2017 IL App (1st) 161660-U

No. 1-16-1660

FIFTH DIVISION
August 11, 2017

IN THE APPELLATE COURT OF ILLINOIS
FIRST JUDICIAL DISTRICT

V. JOSE THOMAS, M.D.,	)	Appeal from the
	)	Circuit Court of
Plaintiff-Appellant,	)	Cook County.
	)	
v.	)	No. 15 CH 14803
	)	
ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION; BRYAN A. SCHNEIDER, In His Official Capacity as Secretary of the Illinois Department of Financial and Professional Regulation; and JAY STEWART, In His Official Capacity as Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation,	)	The Honorable
	)	Mary L. Mikva,
Defendants-Appellees.	)	Judge Presiding.

JUSTICE LAMPKIN delivered the judgment of the court.
Justices Hall and Reyes concurred in the judgment.

O R D E R

¶1 *HELD*: A proper foundation was established for the testimony of the IDFPR's expert, and the administrative law judge did not abuse his discretion in admitting the expert's testimony. The

administrative law judge did not abuse his discretion in limiting plaintiff's cross-examination of the IDFPR's expert.

¶2 Plaintiff, V. Jose Thomas, M.D., appeals the order of the circuit court confirming the final decision of the Director of the Division of Professional Regulation of the Illinois Department of Financial and Professional Regulation (IDFPR) suspending him indefinitely for a period of at least one year and fining him $15,000 for prescribing controlled substances for a purpose other than a medically accepted therapeutic purpose and for engaging in dishonorable, unethical, or unprofessional conduct of a character likely to harm the public. Plaintiff contends the administrative law judge (ALJ) erred in allowing the IDFPR's medical coordinator to testify as an expert where he did not demonstrate the requisite familiarity with the long-term treatment of patients like the one in question. Plaintiff additionally contends the ALJ abused his discretion by limiting plaintiff's counsel's cross-examination of the IDFPR's expert. Based on the following, we affirm.

¶3 FACTS

¶4 Plaintiff held an Illinois certificate of registration as a physician and surgeon. In 2013, defendant, the IDFPR, filed an amended complaint alleging that plaintiff violated sections 22(A)(5) and (17) of the Medical Practices Act (Act) (225 ILCS 60/22(A)(5), (17) (West 2012)). More specifically, IDFPR alleged that, between February 2009 and at least July 2012, plaintiff treated J.M. for an opiate addiction, prescribing narcotics and other drugs, including buspar, ativan, vyvanse, adderall, and xanax, without sufficient safeguards. According to the complaint, plaintiff's lack of adequate safeguards was reasonably likely to cause harm to the public, breached his responsibility to his patient, and constituted dishonorable, unethical, or unprofessional conduct in violation of section 22(A)(5) of the Act. In addition, the complaint

alleged that, by prescribing controlled substances without adequate safeguards, plaintiff provided prescriptions for other than medically accepted therapeutic purposes in violation of section 22(a)(17) of the Act. According to the complaint, during that time, plaintiff failed to seek or obtain mental health records from another psychiatrist that was simultaneously treating J.M., failed to review J.M.'s prescription profile to avoid over or double prescribing medications, and did not terminate J.M.'s prescriptions despite J.M. testing positive for illicit drugs multiple times between July 2011 and July 2012 and testing negative for drugs that had been prescribed.

¶5 Following a nine-day hearing in 2015, the ALJ published a 50-page detailed report and recommendation ultimately finding clear and convincing evidence that plaintiff violated sections 22(A)(5) and (17) of the Act. The ALJ recommended that plaintiff's license be indefinitely suspended for a minimum of one year and that he incur a $15,000 fine. In so finding, the ALJ considered plaintiff's medical records for J.M., the IDFPR's drug compliance investigative report, plaintiff's prescription monitoring program (PMP) profile, J.M's medical records from St. Mary's Hospital and Gateway Foundation-institutions where he received treatment while also under plaintiff's care, letters to plaintiff from J.M's mother, a May 1999 order issued by the IDFPR placing plaintiff's license to practice medicine as a physician and surgeon and to practice as a controlled substance registrant on probation for two years, and heard testimony from plaintiff, the IDFPR's expert, Dr. Brian S. Zachariah, the IDFPR's drug compliance investigator, J.M.'s mother, and plaintiff's employee.

¶6 The evidence demonstrated that plaintiff operated a practice called Neuropsychiatric Partners, PC, in Fairview Heights, Illinois. From 2009 until 2012, plaintiff treated J.M., a nineteen-year-old male, for an opiate addiction. The first visit between plaintiff and J.M. took place on January 26, 2009. The patient intake sheet generated from that office visit provided that

J.M. had been using controlled substances for about three years, including oxycontin, methadone and painkillers, but had never been treated for substance abuse. During the initial office visit, J.M. signed a patient-treatment contract for the medication buprenorphine, in which he agreed to be treated with a buprenorphine called suboxone and indicated he understood that mixing a buprenorphine with other medications, specifically a drug classified as a benzodiazepine, could be dangerous. The contract further required J.M. to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances. The contract provided that violation thereof may be grounds for immediate termination.

¶7 During the three years plaintiff treated J.M., the pair met for 47 office visits and plaintiff prescribed suboxone, buspar, ativan, klonopin, vyvanse, xanax, and adderall. Plaintiff's medical records for J.M. revealed that the prescriptions were changed on multiple occasions and the dosages were increased a number of times without support in the record to establish the reasoning for the prescription changes or increased dosages. For example, on February 2, 2009, plaintiff prescribed buspar to address J.M.'s anxiety complaints; however, on February 7, 2009, plaintiff changed the medication to ativan, which is a benzodiazepine. The initial ativan dosage prescribed was 0.5 mg twice a day, but the dosage was increased on April 27, 2009, to 0.5 mg four times per day without providing support in the record for the modification. Then, on May 26, 2009, plaintiff prescribed klonopin, also a benzodiazepine, at a dosage of 0.5 mg three times per day instead of continuing the ativan without providing any reasoning in the record for prescribing the alternative drug. The klonopin dosage was changed on June 29, 2009, to 1 mg three times per day without recording a reason for the change. On August 27, 2009, plaintiff prescribed vyvanse at a dosage of 40 mg every morning to address attention deficit hyperactivity disorder (ADHD). The dosage then was increased on October 16, 2009, to either 50 or 60 mg per

day, along with an increased dose of klonopin to 1 mg four times per day. The vyvanse dosage was increased again on November 11, 2009 to 120 mg every morning. No rationale was provided for the increased dosages of vyvanse or klonopin.

¶8 In addition, the medical records showed that J.M. completed drug screens on December 1, 2009, March 8, 2011, August 17, 2011, November 9, 2011, February 28, 2012, March 27, 2012, April 24, 2012, May 22, 2012, and July 26, 2012. In nearly all of the drug screens, J.M. either tested positive for illicit drugs or tested negative for drugs that had been prescribed. The record, however, failed to show that plaintiff modified the prescriptions based on those results.

¶9 J.M.'s medical records also revealed that he was admitted to St. Mary's Hospital on July 15, 2011, and discharged on July 21, 2011. J.M.'s diagnosis was "[d]rug-induced mood disorder with psychosis. Polysubstance abuse, specifically cannabis, opiates and stimulants." In addition, J.M. was admitted to a 30-day treatment program at Gateway Foundation in June 2012. He was subsequently seen at the Gateway Foundation Alcohol and Treatment Center in July 2012, was admitted at another Gateway Foundation Alcohol and Drug Treatment Center on August 7, 2012, and then was hospitalized for four or five days in August 2012 at the Gateway Regional Medical Center. Finally, the medical records failed to document J.M.'s vital signs during his office visits.

¶10 At the administrative hearing, the IDFPR called Dr. Zachariah to testify as an expert. A lengthy *voir dire* was conducted prior to Dr. Zachariah being considered an expert. Dr. Zachariah testified that he graduated from University of Louisville School of Medicine in 1986 and completed his residency in emergency medicine in 1989. Dr. Zachariah was board certified in emergency medicine and practiced emergency medicine from 1986 until 2011.

¶11 During the years spanning 1988 until 1995, Dr. Zachariah served in many medical roles, including as an associate medical director for the Houston fire department, the director of

training for the Houston fire department's first responder program, a clinical assistant professor for the division of emergency medicine at the University of Texas medical school, an instructor of clinical pharmacology at Baylor College of Medicine, and an assistant medical director for the 1992 republican national convention. Dr. Zachariah added that, from 1995 to 1998, he was the medical director of the EMS system at the University of Texas Southwestern Medical Center and, from 1998 to 2004, he was medical director of Los Colinas Medical Center in Dallas. Then, from 2004 to 2009, Dr. Zachariah was the medical director for the division of emergency medicine and an associate professor at the University of Texas medical branch. Finally, from 2009 to 2011, Dr. Zachariah was an associate professor of emergency medicine at the University of Texas Health Science Center.

¶12 Dr. Zachariah testified that his clinical practice primarily ceased in 2011 when he became the medical coordinator for the IDFPR. However, in his role as medical coordinator, Dr. Zachariah reviewed complaints against physicians by examining medical records along with the interviews conducted by IDFPR investigators with complainants and physicians. Dr. Zachariah testified that he often reviewed complaints of alleged physician misconduct regarding the prescription of controlled substances. Dr. Zachariah added that, during his clinical practice in emergency medicine, he prescribed controlled substances to patients on a daily basis and frequently treated patients with addiction disorders and those experiencing withdrawal symptoms from controlled substances. According to Dr. Zachariah, at least ten percent of his patients during his years as an emergency physician were psychiatric patients and he often had to review psychiatric records. Dr. Zachariah admitted that his practice primarily involved acute injuries and single instances of treatment. He did not have training, education, work experience, or research experience related to the chronic, long term care of a drug addict with psychiatric or

psychological issues. Rather, Dr. Zachariah referred patients to other physicians for long-term treatment. Dr. Zachariah stated that he did not have authorization to prescribe suboxone because he was not a psychiatrist and did not have the requisite registration to do so. Dr. Zachariah added that he had never prescribed vyvanse or adderall to a patient, but had prescribed xanax and likely had prescribed klonopin.

¶13 Dr. Zachariah testified that he received considerable training in prescribing controlled substances during medical school, in continuing medical education courses, and in federal Drug Enforcement Agency seminars. Dr. Zachariah authored columns on the topic for the Illinois State Medical Society and spoke to groups of medical students as well. Dr. Zachariah stated that he was familiar with the Federation of State Medical Boards guidelines for prescribing controlled substances, which apply to physicians in any specialty wherein controlled substances are prescribed. According to Dr. Zachariah, the most important guideline is that controlled substances need to be prescribed for a valid reason. In addition, controlled substances should be prescribed in the lowest effective doses and should be reassessed periodically. Dr. Zachariah stated that a physician should ensure a patient takes the medication as prescribed. Dr. Zachariah added that a physician may need to run a prescription monitoring program (PMP) to ensure that the patient is not doctor shopping in order to obtain excess controlled substances. The PMP allows physicians to discover whether a patient has had drugs prescribed by other physicians.

¶14 Following extensive *voir dire* regarding his qualifications, the ALJ determined that Dr. Zachariah was qualified to testify as an expert.

¶15 After reviewing J.M.'s medical records, Dr. Zachariah testified that it was his opinion to a reasonable degree of medical certainty that plaintiff breached his responsibility to J.M., breached the standard of care, and violated the standards of professionalism for a physician in

Illinois. Dr. Zachariah found that plaintiff's treatment of J.M. involved prescriptions without clear therapeutic purposes, prescriptions for very high doses of medication that were refilled even where there was evidence the patient was not taking them, and prescriptions that were twice the recommended therapeutic dose.

¶16 More specifically, Dr. Zachariah testified that it was his opinion to a reasonable degree of medical certainty that plaintiff's records did not document or suggest it was therapeutically necessary for J.M to receive the amphetamines prescribed by plaintiff, whether vyvanse or adderall, and plaintiff deviated from the standard of care in prescribing them. Dr. Zachariah explained that vyvanse and adderall typically are prescribed for ADHD and, while there was an ADHD diagnosis noted in J.M.'s record, there was no evaluation to support the diagnosis. In fact, in August 2009, when plaintiff first prescribed vyvanse, there was nothing documented in the medical record demonstrating that J.M. suffered from ADHD. Notwithstanding, after August 2009, J.M. was continually prescribed vyvanse until late 2011 when plaintiff prescribed either vyvanse or adderall. According to Dr. Zachariah, for awhile, J.M.'s medical record did not contain an ADHD or attention deficit disorder (ADD) diagnosis and provided no subjective or objective findings to support such a diagnosis. Then, after plaintiff diagnosed J.M. with ADHD in April 2010, plaintiff failed to verify whether J.M. actually suffered from an ADD-type disorder. Instead, plaintiff simply continually entered a diagnosis code for ADHD. Dr. Zachariah opined that an evaluation was necessary to support the ADHD diagnosis and the prescribing of vyvanse and adderall. In that evaluation, a physician typically would learn that the patient had symptoms potentially attributable to ADHD, the physician would obtain a medical history and perform a physical to rule out other causes, and finally the physician would use a variety of screening and assessment tools to confirm the diagnosis.

¶17 Dr. Zachariah testified that amphetamines such as vyvanse and adderall are dangerous, addictive, and abusable controlled substances, and prescribing them when not therapeutically indicated violated the standard of care. Dr. Zachariah opined that vyvanse and adderall need to be prescribed and monitored carefully. Dr. Zachariah added that the FDA maximum dose of vyvanse was 60 mg and the physician's desk reference maximum does was 70 mg, yet, as of November 11, 2009, plaintiff prescribed 120 mg of vyvanse to J.M. every morning. Plaintiff, however, failed to provide any clinical or justifiable rationale for the dosage.

¶18 It was Dr. Zachariah's opinion to a reasonable degree of medical certainty that plaintiff prescribed the benzodiazepine-class medications, ativan, klonopin, and xanax, to J.M. for non-therapeutic purposes. According to Dr. Zachariah, there was minimal evidence that J.M. occasionally had symptoms attributable to anxiety or panic disorder while in plaintiff's office, but the symptoms only appeared early in plaintiff's treatment of J.M. and were only minimally described. Notwithstanding, plaintiff prescribed the benzodiazepines for a long period of time--up through July 2012. Dr. Zachariah opined that the recorded symptoms could have indicated many other things. Moreover, there was no ongoing documentation that J.M. continued to suffer from anxiety to support the continual prescribing of the medications.

¶19 In terms of drug screens, Dr. Zachariah stated that plaintiff performed them too infrequently. Moreover, the records revealed little to no follow up by plaintiff when J.M. tested positive for illicit substances or negative for medications for which he had been prescribed and was instructed to take. Instead, plaintiff continued to prescribe medications that the drug screens showed J.M. was not taking as instructed. Dr. Zachariah additionally testified that plaintiff failed to use any other potential monitoring parameters, such as pill counts or PMPs, to assess J.M.'s potential abuse and diversion of the medications.

¶20 On cross-examination, plaintiff's counsel questioned Dr. Zachariah regarding his opinions relative to plaintiff's treatment of J.M. In so doing, plaintiff's counsel asked Dr. Zachariah to assume certain facts and whether, under those assumed facts, plaintiff's treatment of J.M. would have deviated from the standard of care or breached his physician's responsibilities. Plaintiff's counsel repeated this exercise for every office visit from January 26, 2009, until January 28, 2010, which equaled 17 visits in total. For example, with regard to the June 29, 2009, office visit, plaintiff's counsel asked whether:

> "[a]ssuming that at the June 29, 2009, office visit, [p]laintiff performed a general assessment of J.M. and his vital signs, [p]laintiff changed J.M.'s prescription of [k]lonopin because his prognosis went from good to fair, and a drug test was performed and returned expected results, he had no opinion as to whether [p]laintiff's treatment of J.M. at that visit deviated from the standard of care or breached his physician's responsibilities to his patient."

Dr. Zachariah agreed. Then plaintiff's counsel inquired whether, assuming all the proposed facts were true, Dr. Zachariah believed plaintiff breached the standard of care with regard to the medications prescribed and the dosages prescribed at each office visit and Dr. Zachariah disagreed. He stated that he could not agree because the records were unclear as to why the medications were prescribed and what the actual dosages were. Plaintiff's counsel, however, represented that plaintiff's testimony would establish the hypothetical facts actually were true.

¶21 While cross-examining Dr. Zachariah, the ALJ alerted plaintiff's counsel that Dr. Zachariah had been on the witness stand for three days, two of which had been devoted to cross-examination and three previous hours were devoted to plaintiff's *voir dire*. The ALJ instructed plaintiff's counsel to finish his cross-examination by the end of the day. It was 2:30 p.m. at the

time. Plaintiff's counsel continued his cross-examination until 5:10 p.m. when the ALJ advised plaintiff's counsel to ask his final question. Plaintiff's counsel informed the ALJ that he had "many more questions of the witness." After a discussion off the record, the transcript reveals that the IDFPR's counsel reminded the ALJ that he had discretion to limit the interrogation of witnesses. The IDFPR's counsel stated that plaintiff's counsel made strategic choices in his use of time in terms of *voir dire* and cross-examining Dr. Zachariah, which often included 30 to 45 second pauses while doing so. The ALJ inquired as to how long plaintiff's counsel needed to complete his cross-examination of Dr. Zachariah and plaintiff's counsel replied that it would not take more than one day. The hearing concluded for the day. On the next scheduled hearing date, a new witness was called to testify.

¶22 In his report, the ALJ stated the following:

> "The ALJ observed Dr. Zachariah during his testimony. Based on his demeanor and the content of his testimony, the ALJ concluded that he testified with credibility and consistency. Dr. Zachariah answered technical questions regarding medicine intelligently and authoritatively. The ALJ observed that on cross examination, he was direct, open and frank in his answers. He was not evasive or defensive."

¶23 ANALYSIS

¶24 Plaintiff contends the ALJ's final decision must be reversed where the ALJ erroneously allowed Dr. Zachariah to provide expert testimony and render opinions regarding plaintiff's long-term, psychiatric treatment of J.M. Plaintiff alternatively contends the matter should be remanded because the ALJ prematurely terminated plaintiff's cross-examination of Dr. Zachariah.

¶25 I. Expert Qualifications

¶26 This court reviews the final decision of the ALJ under the Illinois Administrative Review Law (65 ILCS 5/1-2.1-7 (West 2012)). The findings and conclusions of the administrative agency are considered *prima facie* true and correct. 735 ILCS 5/3-110 (West 2012). Our standard of review depends on the question presented. *Marconi v. Chicago Heights Police Pension Board*, 225 Ill. 2d 497, 532-33 (2006). Determinations involving questions of fact will not be reversed unless they are against the manifest weight of the evidence. *Id*. at 532. In contrast, determinations of law are reviewed *de novo*. *Marconi*, 225 Ill. 2d at 532. Lastly, mixed questions of law and fact are reviewed under the clearly erroneous standard. *Id*. The plaintiff seeking administrative review bears the burden of proof. *Id*. at 532-33. This court reviews the decision of the administrative agency and not that of the circuit court. *Id*. at 531.

¶27 In order for a physician to be deemed qualified and competent to testify as an expert, the supreme court has established that: (1) the physician must be a licensed member of the school of medicine about which he proposes to testify; and (2) "the expert witness must show that he is familiar with the methods, procedures, and treatments ordinarily observed by other physicians, in either the defendant physician's community or a similar community." *Purtill v. Hess*, 111 Ill. 2d 229, 243 (1986). With regard to the first element, "whether the expert is qualified to testify is not dependent on whether he is a member of the same specialty or subspecialty as the defendant, but, rather, whether the allegations of negligence concern matters within his knowledge and observation." *Jones v. O'Young*, 154 Ill. 2d 39, 43 (1992). With regard to the second element, a physician is required to possess and apply that degree of knowledge, skill, and care that a reasonably well-qualified physician in the same or similar community would bring to a similar case under similar circumstances. *Id*. at 242 (citing Restatement (Second) of Torts § 299A,

Comment e, at 74-75 (1965)). Once the foundational requirements have been met, it is within the trial court's discretion to determine whether a physician is qualified and competent to state his opinion as an expert regarding the standard of care. *Id*. at 243.

¶28 The parties do not dispute Dr. Zachariah's qualifications and competency as to the first foundational element. Instead, plaintiff challenges Dr. Zachariah's qualifications and competency regarding his familiarity with the methods, procedures, and treatments ordinarily observed by other physicians in his community or a similar community. More specifically, plaintiff argues that Dr. Zachariah lacked the experience and qualifications to render an expert opinion regarding the long-term specialized substance abuse and psychiatric treatment of J.M., including testimony regarding the medications prescribed to treat J.M.'s opioid addiction and anxiety disorders. Plaintiff maintains that the ALJ abused his discretion in relying heavily on Dr. Zachariah's unqualified opinions without examining his lack of training, education, or experience relative to J.M.'s treatment.

¶29 Because we must apply the facts presented during Dr. Zachariah's *voir dire* to the law in terms of whether he was sufficiently familiar with the methods, procedures, and treatments at issue, we review whether Dr. Zachariah was qualified and competent to testify as an expert under the clearly erroneous standard. "When the decision of an administrative agency presents a mixed question of law and fact, the agency decision will be deemed 'clearly erroneous' only where the reviewing court, on the entire record, is 'left with the definite and firm conviction that a mistake has been committed.' " *AFM Messenger Service, Inc. v. Dep't of Employment Security*, 198 Ill. 2d 380, 395 (2001) (quoting *United States v. United States Gypsum Co.*, 333 U.S. 364, 395 (1948)).

¶30 Dr. Zachariah is a board certified emergency medical doctor and the chief medical coordinator for the IDFPR, while plaintiff is a board certified psychiatrist and neurologist with a suboxone treatment license. From 1986 until 2011, when he became the chief medical coordinator for the IDFPR, Dr. Zachariah practiced emergency medicine in various capacities, including as a professor of emergency medicine, a medical director of medical centers and fire departments, and an assistant medical director for the 1992 republican national convention. Throughout that time, Dr. Zachariah engaged in patient care.

¶31 During *voir dire,* Dr. Zachariah testified that, during his years practicing in a clinical setting, he prescribed controlled substances to patients on a daily basis and frequently treated patients with addiction disorders or withdrawal symptoms from controlled substances. Dr. Zachariah added that ten percent of his patients in the emergency room were psychiatric patients, requiring him to review psychiatric records. Dr. Zachariah additionally treated many patients experiencing anxiety attacks. Moreover, after becoming medical coordinator for the IDFPR, Dr. Zachariah reviewed complaints against physicians by examining medical records along with the interviews conducted by IDFPR investigators with complainants and physicians, often time involving complaints of physicians' misconduct in prescribing controlled substances.

¶32 Dr. Zachariah testified that he, himself, had considerable training prescribing controlled substances during medical school, in continuing medical education courses, and in federal Drug Enforcement Agency seminars, as well as writing about the topic in medical columns and speaking to medical students about the topic. Dr. Zachariah explained that he was familiar with the Federation of State Medical Boards guidelines for prescribing controlled substances. Those guidelines expressly provided that controlled substances must be prescribed for a valid medical reason in the lowest effective doses. Dr. Zachariah added that the dosage should be reassessed

periodically. According to Dr. Zachariah, a physician should make sure the patient is taking all medications as prescribed. The physician may need to run a PMP check to ensure that the patient is not doctor shopping to gain non-medically necessary controlled substances or employ other tools for monitoring a patient's drug use, such as drug tests and pill counts. Dr. Zachariah noted that he was not authorized to dispense suboxone and that he had not prescribed vyvanse or adderrall to any patients, but that he had prescribed xanax and likely had prescribed klonopin.

¶33 Overall, we find that the foundational requirements were satisfied for Dr. Zachariah to testify as an expert in this case. Dr. Zachariah had a demonstrated knowledge and experience treating patients with addiction and anxiety disorders. Moreover, up until 2011, Dr. Zachariah routinely administered controlled substances to patients in a clinical setting. Dr. Zachariah established his knowledge of the requisite guidelines for the prescription of controlled substances, including dosage and monitoring, which he explained was not only learned through his medical education, but also in conjunction with his daily treatment of patients in the emergency setting. The fact that Dr. Zachariah referred patients to other physicians for long-term treatment did not negate his ability to testify regarding the standard of care under the circumstances of this case. See *Khan v. Department of Healthcare & Family Services*, 2016 IL App (1st) 143908, ¶ 13. Rather, plaintiff's challenges to Dr. Zachariah's experience with the long-term treatment of opioid addicts also suffering from anxiety disorders were accorded to the weight of his testimony. *Id*. ¶ 15. Despite not expressly working with patients in a psychiatric setting, Dr. Zachariah demonstrated his knowledge and familiarity with the medications prescribed by plaintiff to J.M.

¶34 We find *Khan* instructive here. In *Khan*, the plaintiff had been suspended from the Medical Assistance Program for having provided medical care of a grossly inferior quality,

placing recipients at risk of harm, and prescribing medications in excess of patient needs. *Id*. ¶ 3. The plaintiff argued that the defendant's witness was not qualified to provide expert medical testimony because the physician specialized in internal medicine not rheumatology and had never treated Medicaid patients. *Id*. ¶ 10. On appeal, this court determined that the defendant's physician properly was qualified as an expert where he demonstrated training in rheumatology and regularly treated patients with rheumatologic issues in his practice. *Id*. ¶ 13. Therefore, as in the case at bar, the expert in *Khan* did not practice within the same medical speciality as the plaintiff; however, the expert did have training within that speciality and experience treating patients suffering from the same or similar symptoms. Therefore, the expert in *Khan* and Dr. Zachariah both demonstrated familiarity with the methods, procedures, and treatments ordinarily observed by other physicians in the given speciality about which the doctors were testifying.

¶35 In contrast, the expert testimony required in this case did not mimic that which was necessary in *Alm v. Loyola University Medical Center*, 373 Ill. App. 3d 1 (2007). In *Alm*, a medical malpractice case, the relevant methods, procedures, and treatments involved postoperative care of a child and discharge decision-making. *Id*. at 6. The proposed expert was a pathologist and the defendant doctors were plastic surgeons and an anesthesiologist. The proposed expert's training and experience involved the examination of dead bodies and tissue samples from living and dead individuals. He had not evaluated a live patient since 1978, had not had hospital privileges since 1985, nor had he treated a pediatric patient since the early 1970s. The proposed expert could not recall ever discharging a patient from the hospital and had no knowledge of the standard of care for the discharge of a postoperative pediatric patient like the one involved in that case. *Id*. As a result, this court found the trial court did not abuse its

discretion in granting the defendants' motion *in limine* to bar the proposed expert from testifying regarding the standard of care. *Id.*

¶36 Unlike *Alm*, the case at bar was not a medical negligence case and did not require the IDFPR to establish a claim of medical malpractice. See *id.* (to prove a medical malpractice claim, a plaintiff must provide expert testimony to establish: (1) a standard of care by which to measure the defendant's conduct; (2) the defendant negligently breached that standard of care; and (3) the defendant's breach was the proximate cause of the plaintiff's injury). Instead, the underlying case was an administrative review action. Administrative proceedings are intended to be simpler, less formal and less technical than judicial proceedings and, therefore, the Code of Civil Procedure generally does not apply to administrative proceedings. *Forest Preserve District v. Illinois Labor Relations Board*, 369 Ill. App. 3d 733, 750 (2006); see also *Jones v. Illinois Department of Human Rights*, 162 Ill. App. 3d 702, 705 (1987); *Desai v. Metropolitan Sanitary District of Greater Chicago*, 125 Ill. App. 3d 1031, 1033 (1984); *Village of South Elgin v. Pollution Control Board*, 64 Ill. App. 3d 565, 570 (1978). As a result, we reject plaintiff's arguments regarding the application of section 8-2501 of the Code of Civil Procedure (735 ILCS 5/8-2501 (West 2014)).

¶37 In sum, we do not find the ALJ's decision deeming Dr. Zachariah to be qualified and competent to testify as an expert in this case was clearly erroneous. After determining that the threshold foundational requirements were met to establish Dr. Zachariah's expertise, we additionally find that the ALJ did not abuse his discretion in determining that Dr. Zachariah was qualified and competent to state his opinion.

¶38 II. Cross-Examination

¶39 Plaintiff next contends the ALJ abused his discretion in limiting plaintiff's cross-examination of Dr. Zachariah.

¶40 "An administrative hearing is governed by the fundamental principles and requirements of due process of law. However, due process is a flexible concept and requires only such procedural protections as fundamental principles of justice and the particular situation demand." *Abrahamson v. Illinois Department of Professional Regulation*, 153 Ill. 2d 76, 92 (1992). "A fair hearing before an administrative agency includes the opportunity to be heard, the right to cross-examine adverse witnesses, and impartiality in ruling upon the evidence." *Id*. at 95. The supreme court has advised that the right to cross examination is not unlimited and may be tailored by an administrative body to the circumstances specifically before it. *People ex rel. Klaeren v. Village of Lisle*, 202 Ill. 2d 164, 185 (2002). In other words, an administrative body may impose limitations on cross-examination according to subject matter, witness, or factual matters relevant to the agency's decision. *Id.* at 186. "An administrative agency abuses its discretion when it acts arbitrarily or capriciously." *Village of Stickney v. Board of Trustees of Police Pension Fund of Village of Stickney*, 347 Ill. App. 3d 845, 852 (2004).

¶41 Plaintiff argues the ALJ prematurely terminated his cross-examination of Dr. Zachariah where he was only allowed to ask Dr. Zachariah about plaintiff's actions in 17 of J.M.'s 47 office visits. According to plaintiff, the ALJ erroneously based his decision to terminate the cross-examination on the belief that plaintiff's counsel frequently paused for extended periods of time between questions.

¶42 We find nothing in the record to support plaintiff's contention that the ALJ abused his discretion. In fact, there is nothing in the record supporting plaintiff's contention that the ALJ

terminated the cross-examination due to the gaps in time between questions. Instead, the record reveals the ALJ expressed concern over plaintiff's counsel's compound hypothetical questions, the repeated questioning of the same office visits, and the overall length of total time used for Dr. Zachariah's cross-examination.

¶43 Moreover, the ALJ's decision to limit Dr. Zachariah's cross-examination does not rise to the level of reversible error. "[A]n agency's decision to exclude evidence may be considered reversible error if the party can show, usually by an offer of proof, the decision prejudiced the party." *Village of Stickney*, 347 Ill. App. 3d at 853. Plaintiff did not make, or even attempt to make, an offer of proof before the ALJ as to what information would have been produced by Dr. Zachariah's continued cross-examination. Dr. Zachariah was questioned on direct based upon the information provided in J.M.'s medical records. Any additional hypothetical questioning of Dr. Zachariah on cross-examination was not based on J.M.'s medical records nor evidence presented at the time. In addition, plaintiff cannot establish he was prejudiced by the limited cross-examination where he was provided ample opportunity to testify on his own behalf, which he did as his own expert, regarding the standard of care appropriate under the circumstances. The fact that the ALJ found Dr. Zachariah's testimony to be credible and plaintiff's testimony not to be credible does not establish prejudice.

¶44 CONCLUSION

¶45 We affirm the judgment of the circuit court affirming the IDFPR's final decision suspending plaintiff indefinitely for a period of at least one year and fining him $15,000 for prescribing controlled substances for a purpose other than a medically accepted therapeutic purpose and for engaging in dishonorable, unethical, or unprofessional conduct of a character likely to harm the public.

¶46 Affirmed.