IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA

FILED

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OKLAHOMA STATE BOARD OF MEDICAL LICENSURE & SUPERVISION

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
v.	)	**Case No. 07-04-3271**
DAHYABHAI DHIMMAR, M.D., LICENSE NO. 11696,	)	
Defendant.	)	

COMPLAINT

COMES NOW the Plaintiff, the State of Oklahoma ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Elizabeth A. Scott, Assistant Attorney General, and for its Complaint against the Defendant, Dahyabhai Dhimmar, M.D., alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §480 *et seq.*

2. Defendant, Dahyabhai Dhimmar, M.D., holds Oklahoma license no. 11696.

PRIOR LETTERS OF CONCERN

3. On or about February 6, 1998, the Board Secretary issued a Letter of Concern to Defendant based upon complaints that numerous patients were receiving stimulants, tranquilizers, and pain medications simultaneously and over a long period of time. Review of Defendant's medical records showed very limited vital signs, lab findings or x-rays. Additionally, the records were so unreadable that the need for these medications could not be established. Defendant was advised to review the need for and continual use of addicting medications and to maintain records which could be used by the patient or others.

4. On or about May 2, 2006, the Board Secretary issued a second Letter of Concern to Defendant based upon the same types of complaints as the February 6, 1998 Letter of Concern. On May 17, 2006, Defendant met with the Board Secretary. During this meeting, the Board Secretary advised the Defendant that his records were essentially unreadable by anyone other than him, and that his records had very few vital signs or neurological examinations.

OBN UNDERCOVER INVESTIGATION

5. On or about April 18, 2007, Oklahoma Bureau of Narcotics Agents Dennis Garza and Paul Hawk conducted an undercover office visit to Defendant's Cushing, Oklahoma office. Agent Garza posed as a Hispanic patient named "Juan Perez". Agent Hawk accompanied Agent Garza into Defendant's office, posing as his interpreter. Agent Hawk additionally recorded the office visit with Defendant via hidden video camera.

6. When Defendant entered the examination room with Agents Garza and Hawk, Agent Garza immediately informed Defendant that he could actually speak English. Agent Garza then told Defendant that he had no medical problems, but that he needed a prescription of Lortab for his wife. Defendant told Agent Garza that he would need to put "back pain" on the medical record in order to prescribe the Lortab. Agent Garza informed Defendant that he could put "back pain" down, but that he had no back pain, nor did his wife. Defendant then wrote a prescription to Agent Garza in the name of "Juan Perez" for thirty (30) Lortab.

7. Medical Board investigators subsequently subpoenaed the patient chart for "Juan Perez". These records reflect that Defendant noted that the patient "C/O lower back pain" and that he has "spasm & tenderness lower back, muscles".

8. On or about November 9, 2007, the Board Secretary conducted a hearing on the State's Application to Determine Emergency. After reviewing the video and audio surveillance tape and the testimony of witnesses, the Board Secretary entered an Order of Emergency Suspension whereby Defendant's license to practice medicine and surgery was suspended on an emergency basis until the January 17, 2008 Board meeting.

OVERPRESCRIBING COMPLAINTS

9. From September 25, 2006 until July 23, 2007, Defendant wrote or authorized fifteen (15) prescriptions for **1,130 dosage units** of controlled dangerous drugs to Patient JPD for alleged back pain. These prescriptions include one (1) prescription for Methadone 5mg., a Schedule II controlled dangerous drug, for a total of **60 dosage units**, twenty (20) prescriptions for Hydrococone, a Schedule III controlled dangerous drugs, for a total of **1,040 dosage units,** and one (1) prescription for Clonazepam, a Schedule IV controlled dangerous drug, for a total of **30 dosage units**. Defendant's chart on this patient is essentially unreadable and reveals very few vital signs. It appears that he failed to perform a sufficient physical examination and in many instances failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, including labs and x-rays, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague pain without any legible physical findings.

10. From July 10, 2006 until March 29, 2007, Defendant wrote or authorized twenty-seven (27) prescriptions for **1,850 dosage units** of controlled dangerous drugs to Patient TRD for alleged chronic pain. These prescriptions include six (6) prescriptions for Methadone and Dihydrocodeine Bitartrate/Ace, Schedule II controlled dangerous drugs, for a total of **340 dosage units,** ten (10) prescriptions for Panclor and Hydrocodone, Schedule III controlled dangerous drugs, for a total of **800 dosage units**, and eleven (11) prescriptions for Alprazolam and Clonazepam, Schedule IV controlled dangerous drugs, for a total of **710 dosage units**. Defendant's chart on this patient is essentially unreadable and reveals very few vital signs. It appears that he failed to perform a sufficient physical examination and in many instances failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, including labs and x-rays, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague pain without any legible physical findings.

11. From July 18, 2006 until February 26, 2007, Defendant wrote or authorized twenty-three (23) prescriptions for **2,300 dosage units** of controlled dangerous drugs to Patient DMD, the husband of Patient TRD in paragraph 9 above, for alleged chronic back and ankle pain. These prescriptions include four (4) prescriptions for Methadone, a Schedule II controlled dangerous drugs, for a total of **270 dosage units**, nine (9) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of **1,070 dosage units,** and ten (10) prescriptions for Carisoprodol and Alprazolam, Schedule IV controlled dangerous drugs, for a total of **960 dosage units**. Defendant's chart on this patient is essentially unreadable and reveals very few vital signs. It appears that he failed to perform a sufficient physical examination and in many instances failed to perform any physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not order appropriate tests, including labs and x-rays, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient. Defendant's chart reflects multiple visits and a diagnosis of vague pain without any legible physical findings.

12. Defendant is guilty of unprofessional conduct in that he:

A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. §509(8) and OAC 435:10-7-4(11).

B. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509(13) and OAC 435:10-7-4(39).

C. Engaged in the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine and surgery in violation of OAC 435:10-7-4(19).

D. Prescribed a drug without sufficient examination and establishment of a valid physician patient relationship in violation of 59 O.S. §509(12).

E. Prescribed, sold, administered, distributed, ordered, or gave any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes in violation of OAC 435:10-7-4(24).

F. Committed an act which is a violation of the criminal laws of any state when such act is connected with the physician's practice of medicine in violation of 59 O.S. §509(9).

G. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509(18) and 435:10-7-4(41).

H. Violated a state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27).

I. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(16) and OAC 435:10-7-4(2) and (6).

J. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

K. Wrote a false or fictitious prescription for any drugs or narcotics declared by the laws of this state to be controlled or narcotic drugs in violation of 59 O.S. 509(11).

L. Engaged in the improper management of medical records in violation of OAC 435:10-7-4(36).

Conclusion

WHEREFORE, the Plaintiff respectfully requests that the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to Defendant's medical license, and an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

Elizabeth A. Scott (OBA #12470)
Assistant Attorney General
State of Oklahoma
5104 N. Francis, Suite C
Oklahoma City, OK 73118

Attorney for the Plaintiff