STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HEALTH
BOARD OF MEDICAL LICENSURE AND DISCIPLINE
THREE CAPITOL HILL
PROVIDENCE, RHODE ISLAND 02908

IN THE MATTER OF:	
PHILEMON T. MARVELL, M.D. **License No. MD 05394**	
RESPONDENT.	

DECISION

I. INTRODUCTION

The above-entitled matter came for hearing before a hearing committee[1] of the Board of Medical Licensure and Discipline ("Board") pursuant to a Summary Suspension ("Summary Suspension") issued March 19, 2012 by the Board to Philemon T. Marvell ("Respondent") suspending the Respondent's license ("License") as a physician held pursuant to R.I. Gen. Laws § 5-37-1 *et seq*. A Time and Notice of Hearing ("Notice") and a Specification of Charges ("Specification") were issued by the Board to the Respondent on March 26, 2012.[2] A hearing was held on March 29 and 30 and April 2 and 19, 2012. The Board was represented by counsel and the Respondent was *pro se*.[3] The parties rested on the record.

[1] On March 26, 2012, pursuant to R.I. Gen. Laws § 5-37-5.2, Michael Fine, M.D., Director of the Department of Health ("Department") designated three (3) members of the Board to act as a hearing panel for the purposes of adjudicating this matter. The committee members are Joan Crawley, Public Member, Mary Reich Cooper, M.D., J.D, and Noubar Kessimian, M.D. See Department's Exhibit One (1).

[2] See Board's Exhibits One (1) (Notice and Specification) and Two (2) (Summary Suspension).

[3] The Respondent chose to go forward without an attorney.

II. JURISDICTION

The Board has jurisdiction over this matter pursuant to R.I. Gen. Laws § 42-18-1 *et seq.*, R.I. Gen. Laws § 5-37-1 *et seq.*, R.I. Gen. Laws § 42-35-1 *et seq.*, *Rules and Regulations for the Licensure and Discipline of Physicians* ("Licensing Regulation"), and *Rules and Regulations of the Department of Health Regarding Practices and Procedures Before the Department of Health and Access to Public Records of the Department of Health* ("Hearing Regulation").

III. ISSUE

Whether the Respondent violated R.I. Gen. Laws § 5-37-5.1(19) and Section 11.4 of the Licensing Regulation as set forth in the Summary Suspension, and if so, what is the appropriate sanction?

IV. MATERIAL FACTS AND TESTIMONY

James McDonald, M.D., ("McDonald") testified on behalf of the Board. He testified that currently he is the Chief Administrative Officer for the Board. He testified that he attended Loyola University of Chicago Medical School and following his residency served in the Navy as a physician and after leaving the Navy went into private practice for seven (7) years and then worked for the Indian Health Service for two (2) years and also obtained his master's degree in public health. He testified that he was then the Director of Health Services for the Naval Health Clinics in New England for four (4) years prior to starting his current position this year.

McDonald testified that Pharmacy Board as well as the Board investigated the Respondent.[4] McDonald testified that he met with the Board's Investigative Committee

[4] See Board's Exhibit 15(a) (Pharmacy Board's investigatory report of Respondent).

and reviewed the Respondent's files and based on the review, the Board determined that the Respondent was an immediate danger to the public and his License should be suspended because of his completely irresponsible approach to prescribing narcotics.

McDonald testified that most physicians use the traditional "SOAP" format for note-taking for patient charts which consists of starting with the subjective information that the patient tells the doctor, then there is the objective section based on the physical examination of the patient and any laboratory data, then there is an assessment which is when the physician takes the information and comes up with diagnosis or assessment, and then finally the doctor formulates a plan of action. He testified that the SOAP note has been used since the 1960's and medical records should be legible and another doctor should be able to follow them. He testified that the SOAP note-taking format is codified in the Licensing Regulation in Section 11.4. See Board's Exhibit Three (3).

McDonald testified regarding the eleven (11) patient files that were the basis for the Summary Suspension. See Board's Exhibits Four (4) to 14 (patient charts by initial as set forth in Summary Suspension). For each chart, McDonald testified that the care rendered did not meet the minimum standard of acceptable practice and did not meet the minimum record keeping standards required by the Licensing Regulation.

For patient CH's chart, McDonald testified that there were concerns about medical management and documentation. He testified that there was a pain management contract which was not enforced since the patient agreed to only use one (1) pharmacy but did not. He testified that there was a drug screen that was not positive for a prescription the patient was taking and there was no follow-up on that discrepancy and there was only one (1) drug screen when Respondent saw this patient for over one (1)

year. McDonald also testified that the Respondent provided the patient with amphetamines prescriptions for a 607 day supply in a 363 day period. He testified that the files were not documented so that one could not tell what was being treated and the records were illegible. He testified that there was no history of a present illness, no meaningful physical exam, and the assessment was incomprehensible. He testified that there was no narcotic log and there should have been a list of narcotics being prescribed because they are controlled substances. He testified that there was no justification in the records that the patient had a history of narcotic addiction in order to justify the patient's suboxone prescription. See Board's Exhibit Four (4).

For patient MC's chart, McDonald testified that there was concern about narcotic prescribing, documentation, and medical management. He testified that the patient's chart did not give reasons for the prescriptions and had no documentation workup, no problem summary list, no active medication list, and no narcotic log. He testified that on the progress notes, the history is scant, no chief complaint given, no taking of vital signs, and no physical therapy referral even though the patient had presented as an accident. He testified that the patient had a shoulder injury and ended up being addicted to narcotics and no attempt was made to wean him and he was given short-term highly addictive medicines with no end in sight and no justification. See Board's Exhibit Five (5)

For patient RC's chart, McDonald testified that there was concern about documentation, narcotics prescribing, medical management, and the pain management contract was not enforced. He testified that the patient was prescribed several different drugs without reasons given in the records. He testified there was no physical exams, no urine screens, and no documentation for what is being treated. He testified there was a

note from the pharmacy about the patient's early refills but the Respondent did not address the pharmacy's questions. He testified that the patient complained about ear pain but no ear examination was given. See Board's Exhibit Six (6).

For patient SD's chart, McDonald testified there was concern about documentation since there was no problem summary list, no active medication list, and no narcotic log. He testified that it is unclear why the patient was treated with suboxone and there is no indication how the diagnosis of depression or anxiety was reached and no evaluation of the patient. He testified that the patient wrote a note that he would not harm himself but there was no assessment of a suicide risk at following visits. He testified that the notes do not support the prescriptions and diagnoses. See Board's Exhibit Seven (7).

For the chart for patient RC (male) and patients JS and LS, McDonald testified that the concern again was documentation, narcotics, and medical management. He testified that for RC (male) and JS, there were illegible records. He testified that none of the files had problem summary lists, active medication lists, or narcotics logs. He testified that the documentation did not support the diagnoses or treatments. See Board's Exhibits Eight (8), 10, and 13.

For patient CK's chart, McDonald testified that there was concern with documentation, medical management, and narcotics management. He testified that there was no problem summary list even with 14 visits for chronic pain, no active medication list, and no narcotics log. He testified that there was no indication of how the diagnosis was reached and no assessment of the pain being treated. He testified that the medical records did not support the care and one does not know what is being treated. He

testified that there was no drug screening so there was no monitoring to see if the patient was taking the medicine. See Board's Exhibit Nine (9)

For patient RF's chart, McDonald testified that there was concern with documentation, medical management, and narcotics management. He testified there was a scant history for the 43 prescriptions for narcotics over a two (2) year period. He testified that there is no problem summary list, no active medication list, no narcotics log, and no attempt to monitor the patient to ensure he took his medicine. He testified there was no reason given for the prescribed drugs and how diagnoses were reached. He testified the patient could have a legitimate medical problem but one cannot tell that from the record or if the treatment was effective. See Board's Exhibit 11.

For patient PG's chart, McDonald testified that there was concern over the documentation, narcotics management, and medical management. He testified that there was no documentation of how the diagnosis for depression was reached and no attempt was made to see if the patient was taking his medicine. He testified this chart had a medication list but only had four (4) medicines on it so was not up-to-date. He testified there were 74 prescriptions in a two (2) year period without documentation and no physical exam was given. He testified that there was no evidence that this patient was on narcotics before he began seeing the Respondent but now apparently has a problem with narcotics. See Board's Exhibit 12.

For patient SA, McDonald testified there was a problem with documentation, narcotics management, and medical management. He testified that there was no physical exam, a very brief history, no problem summary list, no active medication list, and no pain agreement despite a history of past stimulant abuse by the patient. He testified there

was no evidence supporting the depression or ADD diagnoses. He testified that the notes were illegible. See Board's Exhibit 14.

On cross-examination about MC, McDonald testified that it is hard to tell the number of prescriptions given to the patient and that the patient's long-term pattern of narcotic shows that there is an addiction. For CK, he testified that he could not understand the Respondent's pain assessment but the other physician's notes in the file were clear and easy to understand. For PG, he testified that after the Respondent found out about the patient's use of different pharmacies, he did not speak to the patient and the notes indicated that the Respondent did not follow up on the information. For JS, McDonald testified that the Board's investigation was performed two (2) weeks prior to hearing so it became an emergency suspension since the Board had just learned about the issues related to narcotics management, documentation, and medical management.

The Board called the Respondent to testify. The Respondent testified he attended medical school at the University of Bordeaux in France and graduated in 1976. He testified that after his residencies in Rhode Island, he worked in emergency rooms at different Rhode Island hospitals. He testified that in the 1980's he opened walk-in clinics but in the 2000's due to personal issues, he sold them. About that time, he testified there was a complaint to the Board about his involvement with a patient who he eventually married. He testified that in 2004, he resolved the issue with the Board and retained his License after a suspension. He testified that he now works on his own and consults for his wife and obtains some of his chronic pain patients from an on-line e-clinic. He testified those records would be on-line and the clinic mostly sent patients from Massachusetts, Connecticut, and Rhode Island who have to be evaluated in person and not on-line.

The Respondent testified that he helps his patients but none of them have addiction problems and he knows this because he evaluated them. He testified he listens to his patients and they all use the same pharmacy. Tr2 at 23.[5] He testified he calls in prescriptions and refills but mostly for hydrocodone. He testified that hydrocone is the least addictive drug out there and works for pain. He testified that he dealt mostly with an on-line Florida clinic and saw the patients twice a year. He testified he was paid by the on-line service for office visits ($125 per visit) and the prescription ($50 per refill).

The Respondent testified that all 11 patients had neuropsychological evaluations by his wife, Dr. Denise Fleurant, and were referred to him. He testified that his files do not include the referrals but that they are in her files. Tr2 at 32. He testified that the Board received his files but the big file for everything is at Newport Psychological Services and he is only a consultant and the evaluations were performed by his wife. He testified that there is nothing in the files that indicate that he is a consultant. Tr2 at 45. He testified that not all patients were referred by his wife to him but that she would bring patients in to see him. Tr2 at 47. He testified that when she brings the patients in to see him, she had not performed a neuropsychological exam on them yet. Tr2 at 49.

The Respondent testified that he has not done anything different in his 35 years of practicing in terms of note-keeping. He testified that he knows there are regulations about recordkeeping but he does not have any first-hand knowledge about them. He testified at his walk-in clinics, he tried using SOAP notes without much success. He testified he did not think SOAP notes were an industry standard when he was trained.

[5] Tr refers to the transcript of the hearing and 2 refers to the second day of hearing and the following number refers to the page number of the referenced transcript.

The Respondent testified that his patients could call up the pharmacy and pretend to be him to get prescriptions filled. He testified that he never prescribed all the prescriptions listed for his patients. See Respondent's Exhibit Three (3) (EDT print-out of all prescriptions given said patients). Tr2 at 43-44.

The Respondent testified on his behalf. He testified that for RC (male), he (Respondent) never prescribed that many refills of suboxone as contained in the EDT report. See Board's Exhibit 15(b). He testified that for KC, he did not write that many prescriptions for suboxone and that the Pharmacy Board's report and the EDT are in error. He testified that KC is an addict and he has been treating the addiction. He testified that for CH, he did not have a narcotics log and that "I'm going to take the fault for that one" as he is not arguing the point that he does not have good records as he is "old school." Tr3 at 9. He testified that SD is on suboxone which is a miracle drug; the best anti-depressant out there. He testified he is not treating addicts but treating people with dopamine deficiencies. He testified that his intention is to try to help his patients normalize their lives and many of patients who come to him have already been on suboxone and are self-medicating and know what works for them. He testified he is trying to be the physician who cares, listens, and wants to do the best.

For SA, the Respondent testified that he tried to help him since his biggest problem is drug addiction. He testified that he put SA on suboxone since SA had been on it before. For MC, the Respondent testified that was a witch hunt by a nurse practitioner working for an insurance company and the patient does a lot of heavy lifting and can not afford to get his shoulder operated so is in much pain. See Respondent's Exhibit Two (2)

(response to MC complaint). He testified that SD was his first suboxone patient and was an addict and he described her medical problems.

The Respondent testified that almost all his patients had total comprehensive testing which was done by a team (including his wife). See Respondent's Exhibit Four (4) (lists of tests). He testified to LS's medical problems and that she was on suboxone when he first saw her so she knew what she wanted. Tr3 at 37. He testified that for RF, she had been on multiple schedule II drugs and he tried to get her off and he diagnosed her as ADD by in-house testing. For RC (female), he testified he realized she was addicted to darvocet so he put her on suboxone which worked very well. He testified that he discovered she was seeing other doctors so he told her he could not treat her anymore. He testified that CK is one of his e-clinic patients and he consulted with her once a month by telephone and her records should be on the computer and he did not keep hard copies. For PG, he testified that he gave PG better than the minimum care which is more than what most doctors give. He testified that he gives "[c]aring care. Not anything written on a page." Tr3 at 72.

The Respondent submitted e-records for CK. See Respondent's Exhibit Five (5) For JS, the Respondent testified he realized that JS had addiction problem so put him on suboxone and then he disappeared. The Respondent also submitted his own compilation from the pharmacy records for all prescriptions for three (3) of his patients and testified it showed those patients obtained prescriptions from other doctors. See Respondent's Exhibit Six (6). The Respondent also provided other documents including his request to be taken off probation for his first suspension (see Respondent's Seven (7)) and a letter of support from a patient (see Respondent's Exhibit Eight (8)).

On cross examination, the Respondent testified that he downloaded CK's e-record from the e-clinic site. He testified that for the e-clinic, patients fill out the computer form and when he sees the patient in person, he reviews the information given. He testified that CK was a patient for about 2½ years and the record was part of care and treatment of this patient and he used it if it was available. He testified that he treated this patient for chronic degenerative diseases in the spine and lumbar chronic pain. He testified she needed pain medicine to function so he calls it "functional narcotic therapy." Tr4 at 33. He testified that the patient received a hydrocodone prescription on Christmas Day in Texas but he also prescribed it for her on Christmas Day but that anyone could call it in using his DEA number. He testified he does not think he is a danger and the charges regarding his patients are totally inaccurate and the prescriptions, the dosages and the quantity and quality are almost all inaccurate. Tr4 at 52.

V. DISCUSSION

A. Arguments

The Board argued that the maintenance of prescription drugs is an important function for the State and Federal government which regulate the prescription of various drugs. The Board argued that the SOAP note has been the standard for documenting a patient chart for 50 years and is contained in Section 11.4 of the Licensing Regulation and the evidence shows that the Respondent did not use the SOAP note format which the Respondent did not dispute. The Board argued that the Respondent did not follow acceptable practice for care in that there were no evaluations, no diagnoses, no treatments, no reasoning, and no justification and while the Respondent claimed he had

other records, did not produce them and justified the numerous prescriptions given by him as someone else using his DEA number or an error.

The Respondent argued that he mostly prescribes Class Three (3) drugs like suboxone which can be called in. He argued that none of his patients have ever gone into drug overdose. He argued that there is no law that one has to use SOAP notes but rather it is a recommendation and he has been writing the same notes for 35 years. He argued that there are numerous other physicians[6] who prescribe narcotics and he is being scapegoated. He also argued there is no reason for an emergency suspension since had not harmed any patients but rather has normalized and stabilized many at-risk patients who have been abandoned because of the summary suspension.

B. Standard of Review for an Administrative Hearing

It is well settled that in formal or informal adjudications modeled on the Federal Administrative Procedures Act, the initial burdens of production and persuasion rest with the moving party. 2 Richard J. Pierce, Administrative Law Treatise § 10.7 (2002). Unless otherwise specified, a preponderance of the evidence is generally required in order to prevail. *Id.* See *Lyons v. Rhode Island Pub. Employees Council 94*, 559 A.2d 130, 134 (R.I. 1989) (preponderance standard is the "normal" standard in civil cases). This means that for each element to be proven, the fact-finder must believe that the facts asserted by the proponent are more probably true than false. *Id.* When there is no direct

[6] During the hearing, the Respondent requested subpoenas for other doctors' prescription records in order to compare his prescription practices to other physicians. See Board's Exhibits 16 and 17. The undersigned denied the request as irrelevant in that the standard of care by statute and regulation is objective for each licensed physician and does not rely on comparisons between the competency or lack thereof by physicians.

evidence on a particular issue, a fair preponderance of the evidence may be supported by circumstantial evidence. *Narragansett Electric Co. v. Carbone*, 898 A.2d 87 (R.I. 2006).

C. Relevant Statutes and Regulation

The Board suspended the Respondent's License by summary suspension pursuant to R.I. Gen. Laws § 5-37-8[7] for violations of R.I. Gen. Laws § 5-37-5.1(19) and Section 11.4 of the Licensing Regulation. R.I. Gen. Laws § 5-37-6.3[8] provides that the Board may revoke or suspend a license for "unprofessional conduct." See also Section 10 of the Licensing Regulation.

R.I. Gen. Laws § 5-37-5.1 defines "unprofessional conduct" to include as follows:

> Unprofessional conduct. – The term "unprofessional conduct" as used in this chapter includes, but is not limited to, the following items or any combination of these items and may be further defined by regulations established by the board with the prior approval of the director:
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> ***
>
> (19) Incompetent, negligent, or willful misconduct in the practice of medicine which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board. The board does not need to establish actual injury to the patient in order to adjudge a physician or limited registrant guilty of the unacceptable medical practice in this subdivision.
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> ***
>
> (24) Violating any provision or provisions of this chapter or the rules and regulations of the board or any rules or regulations promulgated by the director or of an action, stipulation, or agreement of the board[.]

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[7] R.I. Gen. Laws § 5-37-8 states as follows:

> Grounds for discipline without hearing. – The director may temporarily suspend the license of a physician or limited registrant without a hearing if the director finds that evidence in his or her possession indicates that a physician's or limited registrant's continuation in practice would constitute an immediate danger to the public. In the event that the director temporarily suspends the license of a physician or limited registrant without a hearing, a hearing by the board must be held within ten (10) days after the suspension has occurred.

[8] R.I. Gen. Laws § 5-37-6.3 states in part as follows:

> Sanctions. – If the accused is found guilty of unprofessional conduct as described in § 5-37-6.2, the director, at the direction of the board, shall impose one or more of the following conditions:
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> ***
>
> (4) Revoke indefinitely his or her license or limited registration to practice medicine.

Thus, under R.I. Gen. Laws § 5-37-5.1(24), all licensees are required to comply with the Licensing Regulation including Section 11.4 which states as follows:

> 11.4 Medical Records shall be legible and contain the identity of the physician or physician extender and supervising physician by name and professional title who is responsible for rendering, ordering, supervising or billing each diagnostic or treatment procedure. The records must contain sufficient information to justify the course of treatment, including, but not limited to: active problem and mediation (sic) lists; patient histories; examination results; test results; records of drugs prescribed, dispensed, or administered; and reports of consultations and hospitalizations.

C. Whether the Respondent Violated the R.I. Gen. Laws § 5-37-1 *et seq.* and the Licensing Regulation

The Board provided unrefuted evidence that the Respondent's patient charts were missing evaluations, progress notes, narcotic logs, and reasoning and justifications for diagnoses as well as the care given each patient. The Respondent's explanations regarding his notes and care given his patients were contradictory. For example, the Respondent testified that all his patients received neuropsychological evaluations prior to seeing him and were referred to him by Dr. Fleurant but provided no evidence of this. But then he also testified that his patients had not received neuropsychological evaluations prior to seeing him. He also testified that some patients came from e-clinics so could not have been referrals from Dr. Fleurant. He testified that his patients all went to the same pharmacies but the evidence demonstrates otherwise. See Respondent's Exhibit Three (3) (Pharmacy EDT for relevant patients).

The Respondent was unaware of the SOAP note requirements. Indeed, he testified that there were no regulatory requirements for note taking but rather they were recommendations. This is inaccurate. Section 11.4 of the Licensing Regulation mandates the requirements for doctors' medical records. The Respondent failed to

comply with those standards to be legible and for the records to contain sufficient information to justify treatment including medication lists, patient histories, examination results, test results, record of drugs prescribed, etc. See Board's Exhibits Four (4) to 14.

At hearing, the Respondent recited various treatments and diagnoses for said patients and why he gave certain drugs but the reasons and bases for reasons were not contained in his notes. At hearing, his reasons for prescriptions included that the patient knew what worked for him or her or the patient had dopamine deficiencies. At hearing, the Respondent was unable to review each chart and dispute McDonald's testimony regarding his (Respondent) lack of notes and reasoning for the diagnoses and care given. The Respondent acknowledged that his notes were not good. The Respondent's main argument was that he gave caring care to his patients. However, that is not the standard with which a physician must comply. He also argued that he was no worse than other doctors but that is not the statutory or regulatory standard with which a doctor must comply. He also argued that he did not harm his patients but actual injury is not required to find that a physician has not met the minimal standard of care due a patient pursuant to R.I. Gen. Laws § 5-37-5.1(19).

The oral and documentary evidence at hearing is that the Respondent over-prescribed medications. The Respondent's explanations were that other people called in prescriptions in his name or the prescription records were inaccurate. He provided no evidence for such claims. Instead, a review of the EDT demonstrates that for example, he prescribed RC (male) a 240 day supply of suboxone in approximately 84 days. See Board's Exhibits 15(a) and (b) and Respondent's Exhibit Three (3). For patient CH, he provided more than a 500 day supply in one (1) year for amphetamine salts which require

a new handwritten prescription for every prescription and cannot be refilled by a pharmacy. See Board's Exhibit 15(a) and (b) and Respondent's Exhibit Three (3). Additionally, his patient charts did not contain justifications for his treatment and prescriptions given said patients. Indeed without narcotics logs in the charts, it is hard to understand how the Respondent knew which drugs his patients were on and without drug screening, it is hard to know how the Respondent would know if his patients were taking their prescriptions. The Respondent's failure to control his narcotic prescribing as well as his failure to evaluate patients, justify his diagnoses and treatments, and failure to maintain adequate records all fall below the minimal standard of care owed his patients.

Based on the forgoing, the hearing committee finds that the Respondent's License should be revoked.

The hearing committee further finds that if the Respondent in the future applies for a License, he must provide and abide by the following limitations but that the Board will not necessarily grant a new License upon any application but will make a determination at the time of application whether licensing is appropriate:

1. Provide a complete psychiatric evaluation that has been performed within six (6) months of applying for a License.

2. Provide a complete neurological evaluation that has been performed within six (6) months of applying for a License.

3. Provide a complete competency evaluation that has been performed within six (6) months of applying for a License.

4. Provide evidence of completing training in record keeping that has been performed within six (6) months of applying for a License.

5. If a License is granted upon application – and there is no guarantee that a License will be granted upon application and submission of proof required in paragraphs one (1) to four (4) (as well as any further information required at the time of application) – that such License would be limited (but not necessarily only by these limitations) that the Respondent prescribe no controlled substances and work in a supervised situation with another licensed physician.

VI. FINDING OF FACTS

1. Pursuant to R.I. Gen. Laws § 5-37-1 *et seq.*, the Respondent is licensed as a physician in the State of Rhode Island.

2. On March 19, 2012, the Board summarily suspended the Respondent's License.

3. The Respondent's charts reviewed by the Board's investigative committee failed to comply with the SOAP note standards. The charts did not provide a basis for the diagnoses and treatments of the Respondent's patients. The reason and nature of care given the patients by the Respondent could not be determined from the patients' records. The Respondent's care of said patients did not meet the minimal acceptable standard of care due from a physician to his or her patient.

4. The facts contained in Section IV and V are reincorporated by reference herein.

VII. CONCLUSIONS OF LAW

1. The Respondent violated R.I. Gen. Laws § 5-37-5.1(19) by failing to adhere to the minimal standard of care for all his patients detailed at hearing in terms of diagnoses, treatment, care, and note-keeping, etc.

2. As provided by R.I. Gen. Laws § 5-37-5.1(24), the Respondent violated Section 11.4 of the Licensing Regulation for all his patients detailed at hearing by failing to adhere to the regulatory requirements of record keeping.

VIII. ORDER

Based on the forgoing, the Board hereby orders the following:

Pursuant to R.I. Gen. Laws § 5-37-6.3, the Respondent's multiple violations of R.I. Gen. Laws § 5-37-5.1(19) and (24) and Section 11.4 are grounds for revocation of License. Therefore, the Respondent's License is hereby revoked. Furthermore, any subsequent application for a License shall be subject to the provisions set forth above.

Entered this 13 day of June, 2012.

Mary Reich Cooper, M.D., J.D.
Board Member

Joan Crawley
Board Member

Noubar Kessimian, M.D
Board Member

Ratified and approved by the Director of the Department of Health

Michael Fine, M.D.

Joan Crawley, hereby represents that she read the transcript for the hearing, reviewed the evidence in the administrative record, and adopts the summary of testimony, findings of facts, and Conclusions of Law as her own.

Joan Crawley

Mary Reich Cooper, M.D., J.D., hereby represents that she read the transcript for the hearing, reviewed the evidence in the administrative record, and adopts the summary of testimony, findings of facts, and Conclusions of Law as her own.

Mary Reich Cooper, M.D., J.D.

Noubar Kessimian, M.D hereby represents that he read the transcript for the hearing, reviewed the evidence in the administrative record, and adopts the summary of testimony, findings of facts, and Conclusions of Law as her own.

Noubar Kessimian, M.D

NOTICE OF APPELLATE RIGHTS

PURSUANT TO R.I. GEN. LAWS § 5-37-7, THIS DECISION MAY BE APPEALED TO THE SUPERIOR COURT WITHIN THIRTY (30) DAYS AFTER THE DECISION OF THE DIRECTOR BY SERVING THE DIRECTOR WITH A NOTICE OF APPEAL AND FILING SUCH NOTICE IN SUPERIOR COURT. APPEALS ARE GOVERNED BY THE ADMINISTRATIVE PROCEDURES ACT, R.I. GEN. LAWS § 42-35-1 *et seq.*

CERTIFICATION

I hereby certify on this 13th day of June, 2012 that a copy of the within Decision and Notice of Appellate Rights was sent by first class mail, postage prepaid to Dr. Philemon T. Marvell, 680 Aquidneck Avenue, Middletown, RI 02842 and 552 West Main Street, Little Compton, RI 02835 and by hand-delivery to Bruce McIntyre, Esquire, Department of Health, Three Capitol Hill, Providence, RI 02908.

Amy DiFilippo