disorder. He did not enumerate manic or depressive symptoms in a bipolar patient. He did not provide a clear plan of action in some cases. Comments about psychosocial issues were brief and general. The notes generated during the CPEP Assessment were unorganized and lacked any detail about his clinical thought processes. His treatment plans were vague.

CPEP recommended that Dr. Patel participate in structured, individualized Education Intervention to address the identified areas of need, and noted that such an intervention would likely require significant time and effort.

9. After reviewing the report, the Panel voted to defer action until Dr. Patel had obtained an Educational Plan from CPEP and presented it to the Panel for review. The licensee obtained an Educational Intervention Education Plan from CPEP in July 2006 and it was considered by the Panel at its October 19, 2006 meeting.

10. The parties entered into an Agreed Order of Indefinite Restriction on November 7, 2006. Conditions 2d and 2e of that Agreed Order provided,

    d. The licensee SHALL FULLY comply with the directives of Phase I of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Agreed Order of Indefinite Restriction. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase I of the Education Plan;
    e. The licensee SHALL NOT proceed to or perform any act under Phase II of the CPEP Education Plan, unless and until approved to do so by the Panel by Amended Agreed Order of Indefinite Restriction.

11. Both the licensee and CPEP have advised the Panel that, due to circumstances beyond the licensee's control, he has been unable to complete Phase I of the Education Plan, because of CPEP's lack of ability to properly evaluate the licensee's completion of that Phase. CPEP and the licensee have tried to develop an alternative means of evaluating the licensee's completion of Phase I. However, to date, they have been unable to implement an evaluation process which would provide CPEP with the level of assurance necessary to recommend his transition to Phase II of the Education Plan. Part of the difficulty in formulating and implementing an alternative evaluation process has been the perceived requirement to obtain the Panel's approval of a specific alternative Phase I evaluation process before it is implemented. In order to facilitate this process, the Panel has determined to delegate the authority to CPEP to develop and implement an alternative evaluation process for Phase I.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Amended Agreed Order of Indefinite Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.
2. Based upon the Stipulations of Fact, there were legal grounds for the Board to impose disciplinary sanctions against his license pursuant to KRS 311.595(13). The Board did so by requiring the licensee to enter into the Agreed Order of Surrender. The legal grounds supporting the Agreed Order of Surrender extend to this Amended Agreed Order of Indefinite Restriction. Accordingly, there is a legal basis for this Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully address legal issues, such as the licensee's return to active practice following a period of surrender, by entering into an agreed resolution such as this Amended Agreed Order of Indefinite Restriction.

AMENDED AGREED ORDER OF INDEFINITE RESTRICTION

Based upon the Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the Panel's vote to authorize CPEP to develop and implement an alternative evaluation process for Phase I of the Education Plan without further Panel approval, the parties hereby ENTER INTO the following **AMENDED AGREED ORDER OF INDEFINITE RESTRICTION:**

1. The license to practice medicine in the Commonwealth of Kentucky held by Sharad C. Patel, M.D., remains RESTRICTED/LIMITED FOR AN INDEFINITE

PERIOD OF TIME, with that period continuing immediately upon the filing of this Amended Agreed Order of Indefinite Restriction and continuing until further Order of the Panel;

2. During the effective period of this Agreed Order, the licensee's Kentucky medical license SHALL BE RESTRICTED/LIMITED by the following terms and conditions:

    a. The licensee may resume the practice of medicine, but only as specified in the following terms and conditions;

    b. The licensee SHALL ONLY see and treat patients while under the complete and direct supervision and direction of a Board-certified Supervising Physician, who has been approved in advance and in writing by CPEP's Medical Director;

    c. The licensee SHALL NOT see patients or provide medical or psychiatric treatment to any individual outside of the direct supervision and direction of the approved Supervising Physician, unless and until approved to do so by the Panel;

    d. The licensee SHALL FULLY comply with the directives of Phase I of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Amended Agreed Order of Indefinite Restriction. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase I of the Education Plan;

e. CPEP has the full authority, without the requirement of further Panel approval, to formulate and implement an alternative evaluation process for Phase I, which will enable the licensee to successfully complete that Phase in a manner the provides CPEP with sufficient assurance that he is capable to progressing to Phase II of the Education Plan without undue risk to the safety of patients or the public.

f. The licensee SHALL NOT proceed to or perform any act under Phase II of the CPEP Education Plan, unless and until approved to do so by the Panel by Second Amended Agreed Order of Indefinite Restriction;

g. The Panel will only consider a request by the licensee to proceed to Phase II of the Education Plan, by Second Amended Agreed Order, if the request is accompanied by a favorable written recommendation by CPEP's Medical Director, which details the licensee's completion of and compliance with Phase I of the Education Plan;

h. The licensee SHALL maintain his contractual relationship with the Kentucky Physicians Health Foundation and SHALL fully comply with all contractual requirements, until further Order of the Panel;

i. The licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. Any such medical treatment and prescribing shall be reported directly to the Board in writing by the treating physician within ten (10) days after the date of treatment. The licensee must inform the treating physician of this

responsibility and ensure timely compliance. Failure to inform the treating physician of this responsibility shall be considered a violation of this Amended Agreed Order of Indefinite Restriction;

j. The licensee shall be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, the purpose being to ensure that the licensee remains drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug analyses and reports will be borne by licensee, which costs shall be paid under the terms fixed by the Board's agent for testing. Failure to make timely payment of such costs, to provide a specimen upon request, or to remain alcohol and/or drug-free shall be considered a violation of this Amended Agreed Order of Indefinite Restriction;

k. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Amended Agreed Order of Indefinite Restriction, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Amended Agreed Order of Indefinite Restriction, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or

Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Amended Agreed Order of Indefinite Restriction would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Amended Agreed Order of Indefinite Restriction.

4. The licensee understands and agrees that any violation of the terms of this Amended Agreed Order of Indefinite Restriction would provide a legal basis for additional disciplinary action, including revocation, pursuant to KRS 311.595(13).

SO AGREED on this 21 day of August, 2008.

FOR THE LICENSEE:

SHARAD C. PATEL, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

Randel C Gibson DO

RANDEL C. GIBSON, D.O.
CHAIR, INQUIRY B

C. Lloyd Vest II

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General Counsel
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Louisville, Kentucky 40222
(502) 429-7150

CPEP Center for Personalized Education for Physicians

EDUCATIONAL INTERVENTION

EDUCATION PLAN

Developed July 2006

for

Shared Patel , M.D.

I. INTRODUCTION

This Education Plan was developed based upon areas of need identified in CPEP's Assessment of Shared Patel, M.D., conducted in January 2003 and Assessment Addendum (Addendum) in March 2006, data gathered by CPEP and information obtained from the Kentucky Board of Medical Licensure (Board). The areas of educational need identified in the Assessment and the Addendum have been addressed in the objectives of this Education Plan (Plan). Progress Reports will be generated approximately every trimester and provided to the participant and to other entities for which we have authorization.

PURPOSE

The purpose of this Education Plan is to provide a framework in which Dr. Patel can address educational needs that will ultimately improve his delivery of patient care. Plans are created with the understanding that as the physician's capabilities and/or needs change within the parameters of the practice for which this Plan was developed, the educational focus areas may change accordingly.

The goal of CPEP and this Plan is to provide the participant with the tools and support for a meaningful educational experience that includes:

- Addressing individual, identified educational needs;
- Encouraging life-long, independent learning;
- Providing long-term educational benefits that will enhance quality patient care;
- Achieving successful completion of the Plan and the Post-Education Evaluation within the estimated timeframes defined in the Plan.

Participant strategies to support successful completion of the Educational Intervention include the following:

- Being an active partner in learning;
- Actively integrating feedback and new knowledge into daily practice;
- Submitting educational materials and charts as requested in the Plan;
- Adhering to timeframes and due dates as outlined in the Plan;
- Participating in regularly scheduled communications with CPEP.

PHYSICIAN BACKGROUND

Dr. Patel ceased practicing psychiatric medicine in March 2000. He participated in the Assessment process in January 2003. In December 2005, Dr. Patel contacted CPEP to enroll in an Educational Intervention. Since it had been three years since Dr. Patel 's initial CPEP Assessment, CPEP required Dr. Patel to undergo an Assessment Addendum in order to evaluate his current educational needs. The findings of this Addendum were considered in conjunction with the findings of the January 2003 Assessment in the development of this Plan.

Educational Intervention
Education Plan
Shared Patel, M.D.

II. PRACTICE PROFILE

Dr. Patel provided the following practice profile information to CPEP in July 2006. His perspective practice is yet to be determined, however he reported to CPEP that he will practice adult outpatient psychiatry only. Updates will be obtained from Dr. Patel and reflected in each Progress Report.

Specialty

Psychiatry

Licensure

Licensing State	Status
Kentucky	Inactive

Practice

Years/Description/Location

1980-85; Clinical Director, Comp Care Center; Elizabethtown, KY
1980-1994; 1995-2000 Private practice; Elizabethtown, KY

Active Hospital Privileges

Name/Location	# of Beds	Trauma Level	ICU
TBD			

Current Practice Profile

Volume of patients per day: TBD
Number of days worked per week: TBD
Number of patients admitted per month: TBD
Census of inpatients maintained per month: TBD
Number of days on-call per month: TBD

Commonly Encountered Diagnoses

TBD

Continuing Education

Dr. Patel has not participated in formal continuing medical education in the last five years.

III. REQUIREMENTS

PRACTICE SUPERVISOR AND EDUCATIONAL PRECEPTOR

To participate in the Educational Intervention, Dr. Patel will need to identify a board-certified psychiatrist for the roles of the Supervisor and Preceptor. The Supervisor and Preceptor can be the same individual. The Supervisor should ensure that current evidence-based medical knowledge, skills, and information are addressed. Dr. Patel will provide a copy of the Plan to the proposed Supervisor and/or Preceptor and submit the proposed Supervisor/Preceptor name(s) and resume(s) to CPEP for approval no later than

30 days following the implementation of this Plan. The complete Supervisor and Preceptor Job Descriptions are included with this Plan.

Note:

- CPEP must approve the Supervisor prior to initiating Phase I.
- The Preceptor must be approved prior to initiating Preceptor meetings to ensure that the meetings are applicable to the Plan.

MEDICAL LICENSE

Dr. Patel will need a medical license in order to participate in and complete this Plan. Some educational activities may be completed without a license.

IV. EDUCATIONAL INTERVENTION

This Plan was designed to address adult psychiatric outpatient care. If Dr. Patel 's goals for his anticipated practice change, CPEP may not be able to provide a learning experience to address such changes within the framework of this Plan. Should Dr. Patel independently address issues outside of the Plan, CPEP would be unable to monitor or comment on the experience. It may be possible for CPEP to provide additional assessment that would serve as a foundation for a Supplemental Education Plan.

PHASE I

Phase I is estimated to last between one and two months.

Because of a six-year absence, CPEP recommends that Dr. Patel only see patients with 100% supervision during Phase I. The Supervisor will be present for the entirety of all patient encounters during this period. The volume of daily patient encounters should be restricted so that appropriate and thorough discussion and review occurs immediately after each patient encounter. CPEP recommends a maximum daily patient volume of four.

PERFORMANCE OBJECTIVES

A. Observation of Patient Encounters.
During this experience, Dr. Patel will:
1) Observe the Supervisor for a minimum of 35 encounters in the outpatient setting. For each of the following presenting complaints, he will observe a minimum of two patients: dementia; anxiety; mood disorder; and psychotic and personality disorders. Other patients observed should comprise a variety of diagnoses similar to those Dr. Patel anticipates encountering in his practice. *At the discretion of his Supervisor and the CPEP Associate Medical Director, Dr. Patel may be required to observe more than 35 patient encounters;*

2) Review each case with the Supervisor after each patient encounter. As much as patient diagnoses permit, discussions should focus on content areas identified in Objective I below;
3) Using the Supervised Experience Education Log provided by CPEP, document the diagnosis, treatment, plan, and date of each case, and submit the log to CPEP. The Supervisor will sign the log prior to submission;

B. Supervised Patient Encounters

*With the Supervisor in attendance and with **direct** Supervisor oversight, Dr. Patel will:*

1) Interview and examine no fewer than 40 patients in the outpatient setting. For each of the following presenting complaints, he will see a minimum of two patients: dementia; anxiety; mood disorder; and psychotic and personality disorders. Other patients observed should comprise a variety of diagnoses similar to those Dr. Patel anticipates encountering in his practice. *At the discretion of his Supervisor and the CPEP Associate Medical Director, Dr. Patel may be required to see more than 40 patient encounters;*
2) Review his evaluation and plan for patients with the Supervisor prior to completing the patient encounter. As much as patient diagnoses permit, discussions should focus on content areas identified in Objective I below;
3) Write or dictate a simulated note as if he were the primary physician;
4) Have each simulated note reviewed for completeness and overall quality by the Supervisor after each patient encounter. As indicated, discussion regarding documentation should focus on content areas identified in Objective III below;
5) Using the Supervised Experience Log provided by CPEP, document the diagnosis, treatment, plan, and date of each case, and submit the log to CPEP. The Supervisor will sign the log prior to submission.

EVALUATION METHODS

1) As Dr. Patel nears completion of Part A of Phase I, he or his Supervisor should contact CPEP to schedule a telephone conference between the Supervisor and the Associate Medical Director;
2) Upon completion of all Parts of Phase I, the Supervisor and the Associate Medical Director will determine Dr. Patel 's readiness to advance to Phase II. He or his Supervisor should contact CPEP to schedule a telephone conference between the Supervisor and the Associate Medical Director.

PHASE II

Dr. Patel will transition to a practice-based educational experience after successful completion of Phase I. On-site supervision is no longer required. This experience is estimated to last 10 months. If practicing in Phase I at the Supervisor's practice, Dr. Patel may now transition to independent practice. Dr. Patel will work with the Preceptor to continue addressing the needs identified in the Learning Objectives listed below. If the Preceptor candidate has not been approved at the completion of Phase I, Dr. Patel should continue with self-study activities. Preceptor meetings should be scheduled once CPEP has notified Dr. Patel that the Preceptor candidate has been approved.

LEARNING OBJECTIVES

I. **To improve psychiatric evidence-based medical knowledge, including but not limited to the following:**
   1) Elements of a comprehensive and detailed initial psychiatric assessment, including but not limited to, patient history, family history, and mental status exam;
   2) Algorithms for formulating differential diagnoses;
   3) Symptoms associated with and current management approaches for common psychiatric disorders, including but not limited to the following disorders:
      a) anxiety;
      b) mood (including bipolar disorder);
      c) psychotic;
      d) personality;
      e) post-traumatic stress;
      f) obsessive-compulsive;
      g) dementia;
   4) Non-pharmacologic therapy, including but not limited to, cognitive behavioral therapy;
   5) Legal dimensions of psychiatric practice;
   6) Indicators of substance abuse;
   7) Ability to discern the severity of disorders for appropriate management;
   8) Appropriate testing that is consistent with and supported by the patient's symptoms;
   9) Ability to identify changes in patient behavior and manage accordingly.

II. **To improve knowledge of current pharmacologic therapy that includes but is not limited to the following, especially as related to the disorders identified above:**
   1) Side effects;
   2) Drug-drug interactions;
   3) Dosing.

III. **To improve clinical decision-making in the following areas:**
1) Consistent application of medical knowledge;
2) Organized, detailed, comprehensive, and integrated approach to diagnostic evaluation that includes differential diagnoses;
3) Development of comprehensive and integrative treatment plans for an adequately wide range of psychiatric diagnoses; these plans should include documentation of the patient's progress;
4) Consideration of medication management options;
5) Application of psychopathology.

IV. **To improve patient care documentation, specifically:**
1) Organized and complete chart components, including flow sheets;
2) Consistently organized, detailed and complete notes, that include but not limited to the following elements:
   a) Presenting complaint;
   b) Psychiatric history;
   c) Family and social history;
   d) Mental status exam;
   e) Differential and final diagnoses;
   f) Detailed treatment plans;
   g) Patient/family education;
   h) Consultant reports/communications;
   i) Testing;
   j) Detailed clinical reasoning;
3) Consistent documentation of all patient encounters.

V. **To monitor physician-patient communication:**
1) Effective core communication skills.

VI. **To determine a plan to maintain current standards within the field of psychiatry.**

VI. PERFORMANCE OBJECTIVES and EVALUATION METHODS

Refer to Appendix A for further directions.

PERFORMANCE OBJECTIVES

Dr. Patel will complete the following specified Objectives:

A. Knowledge (Learning Objective I)
1) For each Objective I content area, including subtopics:
   a) Review two current, reputable medical references explicitly relevant to the content area. If assigned a specific guideline for a content area (see below), it can be utilized as one of the references;

b) Submit a brief paragraph, outline or algorithm explaining the applicability of knowledge gained from his reading to his current practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale. Include reference titles and dates of publication;

2) Subscribe to *Focus: The Journal of Lifelong Learning in Psychiatry and the Focus Self Assessment Examination*. The subscription should include the "Influential Papers." Dr. Patel should participate in ongoing reading and assessment. More information can be found at the following web site: http://www.psych.org/edu/cme/selfassess_exam/saexam.cfm. If Dr. Patel identifies an alternative course, the Associate Medical Director must approve the course;
3) Review guidelines/references relevant to diagnosis and treatment of common psychiatric disorders. CPEP recommends the following Internet sites as resources: http://www.guideline.gov and http://www.psych.org;
4) Dr. Patel will participate in Grand Rounds as scheduled at a nearby facility if available.

B. Clinical Decision Making
1) Obtain and utilize the most current publication of the DSM IV-R to assist in developing a more structured and comprehensive approach to the differential diagnosis of patient complaints.

C. Communication
1) Read The Medical Interview by John L., M.D. Coulehan, Marian R., M.D. Block;
2) CPEP will determine if Dr. Patel would benefit from further educational intervention;
3) Discuss with the Supervisor and Preceptor during Phase I and II.

D. Documentation
1) Independently review documentation and medical record keeping;
2) Attend a documentation seminar, with a follow-up component. The follow-up component must consist of at least two chart reviews, preferably three. A course brochure should be submitted for the Associate Medical Director's approval within 30 days of signing the Plan. A certificate of attendance should be submitted to CPEP upon completion;
3) Integrate feedback from the CPEP Associate Medical Director and the Preceptor promptly.

E. Preceptor Meetings and Chart Reviews
1) Address the Objective I content areas with the Preceptor through didactic exercises, as well as case-based and hypothetical discussions;

2) Meet with the Preceptor weekly for a period of time to be determined by the Associate Medical Director and then twice monthly for the duration of the Plan;
3) Provide 16 redacted charts per month (four charts per weekly session and eight charts per twice monthly sessions), for the duration of Phase II for review with the Preceptor. Dr. Patel will submit these charts to the Preceptor prior to their scheduled meeting to allow the Preceptor time for review. As much as possible, the charts selected should be relevant to the content areas of the Plan;
4) Charts should generate discussions addressing medical knowledge, application of medical knowledge to patient care, clinical judgment, and documentation;
5) Submit to CPEP, every other month, four of the 16 redacted charts used in the Preceptor meetings for review by the Associate Medical Director;
6) Discuss his plan for ongoing professional development with the Preceptor.

F. Submission Requirements:
See Appendix A for timelines.
1) Maintain an Education and/or Supervisor Log, documenting all educational activities, including topics discussed with the Preceptor, and submit to CPEP;
2) Submit practice application materials for Objective I to CPEP;
3) Submit title, resource and date of publication, or first page of article, for all assigned guidelines for Objective I to CPEP;
4) Submit a certificate of completion and/or monthly participation in *Focus: The Journal of Lifelong Learning in Psychiatry and the Focus Self Assessment Examination,* or other approved course;
5) Develop a plan for ongoing professional development in psychiatry and submit it to CPEP.

EVALUATION METHODS

A. The Preceptor will:
1) Provide feedback to Dr. Patel on medical knowledge, application of knowledge, clinical judgment, communication and documentation at the time of their meetings;
2) Provide monthly written and scheduled verbal feedback on Dr. Patel 's progress for the duration of the Plan, or as applicable.

B. The Associate Medical Director will:
1) Review and approve the required submissions to CPEP, and provide feedback to Dr. Patel , with regard to medical knowledge, application of medical knowledge, clinical judgment, documentation, and other identified areas, during regularly scheduled telephone conversations;
2) Monitor Dr. Patel 's documentation and overall progress;

3) Review and approve Dr. Patel 's plan for ongoing professional development;
4) Provide a written progress report approximately every trimester.

ESTIMATED DURATION

The duration of the Education Plan can only be estimated. CPEP anticipates that this Educational Intervention will last approximately 12 months. It may be extended or shortened at the discretion of CPEP depending on progress towards meeting the stated educational goals. If new education needs are uncovered during the course of this Plan, these will be addressed accordingly.

REASSESSMENT

Dr. Patel will return to CPEP within two to six months following the completion of the Education Plan for a Post-Education Evaluation that addresses the content of the Plan.

DISCLAIMER

CPEP reserves the right to change the content and/or duration of the Education Plan.

SIGNATURES

Shared Patel , M.D.

8/13/06
Date

Nancy Wilson-Ashbach, M.D.
Associate Medical Director

Date

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Supervisor/Preceptor candidates.

COMMONWEALTH OF KENTUCKY
BOARD OF MEDICAL LICENSURE
CASE NO. 741

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, 1506 BRISTOL COURT, ELIZABETHTOWN, KENTUCKY 42701

AGREED ORDER OF INDEFINITE RESTRICTION

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Sharad C. Patel, M.D., and, based upon the Panel's vote to approve the licensee's return to the active practice of medicine under specified terms and conditions, hereby ENTER INTO the following **AGREED ORDER OF INDEFINITE RESTRICTION:**

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Indefinite Restriction:

1. At all relevant times, Sharad C. Patel, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On March 8, 1999, the licensee filed with the Board an Amended Letter of Agreement, which he executed on March 5, 1999. Condition 1 of the Amended Letter of Agreement specified: "Physician shall fully maintain a contractual relationship with the Impaired Physician Committee and abide by all conditions placed upon him by the Impaired Physician Committee."
4. On March 16, the licensee verbally notified a Board Investigator that he desired to convert his license to inactive status and that he intended to discontinue his

relationship with the Kentucky Physicians Health Foundation ("the Foundation"). In a Memorandum to the Board's Inquiry Panel B, dated March 22, 2000, the investigator notified the Board of this information.

5. In a letter, dated March 17, 2000, Burns M. Brady, M.D., Foundation Medical Director, confirmed a telephone conversation he had with the licensee. In his letter, a copy of which was received by the Board on March 21, 2000, Dr. Brady stated, "As I understand it, you [the licensee] are not going to renew your Kentucky medical license at this time and would like to discontinue your relationship with [the Foundation]." Seeking confirmation of his understanding, Dr. Brady further stated in same: "I look forward to your response and if I have not heard from you within 14 days of your receipt of this letter, then I will assume this establishes for our records and for the Kentucky Board of Medical Licensure that you are discontinuing your relationship with this organization."
6. Given these circumstances, the Panel required the licensee to enter into an Agreed Order of Surrender, which he did and which was filed on June 9, 2000. He has not practiced medicine in the Commonwealth since that time.
7. At its July 2002 meeting, the Panel considered the licensee's request to resume the active practice of medicine. The Panel deferred any action until the licensee completed a clinical skills assessment at the Center for Personalized Education for Physicians (CPEP).
8. The licensee completed that assessment January 27-28, 2003. The Assessment Report included the following findings:

    A. Medical Knowledge

During this Assessment, Dr. Patel's medical knowledge was fairly broad but it lacked depth and was not current. He was aware of the general initial psychiatric assessment process including the mental status examination. However, he omitted important historical areas and lacked necessary details and clarity on the mental status exam. He was knowledgeable about substance abuse issues as well as pain management and psychiatric treatment in workman's compensation patients. He accurately assessed suicidal and homicidal risk. His level of knowledge of the civil commitment process was adequate, although it lacked detail. He demonstrated a general knowledge of anxiety, psychotic, and personality disorders but it lacked depth. Dr. Patel's diagnosis of mood disorders was unacceptable. His knowledge of psychotropic medications including antidepressants, antipsychotics, and mood stabilizers was incomplete and not current. His differential diagnosis did not always reflect the most likely possibilities. Dr. Patel was not well-versed in the DSM IV-R categories of the mood disorders. Dr. Patel's diagnostic and assessment skills lacked sufficient detail and completeness.

B. Clinical Reasoning

Overall, Dr. Patel's clinical reasoning was inconsistent. One consultant thought that, based on the few charts reviewed, Dr. Patel's clinical decision-making was adequate. Another consultant noted that Dr. Patel provided an adequate account of the issues from a drug overdose patient and a workman's compensation injury. Dr. Patel demonstrated flexibility in his ability to modify his management strategies based on changes in the patient's clinical course; however, his approach to pharmacology was more rigid.
Many of Dr. Patel's stated management strategies were reasonable; he did not apply these principles to the actual patient cases reviewed. This included use of mood stabilization in bipolar disorder and use of informed consent. He ordered laboratory tests and developed treatment plans that were not supported by the diagnostic possibilities. Dr. Patel's differential diagnosis did not always reflect the facts of the case. He occasionally assigned a diagnosis without sufficient clinical data, in contrary to the patient's clinical presentation, or without integrating important social issues. His follow-up recommendations did not always correlate with the clinical status and needs of the patient. Dr. Patel did not have an organized theory of psychopathology upon which to guide his prescription for non-pharmacologic-psychiatric treatments.

C. Communication

Dr. Patel's communication skills with the Simulated Patients were adequate but his skills were weak due to the time since he left practice. He demonstrated the core skills needed to be an effective communicator. He asked open-ended questions, listened without interruption, made effective use of summary statements, and had good eye contact. With practice his

interactions became more conversational. His initial attempts at rapport were difficult but these improved over the course of the interview. He sometimes confused the patients by changing his line of questioning too quickly and without the use of transition statements. He did not provide patient education. His interactions with the peer consultants were acceptable.

D. Documentation

Dr. Patel's documentation skills were inadequate. His intake assessments were organized. His documentation of the mental status exams was acceptable. He provided a reasonable accounting of the patient's clinical progress. However, there was no documentation of medication side effects, reasons for psychotherapy or cognitive behavior therapy, or explanations for changes in medications. Dr. Patel did not document all patient encounters with an appropriate note. His management strategies were not consistently reflected in the chart. He did not record a formal diagnosis of PTSD in a patient he was treating for this disorder. He did not enumerate manic or depressive symptoms in a bipolar patient. He did not provide a clear plan of action in some cases. Comments about psychosocial issues were brief and general. The notes generated during the CPEP Assessment were unorganized and lacked any detail about his clinical thought processes. His treatment plans were vague.

CPEP recommended that Dr. Patel participate in structured, individualized Education Intervention to address the identified areas of need, and noted that such an intervention would likely require significant time and effort.

9. After reviewing the report, the Panel voted to defer action until Dr. Patel had obtained an Educational Plan from CPEP and presented it to the Panel for review. The licensee obtained an Educational Intervention Education Plan from CPEP in July 2006 and it was considered by the Panel at its October 19, 2006 meeting.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Indefinite Restriction:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.

2. Based upon the Stipulations of Fact, there were legal grounds for the Board to impose disciplinary sanctions against his license pursuant to KRS 311.595(13). The Board did so by requiring the licensee to enter into the Agreed Order of Surrender. The legal grounds supporting the Agreed Order of Surrender extend to this Agreed Order of Indefinite Restriction. Accordingly, there is a legal basis for this Agreed Order.
3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully address legal issues, such as the licensee's return to active practice following a period of surrender, by entering into an agreed resolution such as this Agreed Order of Indefinite Restriction.

AGREED ORDER OF INDEFINITE RESTRICTION

Based upon the Stipulations of Fact and Stipulated Conclusions of Law, and, based upon the Panel's vote to permit the licensee to resume the practice of medicine under specified terms and conditions, the parties hereby ENTER INTO the following

AGREED ORDER OF INDEFINITE RESTRICTION:

1. The license to practice medicine in the Commonwealth of Kentucky held by Sharad C. Patel, M.D., is RESTRICTED/LIMITED FOR AN INDEFINITE PERIOD OF TIME, with that period commencing immediately upon the filing of this Agreed Order of Indefinite Restriction and continuing until further Order of the Panel;
2. During the effective period of this Agreed Order, the licensee's Kentucky medical license SHALL BE RESTRICTED/LIMITED by the following terms and conditions:

a. The licensee may resume the practice of medicine, but only as specified in the following terms and conditions;

b. The licensee SHALL ONLY see and treat patients while under the complete and direct supervision and direction of a Board-certified Supervising Physician, who has been approved in advance and in writing by CPEP's Medical Director;

c. The licensee SHALL NOT see patients or provide medical or psychiatric treatment to any individual outside of the direct supervision and direction of the approved Supervising Physician, unless and until approved to do so by the Panel;

d. The licensee SHALL FULLY comply with the directives of Phase I of CPEP's Education Plan, which is attached and incorporated in full, by reference, into this Agreed Order of Indefinite Restriction. Even under the direct supervision of the Supervising Physician, the licensee may only perform those acts and procedures specifically detailed in Phase I of the Education Plan;

e. The licensee SHALL NOT proceed to or perform any act under Phase II of the CPEP Education Plan, unless and until approved to do so by the Panel by Amended Agreed Order of Indefinite Restriction;

f. The Panel will only consider a request by the licensee to proceed to Phase II of the Education Plan, by Amended Agreed Order, if the request is accompanied by a favorable written recommendation by CPEP's Medical

Director, which details the licensee's completion of and compliance with Phase I of the Education Plan;

g. The licensee SHALL maintain his contractual relationship with the Kentucky Physicians Health Foundation and SHALL fully comply with all contractual requirements, until further Order of the Panel;

h. The licensee shall completely abstain from the consumption of mood-altering substances, including alcohol, except as prescribed by a duly licensed practitioner for a documented legitimate medical purpose. Any such medical treatment and prescribing shall be reported directly to the Board in writing by the treating physician within ten (10) days after the date of treatment. The licensee must inform the treating physician of this responsibility and ensure timely compliance. Failure to inform the treating physician of this responsibility shall be considered a violation of this Agreed Order of Indefinite Restriction;

i. The licensee shall be subject to periodic, unannounced breathalyzer, blood and urine alcohol and/or drug analysis as desired by the Board, the purpose being to ensure that the licensee remains drug and/or alcohol-free. The cost of such breathalyzer, blood and urine alcohol and/or drug analyses and reports will be borne by licensee, which costs shall be paid under the terms fixed by the Board's agent for testing. Failure to make timely payment of such costs, to provide a specimen upon request, or to remain alcohol and/or drug-free shall be considered a violation of this Agreed Order of Indefinite Restriction;

j. The licensee SHALL NOT violate any provision of KRS 311.595 and/or 311.597.

3. The licensee expressly agrees that if he should violate any term or condition of this Agreed Order of Indefinite Restriction, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that if the Board should receive information that he has violated any term or condition of this Agreed Order of Indefinite Restriction, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Agreed Order of Indefinite Restriction would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Indefinite Restriction.

4. The licensee understands and agrees that any violation of the terms of this Agreed Order of Indefinite Restriction would provide a legal basis for additional

disciplinary action, including revocation, pursuant to KRS 311.595(13).

SO AGREED on this 3rd day of November, 2006.

FOR THE LICENSEE:

SHARAD C. PATEL, M.D.

COUNSEL FOR THE LICENSEE
(IF APPLICABLE)

FOR THE BOARD:

PRESTON P. NUNNELLEY, M.D.
CHAIR, INQUIRY B

C. LLOYD VEST II
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CPEP Center for *Personalized* Education for Physicians

EDUCATIONAL INTERVENTION

EDUCATION PLAN

Developed July 2006

for

Shared Patel , M.D.

Educational Intervention
Education Plan
Shared Patel, M.D.

I. INTRODUCTION

This Education Plan was developed based upon areas of need identified in CPEP's Assessment of Shared Patel, M.D., conducted in January 2003 and Assessment Addendum (Addendum) in March 2006, data gathered by CPEP and information obtained from the Kentucky Board of Medical Licensure (Board). The areas of educational need identified in the Assessment and the Addendum have been addressed in the objectives of this Education Plan (Plan). Progress Reports will be generated approximately every trimester and provided to the participant and to other entities for which we have authorization.

PURPOSE

The purpose of this Education Plan is to provide a framework in which Dr. Patel can address educational needs that will ultimately improve his delivery of patient care. Plans are created with the understanding that as the physician's capabilities and/or needs change within the parameters of the practice for which this Plan was developed, the educational focus areas may change accordingly.

The goal of CPEP and this Plan is to provide the participant with the tools and support for a meaningful educational experience that includes:

- Addressing individual, identified educational needs;
- Encouraging life-long, independent learning;
- Providing long-term educational benefits that will enhance quality patient care;
- Achieving successful completion of the Plan and the Post-Education Evaluation within the estimated timeframes defined in the Plan.

Participant strategies to support successful completion of the Educational Intervention include the following:

- Being an active partner in learning;
- Actively integrating feedback and new knowledge into daily practice;
- Submitting educational materials and charts as requested in the Plan;
- Adhering to timeframes and due dates as outlined in the Plan;
- Participating in regularly scheduled communications with CPEP.

PHYSICIAN BACKGROUND

Dr. Patel ceased practicing psychiatric medicine in March 2000. He participated in the Assessment process in January 2003. In December 2005, Dr. Patel contacted CPEP to enroll in an Educational Intervention. Since it had been three years since Dr. Patel 's initial CPEP Assessment, CPEP required Dr. Patel to undergo an Assessment Addendum in order to evaluate his current educational needs. The findings of this Addendum were considered in conjunction with the findings of the January 2003 Assessment in the development of this Plan.

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II. PRACTICE PROFILE

Dr. Patel provided the following practice profile information to CPEP in July 2006. His perspective practice is yet to be determined, however he reported to CPEP that he will practice adult outpatient psychiatry only. Updates will be obtained from Dr. Patel and reflected in each Progress Report.

Specialty

Psychiatry

Licensure

Licensing State	**Status**
Kentucky	Inactive

Practice

Years/Description/Location

1980-85; Clinical Director, Comp Care Center; Elizabethtown, KY
1980-1994; 1995-2000 Private practice; Elizabethtown, KY

Active Hospital Privileges

Name/Location	**# of Beds**	**Trauma Level**	**ICU**
TBD			

Current Practice Profile

Volume of patients per day: TBD
Number of days worked per week: TBD
Number of patients admitted per month: TBD
Census of inpatients maintained per month: TBD
Number of days on-call per month: TBD

Commonly Encountered Diagnoses

TBD

Continuing Education

Dr. Patel has not participated in formal continuing medical education in the last five years.

III. REQUIREMENTS

PRACTICE SUPERVISOR AND EDUCATIONAL PRECEPTOR

To participate in the Educational Intervention, Dr. Patel will need to identify a board-certified psychiatrist for the roles of the Supervisor and Preceptor. The Supervisor and Preceptor can be the same individual. The Supervisor should ensure that current evidence-based medical knowledge, skills, and information are addressed. Dr. Patel will provide a copy of the Plan to the proposed Supervisor and/or Preceptor and submit the proposed Supervisor/Preceptor name(s) and resume(s) to CPEP for approval no later than

30 days following the implementation of this Plan. The complete Supervisor and Preceptor Job Descriptions are included with this Plan.

Note:

- CPEP must approve the Supervisor prior to initiating Phase I.
- The Preceptor must be approved prior to initiating Preceptor meetings to ensure that the meetings are applicable to the Plan.

MEDICAL LICENSE

Dr. Patel will need a medical license in order to participate in and complete this Plan. Some educational activities may be completed without a license.

IV. EDUCATIONAL INTERVENTION

This Plan was designed to address adult psychiatric outpatient care. If Dr. Patel 's goals for his anticipated practice change, CPEP may not be able to provide a learning experience to address such changes within the framework of this Plan. Should Dr. Patel independently address issues outside of the Plan, CPEP would be unable to monitor or comment on the experience. It may be possible for CPEP to provide additional assessment that would serve as a foundation for a Supplemental Education Plan.

PHASE I

Phase I is estimated to last between one and two months.

Because of a six-year absence, CPEP recommends that Dr. Patel only see patients with 100% supervision during Phase I. The Supervisor will be present for the entirety of all patient encounters during this period. The volume of daily patient encounters should be restricted so that appropriate and thorough discussion and review occurs immediately after each patient encounter. CPEP recommends a maximum daily patient volume of four.

PERFORMANCE OBJECTIVES

A. Observation of Patient Encounters.
During this experience, Dr. Patel will:

1) Observe the Supervisor for a minimum of 35 encounters in the outpatient setting. For each of the following presenting complaints, he will observe a minimum of two patients: dementia; anxiety; mood disorder; and psychotic and personality disorders. Other patients observed should comprise a variety of diagnoses similar to those Dr. Patel anticipates encountering in his practice. *At the discretion of his Supervisor and the CPEP Associate Medical Director, Dr. Patel may be required to observe more than 35 patient encounters;*

2) Review each case with the Supervisor after each patient encounter. As much as patient diagnoses permit, discussions should focus on content areas identified in Objective I below;
3) Using the Supervised Experience Education Log provided by CPEP, document the diagnosis, treatment, plan, and date of each case, and submit the log to CPEP. The Supervisor will sign the log prior to submission;

B. Supervised Patient Encounters

*With the Supervisor in attendance and with **direct** Supervisor oversight, Dr. Patel will:*

1) Interview and examine no fewer than 40 patients in the outpatient setting. For each of the following presenting complaints, he will see a minimum of two patients: dementia; anxiety; mood disorder; and psychotic and personality disorders. Other patients observed should comprise a variety of diagnoses similar to those Dr. Patel anticipates encountering in his practice. *At the discretion of his Supervisor and the CPEP Associate Medical Director, Dr. Patel may be required to see more than 40 patient encounters;*
2) Review his evaluation and plan for patients with the Supervisor prior to completing the patient encounter. As much as patient diagnoses permit, discussions should focus on content areas identified in Objective II below;
3) Write or dictate a simulated note as if he were the primary physician;
4) Have each simulated note reviewed for completeness and overall quality by the Supervisor after each patient encounter. As indicated, discussion regarding documentation should focus on content areas identified in Objective III below;
5) Using the Supervised Experience Log provided by CPEP, document the diagnosis, treatment, plan, and date of each case, and submit the log to CPEP. The Supervisor will sign the log prior to submission.

EVALUATION METHODS

1) As Dr. Patel nears completion of Part A of Phase I, he or his Supervisor should contact CPEP to schedule a telephone conference between the Supervisor and the Associate Medical Director;
2) Upon completion of all Parts of Phase I, the Supervisor and the Associate Medical Director will determine Dr. Patel 's readiness to advance to Phase II. He or his Supervisor should contact CPEP to schedule a telephone conference between the Supervisor and the Associate Medical Director.

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PHASE II

Dr. Patel will transition to a practice-based educational experience after successful completion of Phase I. On-site supervision is no longer required. This experience is estimated to last 10 months. If practicing in Phase I at the Supervisor's practice, Dr. Patel may now transition to independent practice. Dr. Patel will work with the Preceptor to continue addressing the needs identified in the Learning Objectives listed below. If the Preceptor candidate has not been approved at the completion of Phase I, Dr. Patel should continue with self-study activities. Preceptor meetings should be scheduled once CPEP has notified Dr. Patel that the Preceptor candidate has been approved.

LEARNING OBJECTIVES

I. **To improve psychiatric evidence-based medical knowledge, including but not limited to the following:**
   1) Elements of a comprehensive and detailed initial psychiatric assessment, including but not limited to, patient history, family history, and mental status exam;
   2) Algorithms for formulating differential diagnoses;
   3) Symptoms associated with and current management approaches for common psychiatric disorders, including but not limited to the following disorders:
      a) anxiety;
      b) mood (including bipolar disorder);
      c) psychotic;
      d) personality;
      e) post-traumatic stress;
      f) obsessive-compulsive;
      g) dementia;
   4) Non-pharmacologic therapy, including but not limited to, cognitive behavioral therapy;
   5) Legal dimensions of psychiatric practice;
   6) Indicators of substance abuse;
   7) Ability to discern the severity of disorders for appropriate management;
   8) Appropriate testing that is consistent with and supported by the patient's symptoms;
   9) Ability to identify changes in patient behavior and manage accordingly.

II. **To improve knowledge of current pharmacologic therapy that includes but is not limited to the following, especially as related to the disorders identified above:**
   1) Side effects;
   2) Drug-drug interactions;
   3) Dosing.

III. **To improve clinical decision-making in the following areas:**
1) Consistent application of medical knowledge;
2) Organized, detailed, comprehensive, and integrated approach to diagnostic evaluation that includes differential diagnoses;
3) Development of comprehensive and integrative treatment plans for an adequately wide range of psychiatric diagnoses; these plans should include documentation of the patient's progress;
4) Consideration of medication management options;
5) Application of psychopathology.

IV. **To improve patient care documentation, specifically:**
1) Organized and complete chart components, including flow sheets;
2) Consistently organized, detailed and complete notes, that include but not limited to the following elements:
   a) Presenting complaint;
   b) Psychiatric history;
   c) Family and social history;
   d) Mental status exam;
   e) Differential and final diagnoses;
   f) Detailed treatment plans;
   g) Patient/family education;
   h) Consultant reports/communications;
   i) Testing;
   j) Detailed clinical reasoning;
3) Consistent documentation of all patient encounters.

V. **To monitor physician-patient communication:**
1) Effective core communication skills.

VI. **To determine a plan to maintain current standards within the field of psychiatry.**

VI. PERFORMANCE OBJECTIVES and EVALUATION METHODS

Refer to Appendix A for further directions.

PERFORMANCE OBJECTIVES

Dr. Patel will complete the following specified Objectives:

A. Knowledge (Learning Objective I)
1) For each Objective I content area, including subtopics:
   a) Review two current, reputable medical references explicitly relevant to the content area. If assigned a specific guideline for a content area (see below), it can be utilized as one of the references;

b) Submit a brief paragraph, outline or algorithm explaining the applicability of knowledge gained from his reading to his current practice, including how he will utilize the learned information in his practice. If the information is not applicable to his practice, he should explain his rationale. Include reference titles and dates of publication;

2) Subscribe to *Focus: The Journal of Lifelong Learning in Psychiatry and the Focus Self Assessment Examination*. The subscription should include the "Influential Papers." Dr. Patel should participate in ongoing reading and assessment. More information can be found at the following web site: http://www.psych.org/edu/cme/selfassess_exam/saexam.cfm. If Dr. Patel identifies an alternative course, the Associate Medical Director must approve the course;
3) Review guidelines/references relevant to diagnosis and treatment of common psychiatric disorders. CPEP recommends the following Internet sites as resources: http://www.guideline.gov and http://www.psych.org;
4) Dr. Patel will participate in Grand Rounds as scheduled at a nearby facility if available.

B. Clinical Decision Making
1) Obtain and utilize the most current publication of the DSM IV-R to assist in developing a more structured and comprehensive approach to the differential diagnosis of patient complaints.

C. Communication
1) Read The Medical Interview by John L., M.D. Coulehan, Marian R., M.D. Block;
2) CPEP will determine if Dr. Patel would benefit from further educational intervention;
3) Discuss with the Supervisor and Preceptor during Phase I and II.

D. Documentation
1) Independently review documentation and medical record keeping;
2) Attend a documentation seminar, with a follow-up component. The follow-up component must consist of at least two chart reviews, preferably three. A course brochure should be submitted for the Associate Medical Director's approval within 30 days of signing the Plan. A certificate of attendance should be submitted to CPEP upon completion;
3) Integrate feedback from the CPEP Associate Medical Director and the Preceptor promptly.

E. Preceptor Meetings and Chart Reviews
1) Address the Objective I content areas with the Preceptor through didactic exercises, as well as case-based and hypothetical discussions;

2) Meet with the Preceptor weekly for a period of time to be determined by the Associate Medical Director and then twice monthly for the duration of the Plan;
3) Provide 16 redacted charts per month (four charts per weekly session and eight charts per twice monthly sessions), for the duration of Phase II for review with the Preceptor. Dr. Patel will submit these charts to the Preceptor prior to their scheduled meeting to allow the Preceptor time for review. As much as possible, the charts selected should be relevant to the content areas of the Plan;
4) Charts should generate discussions addressing medical knowledge, application of medical knowledge to patient care, clinical judgment, and documentation;
5) Submit to CPEP, every other month, four of the 16 redacted charts used in the Preceptor meetings for review by the Associate Medical Director;
6) Discuss his plan for ongoing professional development with the Preceptor.

F. Submission Requirements:
See Appendix A for timelines.
1) Maintain an Education and/or Supervisor Log, documenting all educational activities, including topics discussed with the Preceptor, and submit to CPEP;
2) Submit practice application materials for Objective I to CPEP;
3) Submit title, resource and date of publication, or first page of article, for all assigned guidelines for Objective I to CPEP;
4) Submit a certificate of completion and/or monthly participation in *Focus: The Journal of Lifelong Learning in Psychiatry and the Focus Self Assessment Examination,* or other approved course;
5) Develop a plan for ongoing professional development in psychiatry and submit it to CPEP.

EVALUATION METHODS

A. The Preceptor will:
1) Provide feedback to Dr. Patel on medical knowledge, application of knowledge, clinical judgment, communication and documentation at the time of their meetings;
2) Provide monthly written and scheduled verbal feedback on Dr. Patel 's progress for the duration of the Plan, or as applicable.

B. The Associate Medical Director will:
1) Review and approve the required submissions to CPEP, and provide feedback to Dr. Patel , with regard to medical knowledge, application of medical knowledge, clinical judgment, documentation, and other identified areas, during regularly scheduled telephone conversations;
2) Monitor Dr. Patel 's documentation and overall progress;

3) Review and approve Dr. Patel 's plan for ongoing professional development;
4) Provide a written progress report approximately every trimester.

ESTIMATED DURATION

The duration of the Education Plan can only be estimated. CPEP anticipates that this Educational Intervention will last approximately 12 months. It may be extended or shortened at the discretion of CPEP depending on progress towards meeting the stated educational goals. If new education needs are uncovered during the course of this Plan, these will be addressed accordingly.

REASSESSMENT

Dr. Patel will return to CPEP within two to six months following the completion of the Education Plan for a Post-Education Evaluation that addresses the content of the Plan.

DISCLAIMER

CPEP reserves the right to change the content and/or duration of the Education Plan.

SIGNATURES

Shared Patel , M.D. — Date: 8/13/06

Nancy Wilson-Ashbach, M.D.
Associate Medical Director — Date

Return the signed original Education Plan to CPEP. Keep copies of the Plan for your reference and to forward to Supervisor/Preceptor candidates.

COMMONWEALTH OF KENTUCKY
STATE BOARD OF MEDICAL LICENSURE
CASE NO. 741

IN RE: THE LICENSE TO PRACTICE MEDICINE IN THE COMMONWEALTH OF KENTUCKY HELD BY SHARAD C. PATEL, M.D., LICENSE NO. 20851, ADDRESS OF RECORD: 1230 WOODLAND DR., #210, ELIZABETHTOWN, KENTUCKY 42701

AGREED ORDER OF SURRENDER

Come now the Kentucky Board of Medical Licensure (hereafter "the Board"), acting by and through its Inquiry Panel B, and Sharad C. Patel, M.D., and, based upon their mutual desire to fully and finally resolve the grievance pending in this matter, without formal disciplinary proceedings, hereby ENTER INTO the following AGREED ORDER OF SURRENDER:

STIPULATIONS OF FACT

The parties stipulate the following facts, which serve as the factual bases for this Agreed Order of Surrender:

1. At all relevant times, Sharad C. Patel, M.D., was licensed by the Board to practice medicine within the Commonwealth of Kentucky.
2. The licensee's medical specialty is Psychiatry.
3. On March 8, 1999, the licensee filed with the Board an Amended Letter of Agreement, which he executed on March 5, 1999. Condition 1 of the Amended Letter of Agreement specifies: "Physician shall fully maintain a contractual relationship with the Impaired Physicians Committee and abide by all conditions placed upon him by the Impaired Physicians Committee."

4. On March 16, the licensee verbally notified a Board Investigator that he desired to convert his license to inactive status and that he intended to discontinue his relationship with the Kentucky Physicians Health Foundation—Impaired Physicians Program ("IPP"). In a Memorandum to the Board's Inquiry Panel B, dated March 22, 2000, the investigator notified the Board of same.

5. In a letter, dated March 17, 2000, Burns M. Brady, M.D., IPP's Medical Director, confirmed a telephone conversation he had with the licensee. In his letter, a copy of which was received by the Board on March 21, 2000, Dr. Brady stated: "As I understand it, you [the licensee] are not going to renew your Kentucky medical license at this time and would like to discontinue your relationship with [IPP]." Seeking confirmation of his understanding, Dr. Brady further stated in same: "I look forward to your response and if I have not heard from you within 14 days of your receipt of this letter, then I will assume this establishes for our records and for the Kentucky Board of Medical Licensure that you are discontinuing your relationship with this organization." To date, neither IPP nor the licensee has reported to the Board any additional information concerning the licensee's decision, which the Board treats as a final one.

STIPULATED CONCLUSIONS OF LAW

The parties stipulate the following Conclusions of Law, which serve as the legal bases for this Agreed Order of Surrender:

1. The licensee's Kentucky medical license is subject to regulation and discipline by the Board.

2. Based upon the Stipulations of Fact, there are legal grounds for the Board to impose disciplinary sanctions upon the licensee's Kentucky medical license pursuant to KRS 311.595(13).

3. Pursuant to KRS 311.591(6) and 201 KAR 9:082, the parties may fully and finally resolve the pending grievance without formal disciplinary proceedings by entering into an informal resolution such as this Agreed Order of Surrender.

AGREED ORDER OF SURRENDER

Based upon the foregoing Stipulations of Fact and Stipulated Conclusions of Law, and, based upon their mutual desire to fully and finally resolve the pending grievance without formal disciplinary proceedings, the parties hereby ENTER INTO the following **AGREED ORDER OF SURRENDER**:

1. The licensee shall surrender his Kentucky medical license for an indefinite period, with said surrender becoming effective immediately upon the filing of this Agreed Order of Surrender.

2. During the period in which the licensee's Kentucky medical license is surrendered, he may not perform any act which would constitute the "practice of medicine," as that term is defined in KRS 311.550(10) – the diagnosis, treatment, or correction of any and all human conditions, ailments, diseases, injuries, or infirmities by any and all means, methods, devices, or instrumentalities.

1. The licensee may not petition the Panel for reinstatement of license for a period of two (2) years from the effective date of this Order. If the licensee should petition the Panel for reinstatement of his license, the burden shall be on him to satisfy the Panel that he is presently of good moral character and qualified both physically and

mentally to resume the practice of medicine without undue risk or danger to his patients or the public. The decision whether to grant the petition will be within the sole discretion of the Panel; the Panel may order the licensee to complete appropriate testing and/or evaluations, at his expense, to assist it in its determination. If the Panel should grant the licensee's petition for reinstatement, his license shall be placed on probation for a period of 2-5 years, under terms and conditions deemed appropriate by the Panel at that time.

2. The licensee expressly agrees that, if he should violate any term or condition of this Agreed Order of Surrender, the licensee's practice will constitute an immediate danger to the public health, safety, or welfare, as provided in KRS 311.592 and 13B.125. The parties further agree that, if the Board should receive information that he has violated any term or condition of this Agreed Order of Surrender, the Panel Chair is authorized by law to enter an Emergency Order of Suspension or Restriction immediately upon a finding of probable cause that a violation has occurred, after an *ex parte* presentation of the relevant facts by the Board's General Counsel or Assistant General Counsel. If the Panel Chair should issue such an Emergency Order, the parties agree and stipulate that a violation of any term or condition of this Order would render the licensee's practice an immediate danger to the health, welfare and safety of patients and the general public, pursuant to KRS 311.592 and 13B.125; accordingly, the only relevant question for any emergency hearing conducted pursuant to KRS 13B.125 would be whether the licensee violated a term or condition of this Agreed Order of Surrender.

3. The licensee understands and agrees that any violation of this Agreed Order of Surrender may serve as the basis for additional disciplinary action, pursuant to KRS 311.595(13), including revocation of his Kentucky medical license.

SO AGREED on this 31st day of May, 2000.

FOR DR. PATEL:

SHARAD C. PATEL, M.D.

COUNSEL FOR DR. PATEL
(IF APPLICABLE)

FOR THE BOARD:

PRESTON P. NUNNELLEY, M.D.
CHAIRMAN, INQUIRY PANEL B

Y. DENISE PAYNE WADE
Assistant General Counsel
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, Kentucky 40222
(502) 429-8046

ENTERED: 06/09/00