

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

BOARD OF MEDICAL LICENSURE :
AND DISCIPLINE :
: No. C00 - 159
IN THE MATTER OF :
CLAUDE E. YOUNES, M.D. :

ADMINISTRATIVE DECISION AND ORDER
TRAVEL OF THE CASE

This matter is before the Board of Medical Licensure and Discipline (hereinafter "Board") upon matters contained in a Specification of the Charges, dated 10 October 2000 (Ex. IVC1), and Time and Notice of Hearing, dated 14 August 2002 (Ex. 1) issued to Claude E. Younes, M.D. (hereinafter "Respondent").

The Specification of the Charges and Time and Notice of hearing informed "Respondent" that a hearing would be held on 11 September 2002 on the question of whether his license as a physician in the State of Rhode Island should be revoked or suspended or why he should not be otherwise disciplined. The "Board" alleges that "Respondent" is guilty of unprofessional conduct by reason of negligence in his diagnosis, evaluation and treatment of Patient A. Further, it is alleged that "Respondent" failed to make, record, and document needed clinical findings on 3 June 1999. This conduct, if proven, is unprofessional and constitutes grounds for the imposition of disciplinary sanctions (RIGL 5-37-5.1(19)).

A hearing on the matters contained in the Specification of the Charges was held on 11 September 2002. Additional hearings were convened on 23 July 2003 and 29 June 2004. The members of the Hearing Committee of the "Board" (hereinafter "Committee") were James Griffin, D.O., Chairperson; Margaret Coughlin, and Dorothy Williams. Mary Ellen McCabe and

Maureen A. Hobson, attorneys for the Department, acted as legal advisors to the Hearing Committee; Joseph G. Miller, Esquire represented the investigating Committee of the "Board". Claude E. Younes, M.D. appeared at the time and date set for hearing with his attorney, David W. Carroll, Esquire. At the hearing conducted on the merits of this matter, Mr. Miller solicited testimony from three (3) witnesses for the State. He also examined the "Respondent" as an adverse witness. Mr. Carroll then also examined his client. Sixteen (16) exhibits were entered into the record. Mr. Carroll made Motions to Dismiss for various reasons set forth in legal memos. Those Motions are hereby denied and the Board renders its decision on the merits.

SUMMARY OF THE TESTIMONY

The first person to testify was John Doe, son of Patient A. During the relevant period, 1998 – 1999, Mr. Doe resided and worked in North Providence, RI, in close proximity to his mother's home. He maintained frequent communication with Patient A and was cognizant of her health status. Mr. Doe testified that Patient A's treating physician was a Dr. Morey until his retirement sometime in 1998. Inasmuch as Dr. Younes took over Dr. Morey's practice, Patient A commenced treating with "Respondent". Mr. Doe related that during 1999, his mother informed him that she was experiencing a pressure feeling in her shoulder and the side of her head and that the right side of her neck was sore. In the spring of 1999, John Doe recalled that Patient A complained of a lump in the right side of her neck.

John Doe testified that in June of 1999 his mother communicated to him that she had scheduled an appointment with Dr. Younes for the purpose of seeking to ascertain the nature and cause of her neck problems and the associated lump. According to Mr. Doe, his mother was frustrated with her illness and sought to find an answer to her problem.

Mr. Doe related that his mother saw Dr. Younes on 3 June 1999. He recalls this day inasmuch as his mother came to his place of business following her appointment with the "Respondent". At that time, Patient A related to her son the substance of her visit to Dr. Younes. Patient A told her son, that prior to seeing the doctor, a nurse took her vital signs, checked her lungs and made notes on her chart prior to a full examination. She told John Doe that she related to the doctor her complaints pertaining to the lump in her neck. His response to her was that this was a pulled muscle. Mr. Doe explained that his mother was frustrated with this explanation. At this point Patient A's son asked his mother if he could see and feel the lump. She acquiesced to his request. John Doe testified that to his touch the lump on his mother's neck was large and very bumpy. It was approximately the size of a quarter. He described the location of the lump as being behind the right ear. He further testified that the lump appeared to be oval in shape and located in her upper neck. It was clearly visible when his mother stood erect.

John Doe then proceeded to query Patient A as to what had transpired during her appointment with Dr. Younes. According to his mother, "Respondent" did not touch the lump. He prescribed pain medication for a pulled muscle. Mr. Doe was concerned and advised his mother to seek a second opinion. Patient A did present to the emergency room on Mineral Spring Ave., North Providence, R.I. where she was diagnosed with cancer. A biopsy confirmed the existence of a tumor in Patient A's lung. Thereafter, she underwent a course of chemotherapy. This series of events prompted his mother to file a complaint with the Board of Medical Licensure and Discipline (Ex 4).

Under cross-examination John Doe acknowledged that he had not seen Dr. Younes' records pertaining to the care and treatment of his mother. Nor was he present with his mother

on 3 June 1999 when she saw Dr. Younes. However, he remained adamant that Patient A told him that "Respondent" did not examine her neck.

Dr. Younes was called as an adverse witness by Mr. Miller. "Respondent" testified that he obtained his medical training in Russia. He served an internship in Russia and at Rhode Island Hospital. He practiced medicine in Lebanon for approximately two (2) years. Dr. Younes testified that he was Board eligible in Internal Medicine. He explained that he had twice taken and failed the examination required for Board Certification. "Respondent" has maintained a private practice in internal medicine on Mineral Spring Ave, North Providence, R.I., since 1995.

Mr. Miller then proceeded to question "Respondent" with respect to the entries contained in his record of the care and treatment he rendered to Patient A (Ex 5). Dr. Younes explained that he first treated Patient A on 23 January 1998. He related that the nurse in his office generally ascertains from the patient his/her past medical history and current complaints. This is recorded in the medical record. Also noted in the record are the vital signs and results of a physical examination. A problem list is also maintained. If the problem list remains constant during subsequent visits no further entries are recorded. Only new problems are noted.

With respect to Patient A, the record of her 23 January 1998 visit indicates anxiety/nervous breakdown; bronchitis; tuberculosis; COPD/emphysema; high cholesterol; SP/CVA in the 80's; and osteopenia as problem areas. The record also contains entries with respect to the medications Patient A was taking in January 1998. Dr. Younes testified it is his practice to conduct an examination of his patients quarterly, that is, he examines the heart, lungs, abdomen and laboratory work is performed.

Dr. Younes' testimony continued with further review of Patient A's medical record and related to the matters contained therein. He explained that the notes for the 24 April 1999 visit

indicate that patient A complained to the nurse, a LPN, that she was experiencing cervical pain in the neck area. The "Respondent" testified that Patient A had also informed him that she had been seen by another physician for an allergic reaction to shellfish. "Respondent's" nurse noted the existence of the cervical pain and the rash in the medical chart.

Dr. Younes acknowledged that he had not personally made any notes addressing the subject of cervical pain in Patient A's chart. He explained the reason for this was the fact that the patient related such complaints to the nurse. He made no inquiry about this of the patient. During the April visit, the record shows a notation regarding cervical pain as being entered by the nurse. According to Dr. Younes, Patient A did not relate to him complaints of cervical pain. Her main concern was the allergic rash. Further, he could not recall any discussions of this subject or whether he saw the nurse's notations regarding the complaint of cervical pain during the April visit. Patient A returned to "Respondent's" office on 3 June 1999. The medical record on this date indicates that she had pain in the top of head which radiated down her face and neck. This was related to the nurse who made the entry in the medical record. The nurse's notes further indicate the patient had phlegm, an upset stomach and a rash on her right forearm. There is no evidence in the medical chart that the "Respondent" made any correlation between the rash of six weeks duration that the patient complained of on 16 April 1999 and the rash on her forearm on 3 June 1999; nor is there any evidence that he associated the cervical pain she complained of in April with the pain on the top of her head radiating down to her face and neck. Although the "Respondent's" note of 29 April 1999 indicates that the earlier rash had been as a result of a reaction to shellfish, he admitted in his testimony that in retrospect the rash was not caused by shellfish.

In response to questions as to why nothing was documented by him regarding the cervical pain being experienced by the patient, the "Respondent" stated that he does not always document what he discusses with or does for a patient. He notes only what he determines is the patient's "major problem". He testified that the fact that the nurse's notes spoke to the cervical pain, whereas his notes did not, was indicative of the fact that cervical pain was not an overriding issue, that the patient was more concerned with the rash on that date. When the "Respondent" was asked how anyone else looking at the record would know whether the neck pain had been addressed at all, he responded because that's the way he does it. It would be too time consuming to write everything down.

Contrary to the patient's son's testimony, the "Respondent" testified that he did conduct a physical examination of Patient A, which although not documented, would have included central nervous system check in response to the patient's complaint of head pain radiating into her face and neck. Though not charted, the "Respondent" testified that he also would have felt the back of the patient's neck. He said that he found no lump at that time and suggested that the patient being on prednisone on that date could have contributed to his failure to locate the lump that was discovered by Dr. D'Amato in his examination of the patient six days later. The nurse's notes of 3 June 1999 indicate that the patient had already stopped taking prednisone prior to seeing the "Respondent". "Respondent" maintains that she was still taking prednisone and discontinued it several days after her visit with him. From the physician's notes, it would appear that the "Respondent" attributed the patient's headache to stress, the prednisone or flu. He testified that the phlegm in her throat was due to the patient's smoking habit. Although he did not notate it, the "Respondent" stated that he had a lengthy discussion with the patient about the head pain. Nothing is noted because assessment of the CNS was negative for any problem. The

“Respondent” acknowledged that there is nothing set forth in his chart that would substantiate an examination of the patient’s head, face or neck. Despite this, the “Respondent” was steadfast that such an examination was performed. The “Respondent” further testified that the patient did not complain, or even tell him about the lump in her neck. He attributed the fact that he did not observe the lump to be due to the fact that the patient was taking prednisone at the time, or to the possibility that the lump appeared between 3 June 1999 and 9 June 1999, when the patient first saw Dr. D’Amato. At the conclusion of this visit Patient A scheduled a routine follow-up visit.

Dr. Younes testified that subsequent to the 3 June 1999 appointment, Patient A was treated by a Dr. D’Amato. This doctor called “Respondent” on 9 June 1999 to notify him that he had discovered a mass in Patient A’s lung. Dr. D’Amato asked “Respondent” how he wished to proceed. Dr. Younes responded that he would see her the following day and that a CT Scan should be ordered. “Respondent” recalled that Patient A cancelled her appointment with him scheduled for 10 June 1999.

Subsequently, in his testimony the “Respondent” said he scheduled the patient for a follow-up appointment on 14 June 1999, but the patient cancelled. The patient’s record does not indicate that an appointment was scheduled, but it was entered into his computer calendar.(Ex.A) The next notation of any kind in the patient’s chart following 3 June 1999 was on 10 December 1999 indicating that the patient had expired. Though the “Respondent” testified that he spoke with Dr. D’Amato about the appropriate course of treatment for the patient after Dr. D’Amato discovered the mass, there is no evidence of that documented in the patient’s chart.

The next person to testify was Stephen John D’Amato, M.D. Dr. D’Amato is Board certified in emergency medicine. He has engaged in the practice of this specialty for approximately twenty-two (22) years at North Providence Medical Services, Inc. Dr. D’Amato

testified that he saw Patient A on 9 June 1999. A copy of the doctor's records of patient A was entered with the record. (Ex 6)

Dr. D'Amato reviewed the record of Patient A. He related the nature and scope of his examination of the patient and his findings. Specifically, Patient A presented with complaints of nausea, lump to the right side of the neck, loss of taste for food and loss of appetite, and increased mucous. Medical history indicates Patient A suffered from dermatitis and a nervous condition. Medications prescribed for the patient included Navane and Diazepam. Vital signs were taken by the nurse at the facility and recorded in Patient A's chart. Dr. D'Amato related that patient A was sixty-two (62) years of age. She had been taking the medication Haldol, but her psychiatrist recently switched her to Prolixin. The patient had been prescribed Prednisone for allergic dermatitis. Patient A had concluded that course of treatment a few days prior to the 9 June 1999 visit.

Dr. D'Amato testified that in addition to obtaining a history from Patient A he ordered a number of diagnostic tests including x-rays of her chest and abdomen, electrocardiogram, blood work, and urinalysis. The doctor also conducted a physical examination of Patient A. The most significant finding identified during the course of this examination was the presence of a firm mass on the right side her neck. This was discovered by the physician palpating this area. Dr. D'Amato explained that he sought to ascertain the nature of this mass by also examining the patient for signs of thyroid condition, inflamed glands or lymph nodes. He testified that he was looking for what is called the differential diagnosis of a mass on the neck. The doctor related that nodes or glands are also present in the area of the neck where he identified the presence of the lump on Patient A's neck. He indicated that lymph nodes can flare up with the onset of certain infections. They become enlarged and vary in size. The glands serve to fight infections.

Once the infection has terminated, residual lymph nodes remain and can be identified upon examination. Likewise, with respect to the thyroid gland. Prior to rendering a diagnosis with respect to the lump on Patient A's neck, Dr. D'Amato sought to rule out its genesis as being lymph glands or thyroid.

Dr. D'Amato also testified that Prednisone, the medication Patient A was prescribed for her dermatitis, could have shrunk her glands. However, upon completion of this therapy the glands could flare up. Accordingly, on one day a physician examining the patient would not feel the gland. Whereas an examination a few days later would identify inflamed glands if they flared up for one reason or another.

After reviewing the results of the diagnostic tests including the chest x-ray and the findings of the physical examination, Dr. D'Amato concluded that Patient A had a growth inside the lung in the upper part called the mediastinum, that is, the section of the chest between the lungs. After making this diagnosis, Dr. D'Amato contacted "Respondent" and notified him of these findings. Dr. Younes said he would see Patient A on the following day. Dr. D'Amato instructed Patient A to call "Respondent" to schedule an appointment for the following day and discharged her. The next day Dr. D'Amato received a call from Patient A. At that time she requested a referral to a lung specialist. He recommended Dr. Beliveau, an oncologist. The witness contacted Patient A on 12 June 1999 in order to ascertain if she had contacted Dr. Beliveau. The record indicates that she had scheduled an appointment with this physician. This concluded Dr. D'Amato's testimony.

Paul J. Agatiello, M.D., F.A.C.P. was presented by Mr. Miller as an expert witness in the field of Internal Medicine. Dr. Agatiello received his undergraduate and medical degrees from Brown University. He served an internship and residency in Internal Medicine at Rhode Island

Hospital from 1981 to 1984. Dr. Agatiello is Board Certified in Internal Medicine and was a fellow of the American College of Physicians (1985-2000). He maintained a private practice as an internist until his retirement in 2002. In this practice, he experienced a broad spectrum of patients and acted as a primary care gatekeeper. Dr. Agatiello is also a clinical instructor with Brown University Medical School. He teaches the science and art of medicine. The science being the knowledge component. Whereas the art of medicine pertains to acquiring knowledge of a patient as a person, that is, to place yourself inside the head of the person under your care. To Dr. Agatiello, this is the more important aspect of medical practice. Dr. Agatiello has testified as an expert witness on behalf of the Board on four (4) or five (5) prior occasions. His remuneration is approximately sixty dollars (\$60.00) per hour.

Prior to testifying in this matter, Dr. Agatiello reviewed several documents to prepare for the hearing. These included the specification of charges (Ex.3); the transcript of the 11 September 2002 hearing; Dr. Younes' progress notes of his treatment of Patient A (Ex.5); letters from Dr. Younes to the Board and Dr. Hamolsky; the letter of complaint from Patient A to the Board (Ex.4); report of biopsy (Ex.6); operative report (Ex.6); prescriptions written by Dr. Younes for Patient A (Ex.5); Dr. D'Amato's summary notes pertaining to his treatment of Patient A (Ex.6); and medical literature. Dr. Agatiello explained that any opinion rendered during the course of his testimony would be based upon reasonable medical certainty. When queried as to whether Dr. Younes care and treatment of Patient A adhered to standards of care, Dr. Agatiello's response would be based upon the standards expected of a reasonably prudent practitioner in a similar class to that of the Respondent.

Dr. Agatiello proceeded to discuss the adequacy of Dr. Younes' documentation of his care and treatment of Patient A. Testimony on this issue was restricted to entries of Patient A's

record dated 3 June 1999 for the reason this was the date cited in Count Three of the Specification of Charges (Ex.2). That count contained allegations that Respondent negligently failed to make, record, and document needed clinical findings on 3 June 1999.

Prior to directing his presentation to the adequacy of the Respondent's entries in Patient A's record for 3 June 1999, Dr. Agatiello explained the importance of appropriate documentation. Failure to adequately record findings and observations leaves the reader in a quandary as to what the writer was thinking and/or actually did on a particular day. The witness testified that if "it is not written, it has not been done". He went on to explain that both positives and pertinent negatives must be recorded.

The doctor then addressed the nature and scope of the entries made in Patient A's record by the Respondent and his nurse. He cited examples of inadequate documentation on the part of Dr. Younes. Specifically, Dr. Agatiello pointed to the fact that the nurse had noted that Patient A's blood pressure was elevated. However, absent from the record is any notation that Dr. Younes provided for any follow-up care for this condition. Dr. Agatiello testified that, expected of a practitioner in "Respondent's" class when a patient presented with a blood pressure above the norm, is to refer the patient to a specialist or conduct a re-evaluation within a month. The record of Patient A maintained by "Respondent" is silent on this issue. Likewise, with respect to entry into the nurse's notes indicating that Patient A's temperature on this date was 99.1. Dr. Agatiello testified that the "Respondent" should address this issue regardless of severity. A prudent physician would need to ascertain if, and when, the temperature returned to normal. Dr. Younes did not do this.

~~Dr. Agatiello testified that, although the nurse's notes referenced that Patient A~~
complained of pain at the top of her head that radiated down her face and neck, the

“Respondent’s” entry for 3 June 1999 does not contain any information indicating an examination of the head or neck. “Respondent” failed to document any information indicative of an examination of the patient’s neck.

Dr. Agatiello opined that “Respondent” failed to adequately document his care and treatment of Patient A on 3 June 1999. Hence, “Respondent” failed to adhere to the standard of care expected of a prudent physician in his class. This opinion was based, in part, upon the omission of pertinent negatives in Patient A’s chart as well as the absence of SOAP notes.

The witness explained that proper documentation would include so-called SOAP notes. This acronym stands for the subjective findings, that is, the information conveyed by the patient to the doctor; objective evaluation which consists of a physical examination of the patient; an assessment by the physician which includes an evaluation of the subjective and objective findings and a determination as to causation of problems presented by the patient; and the development of a plan of cure. Dr. Agateillo testified that Dr. Younes’ progress notes maintained for Patient A were deficient in that they did not contain all the elements noted above. Consequently, it was his opinion, rendered to a degree of reasonable medical certainty and probability, that “Respondent’s” documentation of his care and treatment of Patient A on 3 June 1999 was not consistent with the standard of care expected of a reasonably competent practitioner in his class.

Dr. Agatiello next proceeded to address the treatment issues he identified after reviewing the documents provided to him prior to the hearing. The doctor testified that it was his opinion that Dr. Younes failed to meet the standard of care expected of a practitioner in his class with respect to the care and treatment rendered to Patient A. Dr. Agatiello related that both Taber’s Medical Dictionary and Steadman’s Medical Dictionary define treatment as consisting of

medical/surgical care and management of a patient. Documentation is also encompassed within the concept of treatment. Dr. Agatiello testified that, in particular, on 3 June 1999, "Respondent" failed to conduct a thorough examination of Patient A. Such an examination would include six (6) components which are as follows:

1. comprehensive health history;
2. physical examination;
3. review of symptoms;
4. problem list;
5. coherent assessment and care plan;
6. laboratory and/or other diagnostic tests.

Absent from the records reviewed by the witness, is any evidence that Dr. Younes, in fact, performed a thorough examination of Patient A on 3 June 1999. It is his expert opinion that on this date "Respondent" was negligent with respect to his care and treatment of Patient A.

Dr. Agatiello premised this opinion upon the fact that "Respondent" failed to appropriately address the patient's complaint of pain on her head as noted by the nurse on 3 June 1999. A reasonably prudent physician would inquire as to the severity of the pain; and what measures, if any, the patient took to alleviate the pain. Additionally, Dr. Agatiello testified that a physical examination of the neck was warranted. This would include palpation of the neck, glands, arteries, lymph nodes and muscles. The progress notes for Patient A contain no entries reflecting that Dr. Younes performed any of these procedures on the patient. Hence, he did not meet the expected standard of care.

The witness also testified that, in a letter to the Board, dated 1 November 2000, Dr. Younes stated that Patient A's lymph nodes were within normal limits. The record indicates that Dr. Younes noted the nodes measured 1.5 X 7 X .5. Dr. Agatiello testified that this is not within normal limits. A lymph node measuring more than one (1) cm is abnormal according to medical literature.

Dr. Agatiello was queried as to what impact, if any, the drug Prednisone would have on the size of a lymph node. According to the witness, if the node were cancerous, Prednisone would not alter or shrink its size. From his review of "Respondent's" progress notes, the witness could not ascertain when Patient A stopped taking Prednisone. However, inasmuch as Patient A was diagnosed with a cancerous mass, the drug Prednisone would not have impacted the size of the node. In this regard, Dr. Agatiello testified that he disagreed with Dr. D'Amato on this issue.

Dr. Agatiello also testified at length with respect to the "Respondent's" failure to appropriately care and treat Patient A on 16 April 1999. It was his opinion that the "Respondent" did not address the issue of cervical pain reflected in the nurse's notes for that day. Neither the progress notes nor the transcript of Dr. Younes' testimony at the prior hearing evidence any reference to an examination of Patient A's neck. The physician's entry in Patient A's chart reflects only the matter of a skin rash. Dr. Agatiello opined that Dr. Younes did not meet the standard of care of a prudent practitioner when he neglected to examine Patient A's neck when the nurse's notes referenced a complaint of neck pain.

Dr. Agatiello concluded his direct examination by referencing other areas where "Respondent's" treatment of Patient A failed to adhere to the established standard of practice. The witness pointed to the "Respondent's" failure to provide a plan to address elevated blood pressure; failure to obtain records of the patient's psychiatric care; absence of a neurological examination in response to complaints of insomnia; and the absence of SOAP notes.

In summary, it was this witness' expert opinion that the "Respondent" was negligent in his treatment and care of Patient A. Dr. Younes did not conform to the minimal standards of acceptable practice with respect to Patient A.

Under cross-examination, Dr. Agatiello did not waiver from the opinions he rendered during his direct examination. Notwithstanding, the fact that Dr. Younes did record in the progress notes for Patient A that her lungs, skin, abdomen, heart were examined, there is no reference to any examination of the neck or cervical area.

The Respondent rested his case without presenting any expert testimony. Thereafter, the parties submitted memoranda of law in support of their respective positions.

CONCLUSIONS

The Specification of Charges contains seven separate counts alleging that the Respondent has been guilty of unprofessional conduct pursuant to §§ 5-37-5.1 and 5-37-5.1(19).

Count One alleges that the Respondent has been guilty of unprofessional conduct in his treatment of Patient A for the reason that he negligently treated her. Count Two alleges negligent conduct in the practice of medicine because the Respondent negligently evaluated the patient. The Board finds that the Respondent was negligent in his evaluation and care of Patient A. Over the course of approximately 18 months the patient presented with varying symptoms of neck pain, a lump in her neck, skin rashes, headache, lethargy, low-grade fever, low sodium, shoulder pain and anxiety among other things. The patient was noted to be a heavy smoker with cardiopulmonary disease. The constellation of nonresolving symptoms reported by the patient is an obvious signal that the presence of cancer should have been suspected, especially given the patient's smoking history. Despite the patient's complaints, there is no evidence that the Respondent ordered any diagnostic testing, including, but not limited to a chest X-ray, blood analysis or a CT scan, to assist him in finding the route of the patient's problems. Within one week of her last visit with Respondent, the patient sought medical services at a walk-in emergency center where she saw Dr. D'Amato for the first time. Upon examination, he

immediately noted the lump on the patient's neck and ordered diagnostic testing whereby he was able to ascertain that the patient had cancer. The Respondent's failure to order diagnostic testing for Patient A falls below the minimal standards of acceptable medical care. The Respondent's failure to consider the totality of the patient's symptoms leading to a failed diagnosis likewise constitutes negligent conduct.

With respect to Count Three, the Respondent has filed a Motion to Dismiss that Count as not falling within the parameters of § 5-37-5.1(9) focusing particularly on record-keeping requirements. The Board did not charge the Respondent with a violation of that section. Rather, Count Three alleges violation of § 5-37-5.1 in general and subsection (19) specifically. The Board finds that the Respondent did not make clinical findings of record for Patient A. The failure to do so constitutes negligent conduct that does not conform to minimal acceptable and prevailing medical practices. The Respondent's Motion to Dismiss Count Three is denied.

Count Four alleges negligence in the diagnosis, care and treatment of Patient A. For the reasons elucidated with respect to the Board's consideration of Counts One and Two, the Board finds that the Respondent was negligent in the diagnosis, care and treatment of Patient A. The record is devoid of any diagnostic activities with respect to the patient. Further, there is no indication in the patient's record that the Respondent engaged in SOAP, i.e. evaluating the patient's subjective complaints, objectively evaluating the patient by physical examination, assessing the subjective and objective findings and developing a protocol for treating the patient. This failure does not conform to the minimum standards of acceptable medical care. Count Five alleges that the Respondent was negligent by reason of his failure to order proper tests for Patient A. In the reasons set forth in the Board's discussion of Count Two, the Board finds Respondent negligent with respect to Count Five. As an internist, the Respondent should have evaluated the

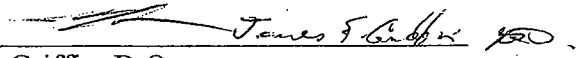
constellation of symptoms presented to him by the patient and demonstrated upon his physical examination of the patient and thereupon take action to address them with diagnosis and treatment (including, but not limited to referral of the patient). His failure to do so does not conform to the minimal standards of medical care for an individual practicing internal medicine.

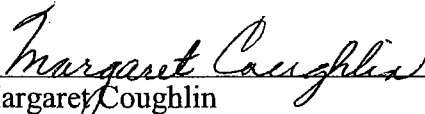
The Respondent's failure to properly assess the patient and order diagnostic testing for her resulted in his failure to recognize her cancer and to make a proper referral for the treatment of that condition. Therefore, the Respondent is found guilty of the allegations set forth in Count Seven.

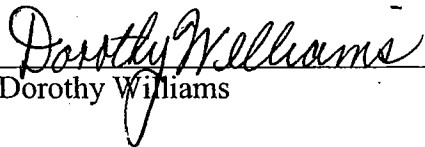
ORDER

1. The Respondent is hereby issued a **REPRIMAND**; and
2. Within four (4) weeks of the issuance of this Order, the Respondent is further ordered to enroll in the Colorado Physician Evaluation Program, or such equivalent program as may be approved by the Board, that will evaluate Respondent's fitness for continuation in the practice of medicine. The Respondent shall furnish the Board with a copy of the report compiled by the evaluating program; and
3. If, as a result of the evaluation, there are recommended limitations, restrictions, terms or other conditions to be applied to Respondent's license, they will be reviewed and acted upon by the Board.

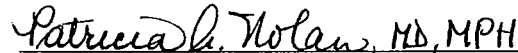
Entered as an Order of the Board of Medical Licensure and Discipline this 20th day of
October, 2004.


James Griffin, D.O.


Margaret Coughlin


Dorothy Williams

Assented to as to form and substance:


Patricia A. Nolan, M.D., M.P.H.
Director of Health

**THIS DECISION MAY BE APPEALED IN WRITING WITHIN THIRTY (30)
DAYS OF THE DATE HEREOF TO THE SUPERIOR COURT OF THE STATE OF
RHODE ISLAND, 250 BENEFIT STREET, PROVIDENCE, RI 02903.**

CERTIFICATION

I hereby certify that I have mailed a copy of the within Administrative Decision and Order to David Carroll, Esquire, 10 Weybosset Street, Providence, RI 02903 on this 30th day of October 2004.

Carole Cessworth