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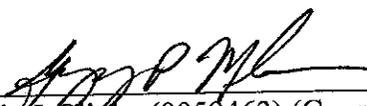
IN THE SUPREME COURT OF OHIO

George D.J. Griffin, III, M.D.,	:	Case No. <b>11-1996</b>
	:	
Appellant,	:	On Appeal from the Franklin County
	:	Court of Appeals, Tenth Appellate District
v.	:	
	:	
State Medical Board of Ohio,	:	Court of Appeals
	:	Case No. 11AP-174
Appellee.	:	

**APPELLANT GEORGE D.J. GRIFFIN, III, M.D.'S MOTION FOR STAY OF COURT OF APPEALS' JUDGMENT**

Pursuant to S. Ct. Prac. R. 2.2(A)(3)(a), S. Ct. Prac. R. 14.4(A), and R.C. 119.12, Appellant George D.J. Griffin, III, M.D. moves this Court for an Order staying the effect of the November 22, 2011 decision and judgment of the Franklin County Court of Appeals, Tenth Appellate District, pending resolution of Dr. Griffin's appeal of this matter to this Court. A memorandum in support is attached hereto.

Respectfully submitted,

  
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 Griffin, III, M.D.

<p><b>FILED</b></p> <p>NOV 29 2011</p> <p>CLERK OF COURT SUPREME COURT OF OHIO</p>
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## MEMORANDUM IN SUPPORT

### **I. Factual and Procedural History**

This case involves an administrative appeal from an Order of the State Medical Board of Ohio (the "Board") concerning the certificate of George D.J. Griffin, III, M.D. to practice medicine and surgery in Ohio. The Order suspended Dr. Griffin's license for a period of 120 days, staying all but 30 days of the suspension. (A copy of the Order is attached as Exhibit A.) The Order also imposed additional probationary terms, conditions, and limitations, including a requirement that Dr. Griffin complete educational courses related to prescribing controlled substances, pharmacology, and medical records.

Dr. Griffin appealed the Board's Order to the Franklin County Court of Common Pleas pursuant to R.C. 119.12. That court previously granted Dr. Griffin's Motion for Suspension of the Order of the State Medical Board of Ohio Pending Appeal. (A copy of the court's entry is attached as Exhibit B.) The Board did not oppose Dr. Griffin's motion at that time. The court found that unusual hardship to Dr. Griffin would result from execution of the Order and that the health, safety, and welfare of the public would not be threatened by suspension of the Order. The court of common pleas did not require a bond. As a result of the decision granting the motion, Dr. Griffin was allowed to continue to practice during the pendency of his administrative appeal to the court of common pleas.

The court of common pleas affirmed the Board's Order in a final judgment entry filed on February 15, 2011. Dr. Griffin filed a Notice of Appeal to the Tenth District Court of Appeals on February 23, 2011. Dr. Griffin also then filed a Motion for Suspension of the Order of the State Medical Board of Ohio Pending Appeal to the Tenth District Court of Appeals with the court of common pleas. The Board opposed that motion, and the court of common pleas denied the

motion on March 11, 2011. (A copy of the decision of the court of common pleas is attached hereto as Exhibit C.)

Dr. Griffin then filed a Motion for Suspension of the Order of the State Medical Board of Ohio Pending Appeal with the Tenth District Court of Appeals. The court of appeals granted Dr. Griffin's motion in part, allowing Dr. Griffin to continue practicing during the pendency of the appeal subject to the Order's probationary terms, conditions, and limitations. A copy of the court of appeals' entry is attached hereto as Exhibit D. The court of appeals did not require a bond.

On November 22, 2011, the court of appeals affirmed the judgment of the court of common pleas. A copy of the decision and judgment entry of the court of appeals is attached hereto as Exhibit E. Dr. Griffin filed a Notice of Appeal with this Court on November 29, 2011. Dr. Griffin now requests that this Court stay the effect of the court of appeals' judgment and suspend the Board's Order while his appeal to this Court remains pending. Consistent with the prior decisions staying the Board's Order, no bond should be required.

Furthermore, because the Board's Order is set to prevent Dr. Griffin from practicing for a period of 30-days, time is of the essence and the interests of justice warrant immediate consideration of this motion before the deadline for filing a memorandum opposing the motion. S. Ct. Prac. R. 14.4(C).

## **II. Argument**

The filing of an administrative appeal by Dr. Griffin did not automatically stay the Board's Order pending judicial review. R.C. 119.12, in pertinent part, provides:

The filing of a notice of appeal shall not automatically operate as a suspension of the order of an agency. \* \* \* In the case of an appeal from the state medical board or state chiropractic board, the court may grant a suspension and fix its terms if it appears to the court that an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal and the health, safety, and welfare of the public will not be threatened by suspension of the order. This provision shall not be construed to limit the factors the court may

consider in determining whether to suspend an order of any other agency pending determination of an appeal.

The Court should suspend the Order while this appeal is pending because (1) Dr. Griffin will suffer unusual hardship if the Order is permitted to go into effect, and (2) the health, safety, and welfare of the public will not be threatened by suspension of the Order.

The State has previously argued that a court should apply the factors set forth in *Bob Krihwan Pontiac-GMC Truck, Inc. v. General Motors Corp.* (2001), 141 Ohio App.3d 777. *Bob Krihwan* is distinguishable and should not be applied in the context presented here, where an individual's constitutionally protected rights are at stake. *Bob Krihwan* involved a dispute between General Motors and a car dealership. After it learned that Bob Krihwan had pleaded guilty to felony income tax evasion, General Motors notified Krihwan that it was terminating the dealership agreement, which expressly allowed General Motors to terminate the agreement upon Krihwan's conviction for a felony. *Id.* at 780. Upon receipt of the termination notice, Krihwan filed a protest with the Ohio Motor Vehicle Dealers Board, arguing that General Motors did not have "good cause" to terminate the dealership agreement. *Id.* After the Ohio Motor Vehicle Dealer Board found in favor of General Motors, Krihwan filed an administrative appeal to the court of common pleas. *Id.* at 781. Krihwan then sought a stay of enforcement of the board's order pending judicial review, which was denied. *Id.*

It was in this context that the court of appeals considered the four factors that traditionally are associated with the standard for injunctive relief in a civil case. *See id.* at 783. *See also The Procter & Gamble Company v. Stoneham* (2000), 140 Ohio App.3d 260, 267. The dispute in *Bob Krihwan* was contractual in nature. Unlike Krihwan, Dr. Griffin, as an individual, possesses a constitutionally protected property interest in his professional license. *See, e.g., Gross v. Ohio State Med. Bd.*, 10th Dist. No. 08AP-437, 2008-Ohio-6826, ¶23. In view of this

heightened protection, the Court should not apply the injunctive-relief factors applied in *Bob Krihwan*.<sup>1</sup>

If the Board's Order is not suspended, Dr. Griffin will suffer unusual hardship by serving a penalty for which he retains a right of judicial appeal. Lower courts have found "unusual hardship" where a decision not to suspend an order would effectively deprive an appellant of any meaningful judicial review. This principle was articulated in *Hayes v. State Medical Board of Ohio*, Franklin County Common Pleas No. 99 CVF 03-2007 (attached as Exhibit F), where the court adopted the magistrate's decision that found that the stay of an order of the Board was appropriate. In reaching its decision, the *Hayes* court quoted the decision in *Ohio Veterinary Med. Licensing Bd. v. Harrison*, Franklin County Common Pleas No. 98 CVF 10-7821, which found:

We normally do not execute prisoners in criminal cases before providing an opportunity for appeal. It may well be that appellant will be unsuccessful in his appeal from the order below. However, the court is satisfied that appellant has met his burden to demonstrate that "unusual hardship" will occur if the administrative revocation order is enforced before the [court] can review the proceedings of the agency.

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<sup>1</sup> Dr. Griffin should prevail on his motion even if the Court applies the standard stated in *Bob Krihwan*. According to *Bob Krihwan*, a court can look to four enumerated factors "as logical considerations when determining whether it is appropriate to stay an administrative order pending judicial review." *Id.* at 783. The factors should be weighed, and no one factor is dispositive. Regarding the first factor (likelihood of success on the merits), although the trial court and court of appeals already have overruled Dr. Griffin's assignments of error, Dr. Griffin retains the right to appeal this matter to this Court. This Court should not negate Dr. Griffin's right to further appeal by affording undue weight to the first factor articulated in *Bob Krihwan* or to the lower court decisions. Moreover, the circumstances in *Bob Krihwan* were very different from those at issue in this case. In *Bob Krihwan*, the court of appeals concluded that the appellant had virtually no chance of prevailing on the merits of his appeal, because his indisputable felony conviction essentially negated any change of winning. *See Bob Krihwan*, 141 Ohio App.3d at 783 ("In light of our decision in *Zinn*, public policy and statutory law, appellant's felony conviction, and the felony termination clause, the court reasoned that appellant's chance of prevailing on the merits was slim."). As to the second factor, contrary to what the Board argues, Dr. Griffin has demonstrated "irreparable injury" by showing that he will suffer unusual hardship if the Order goes into effect while the appeal is pending. Without a suspension of the Order, Dr. Griffin will be required to serve substantially all of the penalty imposed by the Board while his appeal is pending. Once the penalty is served, it cannot be undone. Nothing could be more fundamentally irreparable. Finally, the third and fourth factors essentially encompass considerations regarding the health, safety, and welfare of the public. Allowing Dr. Griffin to continue to practice during this appeal will not threaten the health, safety, and welfare of the public.

A lower court followed the same analysis in *Smith v. State Medical Board of Ohio*, Franklin County Common Pleas No. 99 CVF 07-5481 (attached as Exhibit G), where the court again concluded that the stay of an order of the Board was appropriate because the appellant would serve at least part of his suspension before the matter was fully briefed and ready for review by the court. The court found that completion of a sanction prior to judicial review was unusual hardship. *Id.* at 2.

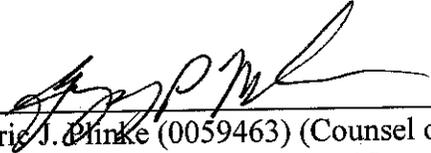
Accordingly, pursuant to R.C. 119.12, a court may grant a suspension if it appears to the court that the appellant would suffer unusual hardship if the order were permitted to go into effect, and the health, safety, and welfare of the public would not be threatened by suspension of the order. Pursuant to the terms of the Order, Dr. Griffin must begin serving his suspension after 30 days from the date of the mailing of the Board's notification. According to the Board's calculations, the Order is set to go into effect on December 8, 2011. If the Board's Order is permitted to go into effect, Dr. Griffin will be required to stop practicing on December 8, 2011.

Execution of the Order will result in an unusual hardship to Dr. Griffin because he will be forced to serve his 30-day suspension before this Court even has had an opportunity to review the fundamental issues presented in the appeal. To require Dr. Griffin to serve his entire suspension period before the appeal is reviewed by this Court would deprive him of meaningful judicial review. This would render Dr. Griffin's ultimate success on appeal hollow. Accordingly, the Court should find that unusual hardship will result from the execution of the Board's Order pending determination of the appeal. Furthermore, allowing Dr. Griffin to continue to practice during this appeal will not threaten the health, safety, and welfare of the public.

### III. Conclusion

R.C. 119.12 allows this Court to suspend execution of the Board's Order if it finds that an unusual hardship to Dr. Griffin will result from the execution of the Board's Order pending determination of the appeal and that the health, safety, and welfare of the public will not be threatened by suspension of the Order. As discussed above, a decision not to suspend the Order will result in unusual hardship to Dr. Griffin, and the health, safety, and welfare of the public will not be threatened by suspension of the Order. Accordingly, a suspension of the Order is warranted in this case.

Respectfully submitted,



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*Attorneys for Appellant George D.J.  
Griffin, III, M.D.*

**CERTIFICATE OF SERVICE**

It is hereby certified that a copy of the foregoing was served via U.S. mail this 29th day of November, 2011, upon:

Henry G. Appel  
Senior Assistant Attorney General  
Health & Human Services Section  
30 East Broad Street, 26<sup>th</sup> Floor  
Columbus, Ohio 43215-3400

  
\_\_\_\_\_  
Eric J. Binke  
Gregory P. Mathews

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# State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.  
Executive Director

(614) 466-3934  
med.ohio.gov

April 14, 2010

George D. J. Griffin, III, M.D.  
3112 Linview Avenue  
Cincinnati, OH 43208

RE: Case No. 09-CRF-002

Dear Doctor Griffin:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Gretchen L. Petrucci, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of Minutes of the State Medical Board, meeting in regular session on April 14, 2010, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal setting forth the Order appealed from and the grounds of the appeal must be commenced by the filing of an original Notice of Appeal with the State Medical Board of Ohio and a copy of the Notice of Appeal with the Franklin County Court of Common Pleas. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO



Lance A. Talmage, M.D.  
Secretary

LAT:jam  
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3936 3068 9404  
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.  
CERTIFIED MAIL NO. 91 7108 2133 3936 3068 9411  
RETURN RECEIPT REQUESTED

*Mailed 5-13-10*



MAY 14 2010

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Gretchen L. Petrucci, State Medical Board Attorney Hearing Examiner; and excerpt of Minutes of the State Medical Board, meeting in regular session on April 14, 2010, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of George D. J. Griffin, III, M.D., Case No. 09-CRF-002, as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage, M.D.  
Secretary

(SEAL)

April 14, 2010

Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

\*

CASE NO. 09-CRF-002

\*

GEORGE D. J. GRIFFIN, III, M.D.

\*

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on April 14, 2010.

Upon the Report and Recommendation of Gretchen L. Petrucci, State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the modification, approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby **ORDERED**, that:

- A. **SUSPENSION OF CERTIFICATE, STAYED IN PART:** The certificate of George D.J. Griffin, III, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for a period of 120 days. All but 30 days of such suspension are **STAYED**.
- B. **PROBATION:** Upon reinstatement of Dr. Griffin's certificate, the certificate shall be subject to the following **PROBATIONARY** terms, conditions, and limitations for a period of at least three years:
  1. **Obey the Law:** Dr. Griffin shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
  2. **Declarations of Compliance:** Dr. Griffin shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Griffin's certificate is reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. **Personal Appearances:** Dr. Griffin shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Griffin's certificate is reinstated, or as otherwise directed by the Board. Subsequent personal appearances shall occur every six months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
  
4. **Controlled Substances Prescribing Course(s):** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Griffin shall submit acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Griffin submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **Pharmacology Course(s):** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Griffin shall submit acceptable documentation of successful completion of a course or courses dealing with pharmacology. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Griffin submits the documentation of successful completion of the pharmacology course(s), he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Medical Records Course:** At the time Dr. Griffin submits his application for reinstatement or restoration, Dr. Griffin shall provide acceptable documentation of satisfactory completion of a course on maintaining adequate and appropriate medical records, such course to

be approved in advance by the Board or its designee. Any courses taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Griffin submits the documentation of successful completion of the course or courses on maintaining adequate and appropriate medical records, he shall also submit to the Board a written report describing the course, setting forth what he learned from the course, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

7. **Monitoring Physician:** Within 30 days of the reinstatement of Dr. Griffin's certificate, or as otherwise determined by the Board, Dr. Griffin shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Griffin and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Griffin and his medical practice, and shall review Dr. Griffin's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Griffin and his medical practice, and on the review of Dr. Griffin's patient charts. Dr. Griffin shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Griffin's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Griffin shall immediately so notify the Board in writing. In addition, Dr. Griffin shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Griffin shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Griffin's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Griffin's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring

physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

8. **Controlled Substances Log:** Dr. Griffin shall keep a log of all controlled substances he prescribes, orders, administers, or personally furnishes. Such log shall be submitted in a format of Dr. Griffin's choosing and approved in advance by the Board. All such logs required under this paragraph must be received in the Board's offices no later than the due date for Dr. Griffin's declarations of compliance, or as otherwise directed by the Board. Further, Dr. Griffin shall make his patient records with regard to such controlled substances available for review by an agent of the Board upon request.
9. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Griffin is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

C. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Griffin's certificate will be fully restored.

D. **REQUIRED REPORTING AND DOCUMENTATION OF REPORTING:**

1. **Required Reporting to Employers and Hospitals:** Within 30 days of the effective date of this Order, Dr. Griffin shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services (including but not limited to third-party payors) or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Griffin shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide health-care services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Griffin receives from the Board written notification of her successful completion of his probation.

In the event that Dr. Griffin provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, Dr. Griffin shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Griffin receives from the Board written notification of her successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities:** Within 30 days of the effective date of this Order, Dr. Griffin shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Also, Dr. Griffin shall provide a copy of this Order at the time he applies for any professional license or for reinstatement of any professional license. This requirement shall continue until Dr. Griffin receives from the Board written notification of the successful completion of his probation.
  
  3. **Documentation that the Reporting Required by Paragraph D:** Dr. Griffin shall provide the Board with one of the following documents as proof of each required notification within 30 days of the date of each notification required above: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.
- E. **VIOLATION OF THE TERMS OF THIS ORDER:** If Dr. Griffin violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.
- F. **EFFECTIVE DATE OF ORDER; NO NEW PATIENTS:** This Order shall become effective 30 days from the date of mailing of the notification of approval by the Board. In the 30-day interim, Dr. Griffin shall not undertake the care of any patient not already under his care.

(SEAL)



Lance A. Talmage, M.D.  
Secretary

April 14, 2010  
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO 2010 MAR 18 PM 4: 18

In the Matter of

George D.J. Griffin, III, M.D.,

Respondent.

\*

\*

\*

Case No. 09-CRF-002

Hearing Examiner Petrucci

### REPORT AND RECOMMENDATION

#### Basis for Hearing

By letter dated January 14, 2009, the State Medical Board of Ohio [Board] notified George D.J. Griffin III, M.D., that it intended to determine whether to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its action on allegations that, in the course of his care and treatment of 14 patients, Dr. Griffin inappropriately and excessively prescribed several Schedule II narcotics, and inappropriately and/or excessively prescribed Neurontin, Lyrica, and Ultram. Additionally, the Board alleged that Dr. Griffin inappropriately prescribed two long-acting opioids concurrently to two patients, and failed to refer one patient for treatment of spasticity. The Board alleged that Dr. Griffin's acts, conduct, and/or omissions constitute: "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in Section 4731.22(B)(6), Ohio Revised Code. The Board advised Dr. Griffin of his right to request a hearing in this matter. (State's Exhibits 19 and 20) On February 5, 2009, Dr. Griffin requested a hearing. (State's Exhibit 21)

By letter dated June 11, 2009, the Board notified Dr. Griffin of two errors in the January Notice of Opportunity for Hearing, namely, that paragraph 1(a) should reference "1600 mg. of OxyContin" instead of "1700 mg. of OxyContin," and that Patient 11's last name on the confidential Patient Key was misspelled. The Board included the correct spelling of Patient 11's last name. The correction letter was served on Dr. Griffin and his counsel. (State's Exhibit 23)

#### Appearances

Richard Cordray, Attorney General, by Barbara J. Pfeiffer, Assistant Attorney General, on behalf of the State of Ohio.

Eric J. Plinke, Esq., on behalf of Dr. Griffin.

Hearing Date: October 5, 8, 9, and 13, 2009

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### SUMMARY OF THE EVIDENCE

All exhibits and the transcript, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

#### Dr. Griffin's Background and his Practice of Medicine and Surgery

1. Dr. Griffin earned his medical degree from the University of Cincinnati in Cincinnati, Ohio, in 1975. Between 1975 and 1980, he completed one year of residency training in general surgery at Cincinnati General Hospital, and four years of residency training in orthopedic surgery at the University of Cincinnati. (Hearing Transcript [Tr.] at 380; Respondent's Exhibit [Resp. Ex.] D)
2. Dr. Griffin is board-certified in orthopedics by the American Board of Orthopaedic Surgery, which is a member of the American Board of Medical Specialties [ABMS], and he is licensed to practice medicine and surgery in Ohio. Also, he obtained certification from the American Academy of Pain Management [AAPM] in 2005.<sup>1</sup> (Tr. at 383, 398, 400; Resp. Ex. D)
3. In 1980, Dr. Griffin started his own private practice in Cincinnati, Ohio. He is a solo practitioner. His areas of practice have been orthopedic surgery, orthopedic spine surgery, arthroscopies, total joint replacement, and pain management. He noted that he has 300-400 active patients currently. He stated that, currently, he spends more than 50 percent of his time with chronic pain patients, and the rest of his time is with orthopedics and spine surgeries. He conducts his surgeries in Cincinnati at Good Samaritan Hospital and Mercy Franciscan Hospital. He was chairman of the Orthopedics Section at Mercy Franciscan for a period of time. (Tr. at 379-383, 404, 405, 549, 809; Resp. Ex. D)
4. Dr. Griffin testified that new patients, other than spine surgery patients referred by a physician whom he trusts, are required to complete a questionnaire, provide past medical records, provide pharmacy logs, and provide all MRIs, CT scans, or films for him to review. Dr. Griffin stated that he personally reviews the information and all MRIs, CT scans, or films. Once he has completed that review, he decides whether he will be able to help the person. (Tr. at 386-387)
5. Dr. Griffin explained the various methods by which he treats his pain patients. Dr. Griffin conducts a variety of interventional procedures to assist his pain patients, including: facet injections, discograms, epidural steroids, local blocks, trigger point injections, major revision spine surgeries, spinal cord stimulators and TENS units. Dr. Griffin also uses a variety of non-surgical modes of treatment for his pain patients: physical therapy, work hardening, work conditioning, aqua therapy, staying conditioned, maintaining activity, education, outside

<sup>1</sup>Dr. Griffin explained that the AAPM is not a member of the ABMS. He also noted that his ABMS board does not offer a subspecialty certification in pain medicine, unlike other ABMS boards. Dr. Griffin also explained that he passed a multi-hour examination to receive certification by the AAPM, and he maintains that certification by completing 100 credit hours of pain-related coursework every four years. He described the AAPM as a "mixed group of physicians who \* \* \* provide some educational background across all specialties and subspecialties regarding the management of pain \* \* \*." (Tr. at 401-402)

consultations, and medications. (Tr. at 424-426, 440-442, 488; State's Exhibit [St. Ex.] 1 at 537, 797; St. Ex. 9 at 1001)

#### **Prior Board Proceeding**

6. In 1990, the Board issued a Notice of Opportunity to Dr. Griffin. The Board alleged that Dr. Griffin: (a) excessively prescribed controlled substance analgesics, depressants, and other drugs to 13 patients; (b) failed to document prescriptions in the medical records; and (c) ignored diagnostic testing results, performed surgical procedures on patients without proper medical indication and failed to keep adequate records related thereto. An administrative hearing was held in February and March 1991. In February 1992, the Board considered that matter and dismissed it. (Ohio E-License Center, State of Ohio, March 4, 2010, <<https://license.ohio.gov/lookup>>)
7. Patients 3 and 5 from this matter were involved in the prior Board matter. (Tr. at 384-285)

#### **Background of Yeshwant P. Reddy, M.D.**

8. The State presented the testimony of Yeshwant P. Reddy, M.D. Dr. Reddy obtained his medical degree in India in 1982. He worked as a medical officer in Iran for four years. In 1988, he moved to the United Kingdom, where he trained in general surgery and orthopaedic surgery for six years. In 1994, Dr. Reddy came to the United States. Between 1994 and 1998, he completed one year of residency in internal medicine at Coney Island Hospital in Brooklyn, New York, and three years of residency in physical medicine and rehabilitation at Temple University School of Medicine in Philadelphia, Pennsylvania. Next, Dr. Reddy completed a fellowship in interventional spine care and pain medicine at the Mid-Atlantic Pain Institute in Wilmington, Delaware. (Tr. at 14-15; St. Ex. 17)
9. Dr. Reddy started in private practice in 1999. He first worked as a spine physiatrist<sup>2</sup> for three years in Little Rock, Arkansas, at the Arkansas Specialty Spine Center. He stated that he provided non-operative patient care, pain consultations, and electrodiagnostic evaluations. In 2002, he moved to Ohio. He has worked as a spine physiatrist and pain consultant at Neurological Associates, Inc., in Columbus, Ohio, for the past seven years. His current practice is devoted to pain management, mostly involving spine pain. Dr. Reddy stated that most of his patients are in chronic pain and "it is the end of the line for them" because there is nobody else to go to. He explained that he has a multi-modal approach with his patients: (a) educate the patient regarding the cause of the pain; (b) explain to the patient that the pain may not be abolished but can be managed; (c) physical therapy; (d) medication management; (e) interventional pain care via procedures; (f) psychological therapy; (g) counseling; and (h) surgery. (Tr. at 11-12, 15, 20-21, 23-26, 62, 203-204; St. Ex. 17)

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<sup>2</sup>Dr. Reddy stated that "physiatrist" is a common name for a physician who specializes in physical medicine and rehabilitation, and a "spine physiatrist" specializes in spine care. (Tr. at 15)

10. Dr. Reddy became board-certified by the American Board of Physical Medicine and Rehabilitation in physical medicine and rehabilitation in 1999, and in the subspecialty of pain medicine in 2000. Additionally, he is a Fellow of the Royal College of Surgeons in the United Kingdom. Moreover, Dr. Reddy is licensed to practice medicine and surgery in Arkansas, Indiana, North Carolina, Ohio, and Texas. (Tr. at 16-17, 36-37; St. Ex. 17)
11. Dr. Reddy has conducted research, made numerous presentations, and published a number of articles.

**Background of Richard V. Gregg, M.D.**

12. Dr. Griffin presented the testimony of Richard V. Gregg, M.D. Dr. Gregg earned his medical degree from the University of Louisville, in Kentucky in 1981. Between 1981 and 1984, he completed one year of residency training in internal medicine at the University of Louisville Affiliated Hospitals and three years of residency training in anesthesia at the University of Cincinnati College of Medicine. In 1985, Dr. Gregg completed a one-year fellowship in pain management at the Pain Control Center in the University of Cincinnati. (Tr. at 670; Resp. Ex. B)
13. Dr. Gregg is board-certified in anesthesiology by the American Board of Anesthesiology, which is a member of ABMS. Also, he is certified by the American Board of Pain Medicine. He is licensed to practice medicine and surgery in Ohio. (Tr. at 679-682; Resp. Ex. B)
14. Dr. Gregg has held faculty positions in the Anesthesiology Department at the University of Cincinnati, been active in a number of professional associations, and made numerous presentations. For multiple years, he has served on the Ohio Pain and Palliative Care Advisory Committee, which has advised the Board on various matters, including the standard of care in pain management. (Tr. at 671-672; Res. Ex. B)
15. Dr. Gregg works at Anesthesia Associates of Cincinnati, Inc. He practices in pain management and anesthesia, with roughly 50 percent of his time spent in each area. He explained that he employs a multi-modal approach to treat his patients, but the main portion of his pain practice is interventional procedures, such as steroid and local anesthetic injections, catheters, and facet blocks. He also explained that he treats pain with medications, including opiates and anti-inflammatory nonsteroidal medications such as Neurontin and Lyrica. Although his current pain management practice is primarily interventional procedures and not long-term prescribing, he has had one to two hundred pain patients whom he has treated for more than a year. The grand majority of those patients did not receive long-acting pain medications. (Tr. at 667, 673-675, 685, 686, 737-739, 765; Resp. Ex. B)

**Summary of Involved Medications**

16. The parties agree that Dr. Griffin prescribed to Patients 1-14 the seven medications and daily dosages listed in the January Notice of Opportunity for Hearing, as corrected. (Tr. at 596-598)

Those medications were described as follows:

Medication	General Description	Other Information	Citation to Record
OxyContin	<ul style="list-style-type: none"> <li>• It is a Schedule II controlled substance.</li> <li>• The active ingredient is oxycodone.</li> <li>• It is a long-acting, time-released medication, so that pain is controlled over longer periods of time.</li> <li>• According to the 2007 Physicians Desk Reference, it is to be given every 12 hours.</li> </ul>	<p>Dr. Reddy stated that it is not intended for use on an "as needed" basis.</p> <p>Dr. Reddy acknowledged that some patients will require more-frequent dosing of OxyContin than every 12 hours.</p> <p>Dr. Reddy stated that, under a proposal in the state of Washington, a daily amount of OxyContin above 67 mg would be considered high.<sup>3</sup></p>	Tr. at 39-44, 147
Avinza	<ul style="list-style-type: none"> <li>• A long-acting morphine sulfate.</li> <li>• It should act for 24 hours.</li> </ul>	Dr. Reddy stated that it is not indicated for use on an "as needed" basis.	Tr. at 47-49, 322
Kadian	<ul style="list-style-type: none"> <li>• It is a Schedule II controlled substance.</li> <li>• A long-acting morphine sulfate.</li> </ul>	Dr. Reddy stated that, under the Washington state proposal, a daily amount of Kadian above 100 mg would be high.	Tr. at 52, 147, 322
Methadone	<ul style="list-style-type: none"> <li>• It is a Schedule II controlled substance.</li> <li>• It is used in the treatment of heroin addiction, but a secondary use is for the treatment of chronic pain.</li> </ul>	Dr. Reddy stated that Methadone is not a long-acting medication, but it should be given less frequently because it stays in the body a long period of time before being eliminated. Also, Dr. Reddy stated that Methadone doses are generally taken twice a day.	Tr. at 52-53, 139, 322-323
Lyrica	<ul style="list-style-type: none"> <li>• It is a Schedule V medication.</li> <li>• The active ingredient is Pregabalin.</li> <li>• It is used to treat neuropathic pain, seizures, and fibromyalgia.</li> <li>• The maximum dose varies from 300-600 mg per day, depending on the diagnosis.</li> <li>• It is used in an off-label fashion for the treatment of chronic pain.</li> </ul>		Tr. at 53-56, 800-801
Neurontin	<ul style="list-style-type: none"> <li>• It is used to treat epilepsy and peripheral neuropathy.</li> <li>• The maximum dose is 4,800 mg per day for well-known conditions.</li> <li>• It is used in an off-label fashion for the treatment of chronic pain.</li> </ul>	Dr. Griffin stated that Neurontin's safety window extends to 49 grams.	Tr. at 58, 60, 107, 459
Ultram	<ul style="list-style-type: none"> <li>• It is a mild pain medication.</li> <li>• It used in an off-label fashion to decrease the function of a chemical in the spine, which decreases the perception of pain.</li> </ul>		Tr. at 329, 357-360, 389-391; Resp. Ex. A

<sup>3</sup>The state of Washington is considering a proposal, pursuant to which opioid doses above 100 mg of Morphine, or its equivalent, are considered to be "high" dosages, which require a consultation with a "fully trained" pain physician. Sixty-seven mg of OxyContin is roughly the equivalent of 100 mg of Morphine. (Tr. at 146-147, 813, 834)

## The Standard of Care in Prescribing Pain Medications

### *History*

17. Dr. Reddy stated that, in this country, there had been differing treatment for pain patients depending on whether the patient was a cancer patient or a non-cancer patient. The approach had been to keep cancer patients comfortable and there were no limits on the amounts of medications that could be used because the cancer patient could be offered nothing more. Non-cancer patients were prescribed pain medications on a much more limited basis. Dr. Reddy stated that pain medications are no longer so limited for non-cancer patients because pain is pain, and it should be treated. (Tr. at 35-36, 206-207)

Moreover, the Federation of State Medical Boards [FSMB] adopted model guidelines in 1998 so that pain would be adequately treated in the United States. Those model guidelines acknowledged the use of opioids for patients with pain. (Resp. Ex. L at 1)

18. In 2004, the FSMB adopted the "Model Policy for the Use of Controlled Substances for the Treatment of Pain" because there was a "significant body of evidence suggesting that both acute and chronic pain continue[d] to be undertreated." The Model Policy is an update to the 1998 model guidelines of the FSMB, and is intended to be adopted by individual state medical boards. The Model Policy states in part:

The [name of board] recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The [name of board] will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained uses of opioid analgesics and are not the same as addiction.

\* \* \*

The [name of board] will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors.

Allegations of inappropriate pain management will be evaluated on an individual basis. The [name of board] will not take disciplinary action against a physician for deviating from this policy when contemporaneous medical records document reasonable cause for deviation. The physician's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

(Resp. Ex. L at 2-3)

*Maximum Dosages of OxyContin, Kadian, Avinza, and Methadone*

19. Dr. Reddy explained that physicians must be cautious in prescribing pain medications because there is no specific instrument or measure to determine an acceptable dose of pain medication. (Tr. at 213-215; See, also, Resp. Ex. P at 3)
20. Furthermore, Drs. Reddy, Griffin and Gregg all testified that there are no maximum dose limitations according to the Physicians' Desk Reference [PDR] or the medical literature for long-acting pain medications (those not combined with other pain medications such as acetaminophen). They also testified that the medical literature states that the highest dose of such medication is the amount that keeps the patient's pain under reasonable control, makes the patient functional, and causes no side effects. Dr. Griffin noted that one should start at low doses, and go slow in titrating upward. Dr. Reddy added that a physician must "be cautious, [and] follow all the red flag alerts if you are writing higher doses." (Tr. at 49-50, 90, 206-207, 216, 231, 241-243, 256-257, 454, 465-466, 472, 477, 486, 506, 526, 693, 695-696, 742, 828; Resp. Ex. A; See, also, Resp. Ex. P at 1)
21. Because the standard of care does not set forth a maximum dose, Dr. Reddy stated that he has pondered the question of what is an acceptable dose of long-acting pain medication versus an excessive dose of such pain medication. He noted that he had asked other interventional pain practitioners at conferences, including one in early 2009, about their prescribing levels for long-acting opioids. At that 2009 conference, the highest reported dose of OxyContin was 320 mg per day. Dr. Reddy also stated that he is aware of another physician who prescribes OxyContin at 780 mg per day for a patient with a very unusual condition. In Dr. Reddy's practice, his "threshold" for OxyContin is 120 mg per day and his threshold for Kadian is 500 mg per day. (Tr. at 102, 146-149, 216-217, 271, 306-308, 310-311, 319)
22. Dr. Reddy stated that, despite the fact that there are no maximums on these pain medications in the literature, there are points beyond which more medication "is not going to do anything more." Dr. Reddy stated that he investigates why the patient's pain is not being controlled at the lower levels, and he will examine whether: the medication is not effective, a new pain problem has developed, the same pain problem is progressing, or tolerance has developed. Dr. Reddy stated that he will switch pain medications, reduce medication levels, and/or intervene with other modalities. (Tr. at 103-104, 182)

In addition, Dr. Reddy explained his approach in the following exchange:

Q. So are you saying in those instances where you have a pain patient who may be developing a tolerance, your reaction may be not to increase, say, the OxyContin, but to intervene with some other nonmedicine modality?

A. Yes. I want to clarify that. Let's say initially I want to act on why is this patient's pain not being controlled? Let's say there is no progression of disease, there is no new pain complaint, [and] there is no other modality I could offer this patient.

Then I would give that patient a little bit more medication, taking into consideration that same condition, but the patient is developing tolerance, and hence, the body needs more medication.

(Tr. at 104-105)

23. Dr. Gregg explained that, since there is no maximum dosage with long-acting pain medications, a physician will not automatically fall below the standard of care by writing at a certain dosage. However, a physician must follow the patient, make sure the medications are not harming the patient, and make sure the medications are not being diverted. Dr. Gregg also stated that, with chronic pain patients, he expects most patients to escalate slowly until an effective dose is found or until the side effects require stopping the escalation. (Tr. at 788-790)
24. Dr. Griffin presented an article by Forest Tennant, M.D., Ph.D., and Jeffery Reinking, M.D., from the November/December 2008 issue of *Practical Pain Management*, which describes the current viewpoint on maximum opioid dosages as follows:

The prevailing view is clearly that the proper dosage, regardless of daily amount, should be whatever allows the patient to achieve pain relief while performing normal physiologic, mental, and social functions of daily living. Unfortunately, some individuals and institutions are trying to arbitrarily establish a maximal ceiling dosage for opioids. Their basis for this desire appears to be the erroneous belief that opioids are either not effective above a certain dosage or that a pain patient never reaches a plateau or maintenance dosage and eternally desires to continually raise his/her opioid dosage. Another misconception is that withdrawal from opioids is a difficult and dangerous procedure once chronic pain is reduced or cured. The high cost of opioids and other financial motives also likely underlie a desire to limit opioid dosages and make false claims of excessive prescribing.

(Resp. Ex. P at 1) Drs. Tennant and Reinking also stated that excessive opioid prescribing can be found when a physical examination discovers such things as a low pulse, small pupils, or very warm hands/feet. (Resp. Ex. P at 2, 5, 6)

*Dosing Intervals*

25. Some of the prescriptions at issue in this matter involve long-acting medications that Dr. Griffin prescribed to be taken in short time intervals. For example, on March 6, 2007, Dr. Griffin prescribed to Patient 1 OxyContin, 80 mg, #600, with instructions to take three to five tablets every six hours. Dr. Reddy testified that the long-acting medications are to be consumed less frequently because the medications are considered to last throughout the longer interval. For OxyContin, the PDR states that it is to be taken every 12 hours. Dr. Reddy acknowledged that he has had "one or two" patients who required more-frequent dosing of OxyContin than every 12 hours, and noted that, in those cases, he did not discontinued any break-through medication. (Tr. at 40-44, 98-99; St. Ex. 1 at 987)
26. Dr. Griffin stated that it was within the standard of care to prescribe long-acting opioid prescriptions to be taken on shorter than 12-hour intervals. In Dr. Griffin's view, some patients require shorter dosing intervals, not larger doses of medication, in order to relieve the pain and allow them to function. He believes that he adequately documented his thinking at the time he prescribed less than 12-hour dosages. In summation, Dr. Griffin stated that his dosing intervals are consistent with the standard of care, which is to "provide the patient with the maximum amount of medication they require by slowly titrating them upward and by quizzing them along the way for side effects and pain relief." He stated that he is aware that other physicians prescribe OxyContin to be taken every six hours or more frequently. (Tr. at 500-501, 824, 831, 833, 835-838)
27. Dr. Gregg stated that OxyContin every 12 hours does not work well for many patients, and he usually does not dose that medication in that fashion. He acknowledged that he has prescribed OxyContin every eight hours and every six hours. (Tr. at 763)

*Range of Pills at Fixed Intervals*

28. Dr. Reddy testified that it is improper to prescribe the long-acting medications such that the patient decides how many pills to take at each interval. He stated that the long-acting medications are to be given in fixed doses, and if the patient decides how many pills to take at each interval, there is no fixed dose consumed. Dr. Reddy considered such prescriptions to be used like an as-needed [PRN] medication. Additionally, Dr. Reddy stated that he did not see any notes in the medical records where Dr. Griffin documented the number of pills in the ranges that the patients actually took. (Tr. at 97-99)
29. Dr. Griffin acknowledged that he had issued prescriptions that included a range on the number of pills to be taken at set intervals. Dr. Griffin stated that he had provided the patients with oral and written instructions when he issued prescriptions of this nature, and that he reflected that fact in his progress notes via the acronym "MIPG," which means medication instructions and precautions given. He also stated that the patient decides how many pills to take within the range based on experience and need. Dr. Griffin stated that he had followed up with the patients to determine how the patients were consuming the medications under those prescriptions so that he could determine future prescriptions. Dr. Griffin acknowledged that

he did not include in his progress notes how many pills the patients took at each interval. (Tr. at 496-498, 601-603, 621, 806)

30. Although he acknowledged that his long-acting opioid prescriptions included a range on the number of pills to be taken, Dr. Griffin stated that he did not write the prescriptions on an "as needed" basis, as alleged. He testified:

Well, a true PRN prescription is as needed. It's how you can take it. You take it if you need it or not if you don't.

When I wrote those prescriptions which [Dr. Reddy] is talking about, I was trying to express on a piece of paper a contract that I had with the patient based on their need for medication.

For example, the patient might need four OxyContin in order to start his day. He might only need three at lunch, four again at supper and five so he can get some sleep at night. That's a dosing range of three to five, as needed through the day, but it's every six hours.

\* \* \*

It's not take if you want it, it's a standard dosing time interval, but the dose will vary through the day. And not everybody takes the same dose every single time because their needs through the day vary.

(Tr. at 495-496; See, also, Tr. at 814)

31. Dr. Gregg did not agree that a prescription for three to five pills every six hours constitutes a PRN prescription because there are regular intervals at which some amount of medication is to be taken. Moreover, Dr. Gregg stated that, in general, such a prescription for a pain patient is not below the standard of care because it is reasonable to adjust when the patient suffers periods of increased pain and to use something that would work longer than two to four hours. Dr. Gregg stated that the medical literature reflects that the greatest problem for pain management is handling break-through pain. He explained that one way to address it is with short-acting medications and another way to address it is to adjust the long-acting medications in a reasonable way. (Tr. at 725-726)

Dr. Gregg noted that he has written prescriptions for a few patients that include ranges on the number of pills to be taken at a fixed interval. (Tr. at 764)

*Responding to Evidence of Abuse or Misuse*

32. Dr. Reddy testified that, he personally "would certainly not give these high doses [of opioids] when I know that the patient is using illicit drugs," namely, marijuana. Dr. Reddy stated that the standard of care requires a reduction in the amount of pain medication given when a

patient's urine screen show evidence of misuse or abuse, or the absence of a prescribed medication. He elaborated that, in such situations, he would be extra careful and try to reduce the doses so that the patient cannot abuse the prescribed medications. In his view, the amount of the reduction would depend on the existing dose. (Tr. at 88-89, 159, 173-174, 302, 322)

33. Dr. Griffin disagreed with Dr. Reddy's statement that pain medications should be abruptly decreased when a patient's urine screen demonstrates marijuana usage. He described such action as "negative reinforcement of the probable reason they smoke the marijuana." Moreover, Dr. Griffin stated that a decrease in pain medication will not entice the patient to stay with the physician and get better. Dr. Griffin stated that, instead of decreasing the pain medication, he requires an addiction medicine consultation to evaluate the marijuana use, and he counsels against the marijuana usage. If the patient fails to respond, then he would terminate the pain medications. Moreover, Dr. Griffin stated that, if the physician continues to prescribe adequate medications to control the patient's pain, it is much more likely that the patient will stop the marijuana use. Additionally, Dr. Griffin notes that any urine screens that indicate use of cocaine, heroin, or methamphetamines will prompt him to require an addiction medicine consult and, pending the results of the consultation, termination of the pain medications. (Tr. at 408-411, 520-521, 664, 810-812, 822-823)
34. Dr. Gregg testified that the standard of care does not automatically require reduction in a patient's medication if there is an abnormal urine screen or evidence of drug abuse. He views that type of response as punitive, without helping to resolve the circumstances that may have led to the abuse. He further stated that, it would be improper to reduce the medications in an attempt to remove the patient from the practice because of urine screens. He finds that the response to evidence of drug abuse is a case-by-case assessment. (Tr. at 720, 743-745, 759-760)
35. The authors in the *Practical Pain Management* article stated that, in general, there is no need to reduce opioid dosages as long as the patient claims severe pain and there are no physical signs of excess opioids. However, they also noted that credible reports of diverting, sharing, or theft for abuse by others justify curtailment of the opioid prescriptions. In addition, the authors stated that "[p]hysicians who fail to heed third party reports of abuse, misuse, impairment, or diversion and continue to prescribe must be declared to 'excessively prescribe.'" (Resp. Ex. P at 4, 6)

*Off-Label Use of Lyrica and Neurontin for Pain*

36. Dr. Griffin stated that, when he prescribed Lyrica or Neurontin for Patients 1, and 3-6, he had prescribed those medications in an "off-label" fashion for the patients' pain. He also stated that he reflected in the medical records that those prescriptions were for off-label purposes. (Tr. at 806, 825)
37. Dr. Reddy testified that, although Lyrica is not indicated in the PDR for the treatment of pain, "it is accepted among the physician population" for use with chronic pain patients as long as

the patients are warned and consent to its use.<sup>4</sup> Additionally, he stated that it would be within the standard of care to use Lyrica to treat chronic pain, but it must be prescribed within the existing maximum dosage level. According to Dr. Reddy, to prescribe a medication for off-label use above the maximum dosage set forth for its on-label use is inappropriate. Dr. Reddy stated that the maximum dose for Lyrica is 300- 600 mg depending on the medical condition, and the reason is because the benefits do not increase with further increases in the dose, but the side effects become worse. (Tr. at 54-58, 139-140)

Dr. Griffin stated that Lyrica has been tested for a certain group of people, and the limitation in the PDR is the point beyond which the federal government felt that there was no real additional benefit to the patient. Dr. Griffin stated, however, some patients are "outliers," and he used Lyrica in an off-label fashion for "outlier patients." He concluded that it is appropriate and within the standard of care to prescribe Lyrica up to the point where the patient gets a benefit without side effects because it relieves the patient's pain and lessens the need for an opioid. (Tr. at 484, 807)

38. Dr. Griffin also testified that, if using a medication in an off-label fashion, one is not limited to the medication limits for its on-label use. Dr. Griffin stated that, with off-label use, one starts with the PDR levels and "works" from there. He explained that experience, medical literature, and discussions with colleagues are the guides for the maximum dosage level in off-label prescribing. (Tr. at 485, 606)

39. Dr. Reddy acknowledged that Neurontin is also used, acceptably, in an off-label fashion for the treatment of chronic pain. Dr. Reddy stated that the maximum dosage, as set forth in the PDR, is 4,800 mg per day because its absorption rate never improves even if higher dosages are given. Thus, Dr. Reddy contends that there is no benefit to prescribing Neurontin at dosages above 4,800 mg, when the body will not absorb more of the medication. In his practice, his threshold for Neurontin is 3,600 mg per day. (Tr. at 58, 60, 107)

Dr. Griffin agreed in part with Dr. Reddy's position about Neurontin. He agreed that Neurontin has been tested at 4,800 mg and its rate of absorption does not improve beyond 4,800 mg. Dr. Griffin explained that, at 4,800 mg and beyond, the body absorbs 27 percent of the active medication in Neurontin, and the remainder is excreted. However, Dr. Griffin pointed out that, if a higher dose is given, the body will absorb 27 percent of that higher dose, and thus the patient receives more medication at the higher dosage. (Tr. at 460-461)

40. Dr. Gregg contended that Lyrica and Neurontin have no clear ceiling doses for pain, and are safe if titrated to dose. Dr. Gregg stated that the off-label use of both Lyrica and Neurontin at higher doses than the "on-label" maximum is reasonable and used frequently. He further stated that to prescribe above the on-label maximum is not below the standard of care. (Tr. at 757, 803; Resp. Ex. A)

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<sup>4</sup>Dr. Gregg does not consider the use of Lyrica for chronic pain patients to be an "off-label" use of the medication. He explained that Lyrica was approved for neuralgic use, and spine pain is part of neuralgic pain. However, he acknowledged that the government did not categorize it the same way. (Tr. at 787-788, 795-796)

Dr. Gregg stated that he has written doses of Neurontin in the same range as the patients involved in this matter. Because his current medical practice as related to pain management focuses on interventional procedures, Dr. Gregg is not prescribing pain medications on an on-going basis. However, he speculated that, if he were still writing all of his patients' medications, he would probably write prescriptions of Lyrica in the same range as the patients involved in this matter as well. (Tr. at 802)

*Combinations of Pain Medications*

41. Dr. Reddy also stated that certain combinations of pain medications can be appropriate, such as OxyContin combined with Neurontin and/or Lyrica. He noted that such combinations are given to avoid increasing the dosage of the opioids and are totally acceptable even though Neurontin and Lyrica would be used in an off-label fashion. He noted, however, that combinations of two long-acting opioids would not be appropriate because their mechanism of action is the same. (Tr. at 230-231, 234-235, 366-367)

*Intractable Pain*

42. Dr. Griffin referred in all 14 medical records to the patients' pain as chronic, long-term intractable pain, which is "a condition that exists as part of [the] other diagnoses and other medical conditions." Dr. Griffin explained that in using the term "intractable pain" in the charts, he was stating that the patients' pain would not stop despite the levels of medication used, and that even at those levels the patients were in pain. Dr. Griffin noted that, under Ohio law, a physician treating patients with intractable pain may use amounts or combinations of medications that may not be appropriate when treating other conditions. (Tr. at 490-492, 807; Resp. Ex. Q)
43. Rule 4731-21-02, Ohio Administrative Code, states that, when a physician "utilizes a prescription drug for the treatment of intractable pain on a protracted basis or when managing intractable pain with prescription drugs in amounts or combinations that may not be appropriate when treating other medical conditions," the physician shall comply with accepted and prevailing standards of care, which shall include:
- A documented evaluation of the patient's history, assessment of the impact of the pain on the patient's physical and psychological functions, a review of prior diagnostic studies and therapies, an assessment of coexisting conditions, and a physical examination.
  - A documented diagnosis, including the presence of intractable pain, the signs, symptoms, causes, and the nature of underlying disease and pain mechanism.
  - A documented treatment plan with justification, including documentation that other medically reasonable treatments for relief have been offered or attempted without adequate success and the patient's response to treatment.
  - The diagnosis of intractable pain was made after the patient was evaluated by a specialist in the treatment of the anatomic area, system, or organ of the body perceived as the source of pain, unless the patient was evaluated and treated

within a reasonable period of time by such a specialist and the treating physician can rely on that evaluation.

- Consent to treatment of prescription drug therapy on a protracted basis or in amounts or combinations that may not be appropriate when treating other medical conditions.

44. Dr. Griffin stated that Patients 3, 4, 7 and 10 had been referred for surgical consideration and/or for evaluation due to a failed surgery. He also stated that, as a result, they had seen other practitioners who specialize in the treatment of the anatomic area, system or organ of the body perceived as the source of the patient's pain. He also stated that he may have referred the other patients as well. (Tr. at 588-590)

#### Overall Conclusions Regarding the Care and Treatment of Patients 1-14

45. Dr. Reddy concluded that Dr. Griffin followed and cared for his patients regularly. He further stated that it appeared that Dr. Griffin is a very compassionate doctor, who intends to help his patients. Also, Dr. Reddy stated that Dr. Griffin had used a multi-modality approach to treat these patients' pain, finding that Dr. Griffin is doing "what is needed in a good pain practice." He noted that Dr. Griffin uses a number of protocols to ensure that his patients are taking the medications as prescribed, and not diverting or abusing them. Dr. Reddy stated that Dr. Griffin has "made every effort, every time, to follow certain protocols."<sup>5</sup> However, Dr. Reddy found that these 14 patients were patients with usual pain for whom Dr. Griffin prescribed unusual doses of pain medications, which were inappropriate and excessive. Dr. Reddy also took issue with certain combinations of medications and the lack of a referral or specific treatment for one patient. (Tr. at 149-150, 268-269, 291, 298, 300-303)
46. Dr. Griffin described the 14 patients involved in this matter as the most difficult patients in his practice because they have a large number of co-morbidities, are complex, and are unusual. (Tr. at 387-388) Moreover, he stated the following regarding Patients 1-14:

There [are] many complex reasons why these patients hurt. They don't have one thing that causes one kind of pain in one place. They have different kinds of pain from different pain generators that are all laid on top of each other, on top of the co-morbidities.

(Tr. at 388; see, also, Tr. at 543) Dr. Griffin stated that he believes his treatment of all 14 patients complied with Ohio law because he had diagnosed each patient with a condition that

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<sup>5</sup>Dr. Griffin uses the following protocols to ensure that his patients are taking the medications as prescribed, and not diverting or abusing them: intake information, frequent appointments, limited durations on medications, restrictions on who may pick up prescriptions, the Ohio Automated Rx Reporting System [OARRS] and the Kentucky and Indiana equivalents, on-site random drug screens, drug contracts/medication agreements, electronic prescriptions (since 1999), use of tamper-resistant prescription paper, the "CAGE" substance abuse and dependency screening/assessment tool, mandatory use of one pharmacy for opioids, documentary proof of events resulting in loss or destruction of pain medication, and talking with pharmacies. (Tr. at 272-276, 411-421, 424; Resp. Ex. N) Dr. Griffin occasionally will conduct pill counts, but he did not do that with any of the involved 14 patients. (Tr. at 827)

is known to be chronically painful, he had treated each patient for that chronic pain, and he was in compliance with similar physicians in similar circumstances. Dr. Griffin testified that, in particular with regard to the doses of OxyContin, Kadian, Lyrica and Neurontin, the medications were what had been required to relieve the patients' pain appropriately. In essence, he felt that he had met Ohio's chronic pain management requirements. (Tr. at 591, 808)

He explained that he uses a conservative approach to pain medicine, but he is willing to prescribe at the dose that is necessary to relieve the patient's pain. Dr. Griffin also stated that most of his patients have "been through" other physicians and been dissatisfied. He stated that most of his patients come to him almost as a last resort. He noted that he is willing to take on the difficult cases. (Tr. at 808)

47. Dr. Gregg noted that Dr. Griffin treats patients with spine-related pain issues, and not all of those patients are going to do well. Dr. Gregg stated that he found that Dr. Griffin provided appropriate care to Patients 1-14, did not fall below the standard of care, and did not prescribe excessively. He also stated that the medication doses do not exceed others that he has seen and used for patients in his own practice. (Tr. at 690-692; Resp. Ex. A) Dr. Gregg stated:

\* \* \* And the normal stuff, anti-inflammatories, the physical therapy, the time and surgeries if they need it or had them, have not done the job, they are still hurting. Then for him to write for opiates in that setting, to me you're not going to set something if it's one year, five years, ten years.

If you hit a stable dose even and hold it there, that's amazing. You've actually almost guaranteed that you're helping that patient because they are not escalating the kind of dose that seems to be helping.

(Tr. at 793-794) In addition, Dr. Gregg stated that Dr. Griffin responded to the abnormal urine screens appropriately and documented such. He stated: "The chart notes are remarkably complete, specific, and deal with these problems in a manner appropriate to a physician working to understand and help the patient \* \* \*." (Resp. Ex. A)

**Evidence Specific to Patients 1, 2, 9, 10, 11 and 13**

(In relation to these six patients, the Board alleged inappropriate and excessive prescribing, and raised several additional allegations that are patient-specific. As a result, the evidence regarding these six patients will be summarized individually, on a patient-by-patient basis. The evidence regarding the other eight patients will be summarized collectively later in this Report.)

*Patient 1 (Allegation: Inappropriate and excessive OxyContin and Neurontin prescriptions, and inappropriate Ultram prescriptions)*

48. Patient 1 is a 48 year-old female. She began treatment with Dr. Griffin in 1993, following a work-related injury. In 1995, she suffered injuries from a significant motor vehicle accident. She has been diagnosed with: (a) a T8 wedge compression fracture without spinal cord injury; (b) degenerative disc disease; and (c) disc herniations in the lumbar and cervical areas.

Initially, Dr. Griffin treated Patient 1 with non-opioid medications. He treated her with opioids for a limited period of time following the 1995 automobile accident, and he prescribed Ultram. He continued the Ultram prescriptions, and began prescribing opioids in 2000, starting with Lortab, and then moving to Percocet and OxyContin in 2002. Percocet and OxyContin continued to be prescribed to Patient 1, and since June 2005, the OxyContin prescriptions have remained at the same level: OxyContin, 80 mg, three to five tablets every six hours, which equals 960 mg to 1,600 mg of OxyContin per day. The Percocet prescriptions decreased, and the Ultram prescriptions remained essentially at the same level. (St. Ex. 1 at 3, 537, 571, 839, 845, 915-949, 985-1017; Tr. at 192, 454-456, 539, 544, 609; Resp. Ex. C)

49. Dr. Reddy raised several criticisms of Dr. Griffin's prescriptions to Patient 1. First, he addressed the OxyContin prescriptions. Dr. Reddy noted that, between June 2005 and September 2007, Dr. Griffin prescribed OxyContin (80 mg, three to five tablets, every six hours).<sup>6</sup> Additionally, for much of that same time period, Dr. Griffin prescribed 100 mg of oxycodone each day via Percocet (either 5/325 mg or 10/325 mg, one to two tablets, every four to six hours). Dr. Reddy stated that the OxyContin and the larger dose Percocet prescriptions, when considered together, result in Patient 1 receiving 1,060 – 1,700 mg of oxycodone every day. (St. Ex. 1 at 985-1007; Tr. at 96-97, 118, 193) Dr. Reddy opined that those prescriptions were inappropriate, excessive and below the standard of care for the following reasons:

- The amount of OxyContin per day is too high, given Patient 1's diagnoses.
- The OxyContin should have been prescribed to be taken every 12 hours [q12 hours], not in shorter time periods because it is a time-released medication.
- The OxyContin dose should have been a fixed amount; not a dose that allows the patient to select the number of pills to consume.

(Tr. at 97-100, 194; St. Ex. 18 at 1-2) Dr. Reddy commented that, during this same time period, Dr. Griffin did not attempt to reduce the OxyContin dosages, or switch to other long-acting opioids, or provide other interventional procedures, such as medial branch blocks and radio frequency neurotomny. (Tr. at 102, 106, 111-113)

Second, Dr. Reddy found that, between August 2006 and August 2007, Dr. Griffin prescribed Neurontin (1,800 mg, one to two pills every four to six hours) for a total of 2,400 to 7,200 mg each day. Dr. Reddy stated that it was acceptable to prescribe Neurontin in an off-label fashion for the patient's nociceptive pain, which is pain from any non-neurological structural damage such as muscle trauma or a broken bone. However, he found the amount of Neurontin at 7,200 mg each day to be excessive for Patient 1's conditions. (St. Ex. 1 at 3, 31-41, 985-1003; Tr. at 59, 107-109, 326-327; St. Ex. 18 at 2)

Third, Dr. Reddy noted that Dr. Griffin had prescribed Ultram to Patient 1 for multiple years, while he also had prescribed OxyContin and Percocet to Patient 1. Dr. Reddy concluded that

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<sup>6</sup>Dr. Reddy actually stated that the problematic OxyContin prescriptions were issued by Dr. Griffin beginning in May 2004, but the prescription log indicates that they began in June 2005. (St. Ex. 18 at 1-2; St. Ex. 1 at 1001, 1007)

Ultram was prescribed for Patient 1's pain,<sup>7</sup> and there was no need for it when stronger and longer-acting medications for pain were simultaneously prescribed. As a result, Dr. Reddy concluded that Dr. Griffin's action on that point was below the standard of care. (St. Ex. 1 at 3, 31-41, 985-1013; Tr. at 109-111, 329-330, 357-358; St. Ex. 18 at 2)

50. Dr. Griffin testified that he started Patient 1 on low-dose opioids, but it later became necessary to switch to long-acting opioids as she continued to work at her "relatively heavy job." He further stated that Patient 1's conditions are either not repairable by surgery, or not severe enough for surgery. (Tr. at 456-457; Resp. Ex. C at 1)

With regard to the OxyContin and Neurontin prescriptions, Dr. Griffin disagreed with Dr. Reddy. He acknowledged that the OxyContin and Neurontin prescriptions are high doses, but stated that they are stable doses for Patient 1. He stated that similar physicians, under similar circumstances, will prescribe those amounts to provide appropriate pain relief and allow functioning in society. (Tr. at 452-454; Resp. Ex. C at 1)

51. Dr. Griffin testified that he had prescribed Ultram to Patient 1 in an off-label fashion. On two occasions, in 2005, the progress notes reflect that off-label use of Ultram was discussed with Patient 1. He stated that the medical literature mentions another use for Ultram. (Tr. at 389-392, 449-451, 606, 807, 829; St. Ex. 1 at 683, 689) He explained:

The Ultram in Patient 1 was prescribed off-label for the sole purpose of attempting to decrease the activity of a chemical in the spinal cord, which Ultram is known to work on. It is not a centrally acting opioid benefit that I was searching for.

That particular chemical is called NMDA which stands for N-methyl-D-aspartic. If you can decrease NMDA function, what happens is that the patient's perception of the pain coming to them is lessened, and so they perceive less pain.

This lowers your need for opioids so that you don't have to give a higher dose of essentially active chemical in order to achieve the same level of pain relief.

(Tr. at 389; see also Tr. at 608) Dr. Griffin testified that his off-label use of Ultram was within the standard of care and that other physicians prescribe Ultram in the same off-label fashion. He stated that the only other medication that affects the NMDA receptor is Methadone, and in his medical judgment he selected the better medication for Patient 1. Dr. Griffin acknowledged that the Ultram did not allow Patient 1 to have lower doses of the long-acting opioid; he stated, however, that the Ultram allowed her to be more active. (Tr. at 449, 607, 830)

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<sup>7</sup>Dr. Reddy stated that Ultram has a dual effect – as an analgesic and as a serotonin uptake inhibitor. He stated that the indication of Ultram in Patient 1 is "no doubt" for pain. Dr. Reddy further stated that, although Ultram inhibits serotonin levels which affect a patient's perception of pain, there are better medications and "[y]ou don't use Ultram to help serotonin levels." (Tr. at 329-330, 357-360)

52. Dr. Gregg testified that the OxyContin and Neurontin prescriptions were not excessive or inappropriate. Also, Dr. Gregg stated that Dr. Griffin's Ultram prescriptions for Patient 1 were within the standard of care. Dr. Gregg stated that Ultram has two modes of action: opiate receptor effect and non-opiate effect, which occurs in the spinal cord. Dr. Gregg stated that Ultram is a very reasonable medicine to prescribe, along with opioids because of the non-opiate effect. He further noted that he too has prescribed Ultram in addition to opioids. (Tr. at 697-698; Resp. Ex. A)

*Patient 2 (Allegation: Inappropriate and excessive OxyContin prescriptions, and failure to refer, treat and/or document treatment for spasticity)*

53. Patient 2 is a 50 year-old male. In 2004, he began treatment for his pain with Dr. Griffin. He has been diagnosed with: (a) T6 fracture with paraplegia, which occurred in 1981 following a motorcycle accident; (b) bilateral shoulder dislocations; and (c) cervical disc herniations. Dr. Griffin initially prescribed short-acting opioids, but escalated them. In September 2006, Patient 2 underwent surgery for a femur fracture, after which Dr. Griffin escalated his pain medication again. From October 2006 to October 2007, Dr. Griffin prescribed OxyContin, 80 mg, four times each day. During that time period, Dr. Griffin instructed Patient 2 to take two OxyContin pills at each time interval, and then escalated up to six pills at each time interval. Additionally, during this 2006-2007 time period, Dr. Griffin prescribed Percocet. (St. Ex. 2 at 3, 5, 651-655, 783, 841-849; Tr. at 120, 125-126, 544; Resp. Ex. C at 2)
54. Dr. Reddy again had three criticisms. First, Dr. Reddy stated that, following the 2006 surgery for the femur fracture, it would have been normal for Patient 2 to experience pain for an extended period of time because his central nervous system would not react normally to the injury. However, Dr. Reddy stated that, by September 2007, Patient 2 was prescribed 1,920 mg of OxyContin each day and, at the same time he was prescribed 100 mg of Percocet each day. Dr. Reddy stated that amount of oxycodone is excessive and below the standard of care.<sup>8</sup> (Tr. at 132; St. Ex. 18 at 3)

Second, Dr. Reddy noted that Patient 2's pain was not well controlled with the large amounts of pain medications and, therefore, Dr. Griffin should have considered that the patient's pain was due to something other than the T6 fracture and the femur fracture. Dr. Reddy opined that Patient 2 may have been suffering from spasticity,<sup>9</sup> and stated that Dr. Griffin should have referred Patient 2 to a spinal cord injury clinic. Dr. Reddy noted that Dr. Griffin did not diagnose spasticity or refer Patient 2 for an evaluation. Dr. Reddy concluded that Dr. Griffin's failure to make that referral was below the standard of care. (Tr. at 126, 131-133, 287-289, 333; St. Ex. 18 at 3)

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<sup>8</sup>Patient 2's pharmacy questioned the amount of Oxycodone prescribed by Dr. Griffin in April 2007, stating that it is "much more than the manufacturer recommends." (St. Ex. 2 at 73).

<sup>9</sup>Dr. Reddy and Dr. Griffin stated that "spasticity" is a non-stopping contraction of the muscle. Dr. Griffin stated that the contraction is "almost impossible to break" manually. Drs. Reddy, Griffin and Gregg agreed that such a diagnosis is accomplished by physically examining the patient. Dr. Reddy testified that "spasms" are different from "spasticity." He noted that a paraplegic who has spasms should be watched for spasticity. (Tr. at 127, 368, 394, 699)

Third, Dr. Reddy noted that, in June 2006, a urine test established that Patient 2 had cannabinoids in his system. In Dr. Reddy's view, it was inappropriate, and below the standard of care, for Dr. Griffin to continue prescribing excessive doses of OxyContin to this patient following the positive result for an illicit drug. (St. Ex. 2 at 585; St. Ex. 18 at 3; Tr. at 131-132)

55. Dr. Griffin disagreed that he prescribed excessive amounts of OxyContin to Patient 2, and stated that he prescribed OxyContin as would other physicians in similar circumstances. Dr. Griffin testified that he titrated the dose of OxyContin over time, and Patient 2 reported at that high level an improvement in his ability to function and interact with society, family and friends, including an ability to sleep six hours a night. (Tr. at 471, 472; Resp. Ex. C at 2)
56. Dr. Griffin agreed that an evaluation for spasticity would be appropriate, and stated that he did evaluate Patient 2 for spasticity via a physical examination. Dr. Griffin pointed to his progress note from Patient 2's first office visit as evidence of his physical examination of Patient 2 and the lack of indication of spasticity. (Tr. at 393-395, 397) Dr. Griffin's progress note from Patient 2's first office visit included:

The patient denies any leg pain at this time. He does have the typical paraplegic hamstring and gastroc [sic] spasms on occasions. These are not predictable.

\* \* \*

[Straight leg raises] are weakly positive bilaterally, left more so than right at 90 degrees. Muscle mass is greatly decreased in both legs. There is no control of the hips or knees. \* \* \*

(St. Ex. 2 at 783) Dr. Griffin further stated that, if Patient 2 had spasticity at the time of the first office visit, he would have found increased pain with attempted motion. (Tr. at 395)

Dr. Griffin further testified that he conducted other physical examinations of Patient 2, and Patient 2 did not suffer from spasticity. Dr. Griffin agreed that Patient 2 suffered from muscle spasms, and he stated that he treated the spasms at different times with Baclofen, Valium and Xanax. For instance, at the June 25, 2007, office visits, leg and back spasms were noted, and at the September 18, 2007 office visit, Patient 2 had visible spasms in the back and upper leg, and in his back as well. Dr. Griffin noted, at that latter visit, that Patient 2's "pain is relatively well controlled with the use of the current medications other than the back spasms." (Tr. at 467-470; Resp. Ex. C at 2; St. Ex. 2 at 597, 611, 761, 763, 767, 769, 771, 773)

57. With regard to the June 2006 urine sample that tested positive for marijuana, Dr. Griffin stated that he had counseled Patient 2, told him to stop using marijuana, and referred him to an addictionologist, although it is not reflected in his progress notes. Dr. Griffin further stated that he did not mention it in his notes because mention of it "would have compromised or negated this person's access to his necessary medications" by the Bureau of Workers'

Compensation. Dr. Griffin also noted that he was successful in counseling Patient 2 to stop the marijuana use. (Tr. at 633-634; Resp. Ex. C at 2)

58. Dr. Gregg reviewed the progress notes from Patient 2's office visits between October 2006 to October 2007. He noted that Patient 2's pain levels varied, and he expressed that his pain levels on "bad days" exceeded a five out of ten. Dr. Gregg stated that "we would like to keep it down somewhere more in the - two to three is the average run, and not really exceeding five." As a result, he found that Patient 2's pain scores were "pretty severe," and there was a need to adjust the medications to deal with the patient's pain. Additionally, Dr. Gregg stated that Dr. Griffin physically examined Patient 2 and reviewed his "systems" during that same time period. As a result, Dr. Gregg stated that Dr. Griffin investigated whether Patient 2's pain could have been generated from another source. Dr. Gregg felt that Dr. Griffin had decided that Patient 2's pain was pretty much the same and was trying to find a medication dose that would help. Moreover, Dr. Gregg saw nothing in the medical record to indicate that there may have been another source of pain that would have required a referral. (Tr. at 780-781, 783-784)

Dr. Gregg was skeptical that spasticity would have been an issue for Patient 2 because the time frame was more than 20 years after his spinal cord injury. He added that any later developments would probably have been related to nerve or muscle spasms, and those would not require a referral to a Physical Medicine and Rehabilitation physician as recommended by Dr. Reddy. Moreover, Dr. Gregg stated that one must physically examine the patient and listen to the complaints and symptoms in order to diagnose spasticity. He further stated that Patient 2's medical record demonstrates that Dr. Griffin repeatedly physically examined Patient 2's lower extremities to determine their function and to determine whether there was ongoing spasticity. Accordingly, Dr. Gregg stated that there was no failure on Dr. Griffin's part to adhere to the standard of care. (Tr. at 699-703, 779; Resp. Ex. A)

*Patient 9 (Allegation: Inappropriate and excessive OxyContin, Avinza and Kadian prescriptions, and inappropriate concurrent prescribing of two long-acting opioids)*

59. Patient 9 is a 55-year-old female. She began treatment with Dr. Griffin in 1985 following an injury to her back. She was diagnosed with: (a) L4-5 right disc herniation and (b) post-laminectomy syndrome. She reinjured her back in 1995. Dr. Griffin stated that Patient 9 has a recurrent disk herniation due to the second injury, and now has an unstable spine called "retrolisthesis." (St. Ex. 9 at 957, 989, 1085, 1181-1185; St. Ex. 18 at 11; Resp. Ex. C at 9; Tr. at 545)

Dr. Griffin prescribed: (a) OxyContin, 960 mg per day from December 2005 to March 2006; (b) Avinza, 960 mg per day in April 2006; (c) Kadian, 1,200 mg per day from April 2006 to June 2006 and from December 2006 to September 2007; and (d) Methadone, 40mg escalating up to 105 mg per day from July 2006 to January 2007. Between September 2003 and September 2007, Dr. Griffin also prescribed Neurontin at 4,800 mg per day. (St. Ex. 9 at 1193-1221)

60. Dr. Reddy took issue with the OxyContin, Avinza, and Kadian prescriptions noted above, stating that they were excessive given Patient 9's diagnoses. Also, he stated that Dr. Griffin prescribed Kadian and Methadone during the same six-month period (July 2006 to January 2007), which was inappropriate because they are both long-acting opioids. Dr. Reddy further explained that Patient 9's condition is a common one in pain clinics, but Dr. Griffin's prescriptions were unusual and inappropriate. Dr. Reddy acknowledged that he personally had prescribed two long-acting opioids at the same time, but did so while he was reducing one long-acting opioid in order to switch the patient to another long-acting opioid. Dr. Reddy concluded that Dr. Griffin's actions were below the standard of care. (St. Ex. 18 at 11; Tr. at 166-171, 266-267, 317-318)

Dr. Reddy explained that he had relied on a medication listing in the beginning of the patient record to conclude that Kadian and Methadone were simultaneously prescribed to Patient 9 between July 2006 and January 2007. Dr. Reddy acknowledged that the log of prescriptions, which is updated as the prescriptions are written, does not indicate that Kadian and Methadone were simultaneously prescribed to Patient 9 between July 2006 and January 2007. Instead, the prescription log suggests that the Kadian had been prescribed, that Methadone replaced it between July 2006 and January 2007, and that then again Kadian was prescribed in February 2007. Dr. Reddy also acknowledged that the progress note from Patient 9's office visit in December 2006 also reflects that the Methadone was switched to Kadian at that time. As a result of a re-review of the medical record, Dr. Reddy agreed that the medical record does not support a finding that there was concurrent use of two long acting opioids by Patient 9.<sup>10</sup> However, Dr. Reddy still finds that excessive levels of Kadian and Methadone were prescribed. (Tr. at 278-285, 316-317, 342-351, 369; St. Ex. 9 at 5, 775-777, 1191-1197)

61. Dr. Griffin disagreed with Dr. Reddy's contention that the OxyContin, Avinza and Kadian prescriptions were excessive. He stated, instead, that the doses were necessary to improve Patient 9's function in society, noting that she was able to participate in hobbies. Moreover, he stated that he documented the improvement in her pain scores and in her quality of life. He also stated that the Schedule II narcotics were prescribed within the standard of care. (Tr. at 513-514; Resp. Ex. C at 9)

In addition, Dr. Griffin testified that he was rotating the long-acting medications for Patient 9, and there was some cross-over as one medication was decreased and the other was introduced. He also explained that the listing Dr. Reddy had relied on initially is part of his electronic records, and the listing generated by the program does not separately list prescription periods for the same medication. Dr. Griffin stated that he has complained to the company, but the program has not been altered. He further stated that because of that flaw in the program, he maintains a separate paper copy of the prescription log for his patients. (Tr. at 508-512)

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<sup>10</sup>Dr. Reddy also looked at prescriptions for Avinza and Kadian in April 2006, believing that those two long-acting opioids were concurrently prescribed. He later acknowledged that the one prescription was canceled, and therefore there was no concurrently prescribing issue related to Patient 9. (Tr. at 364-366)

62. When Dr. Gregg reviewed Patient 9's medical record, he found no concurrent prescribing of long-acting opiates. (Tr. at 704-706) In addition, he testified:

As I mentioned, the treatment appeared to be trying to find doses of medications that were effective. And as he was working through these medicines, when he did find side effects and lack of benefit, the medicine was discontinued.

In a process that, to me, is trialing the medicines to see what is effective, it did not deviate from [the] standard of care if you can find a dose of these medicines that is effective.

There's a number of combinations that people have tried. I have had patients on combinations of long-acting opiates, whether it be a Duragesic patch and an oral, or whether it be Methadone and Morphine.

These combinations can be effective. They are different drugs, they occupy different receptors, and if that patient responds better to higher doses of one or a combination of two, then it would be reasonable.

(Tr. at 708-709)

*Patient 10 (Allegation: Inappropriate and excessive OxyContin prescriptions, despite a drug screen positive for illegal drugs of abuse, the presence of Hepatitis C, depression, anxiety and migraine headaches)*

63. Patient 10 is a 55-year-old male. He began treatment with Dr. Griffin in 2002. He was diagnosed with: (a) burst fracture at L1 following a construction accident; (b) status post T12-L2 fusion in 1999; and (c) chronic draining infection of the left flank. He also has depression, anxiety and migraine headaches. From February 2004 to September 2007, Dr. Griffin prescribed escalating prescriptions of OxyContin, including prescriptions for 1,040 mg of OxyContin per day. During that time, he prescribed Neurontin, 4,800 mg per day, as well. (St. Ex. 10 at 285, 391, 651, 691, 737, 853, 903, 1027-1033, 1073-1101; Resp. Ex. C at 11; Tr. at 656)

Dr. Griffin first noted Patient 10's depression and anxiety issues in October 2003. He discussed "the need for a psychological consultation" with Patient 10 in September 2006, following a June 2006 urine screen that was positive for marijuana. A second urine screen was positive for marijuana in June 2007. On both occasions, Dr. Griffin instructed Patient 10 to consult with an addiction medicine specialist, and he testified that Patient 10 did so. It appears from the medical record that Patient 10 obtained psychotherapy as part of those consultations. Additionally, Dr. Griffin included in his March 2007 progress note that Patient 10 suffers from migraine headaches. (St. Ex. 10 at 218, 285, 603-613, 691, 853, 909, 911, 919; Tr. at 657-659)

64. Dr. Reddy found that Dr. Griffin's OxyContin prescriptions were excessive and below the standard of care. In addition, Dr. Reddy stated that the OxyContin prescriptions were below the standard of care because Patient 10 suffers from Hepatitis-C, had urine screens that were positive for illegal drugs (marijuana), and has depression, anxiety, and migraine headaches. Dr. Reddy explained that he would have obtained consultations for Patient 10's illegal drug use, anxiety, depression and migraine headaches, and he might have reduced the dosages until those other issues cleared. (St. Ex. 18 at 14; Tr. at 175-178, 287, 315)

Dr. Reddy stated that, if Patient 10 had contracted Hepatitis C from a blood transfusion, rather than intravenous drug use, he would still consider Dr. Griffin's OxyContin prescriptions to be excessive and below the standard of care because the drug screen demonstrated that the patient was using illegal drugs. Dr. Reddy stated that Dr. Griffin still should have controlled the amount of OxyContin or should have used an alternative route to prevent abuse or diversion. (Tr. at 285-287)

65. Dr. Griffin disagreed with Dr. Reddy's conclusions, finding that he met the standard of care and his prescriptions were not excessive. He stated that the doses were necessary to improve Patient 10's function in society, and he had documented such in the medical record. Dr. Griffin included in his progress notes (for the first time in May 2004) that Patient 10 told him he had contracted Hepatitis C from a blood transfusion, and Dr. Griffin therefore believed that the Hepatitis C was not the result of intravenous drug use. Moreover, Dr. Griffin stated that Hepatitis C is not a contraindication for pain medications. Dr. Griffin also stated that Patient 10 suffered from chronic pain, which led to depression. He explained that Patient 10's depression was not a "primary depression;" rather, it was a reactive or secondary depression and therefore, Patient 10 was not in an "at-risk" category for medication. Dr. Griffin explained that he treated that secondary depression by prescribing Cymbalta for Patient 10. Similarly, Dr. Griffin stated that Patient 10's anxiety was due to the ongoing nature of his chronic pain and concerns for providing for his family. Dr. Griffin stated that the depression, anxiety and migraines were not contraindications for the opioid prescriptions. (Tr. at 514-518, 522, 655; St. Ex. 10 at 725, 737, 823; Resp. Ex. C at 11)

Dr. Griffin testified that he responded to the positive urine screens by instructing Patient 10 to consult an addictionologist. Dr. Griffin explained that Patient 10 was compliant with the instructions. He further stated that the standard of care did not require him to reduce the opioid prescription. Also, Dr. Griffin stated that Patient 10 had not abused the pain medications and deserved pain medication. Dr. Griffin noted that, following the first positive urine screen, he increased Patient 10's pain medications "because in talking with him I felt that he had inadequate pain relief when he reported a level five out of ten on his activities, and eight out of ten." (Tr. at 519-520, 662-664; Resp. Ex. C at 11; St. Ex. 10 at 909, 919)

66. Dr. Gregg found that Dr. Griffin's treatment was appropriate and that the issues with the drug screens were addressed. Dr. Gregg explained that Dr. Griffin noticed the results, addressed them in the subsequent visits, appropriately referred Patient 10, and documented the referrals. With regard to the second abnormal drug screen, Dr. Gregg stated that there is not an automatic rule as to how to handle the situation; rather, it is a judgment call by the physician, and

Dr. Griffin's approach was acceptable. Dr. Gregg contended that the issues of Hepatitis C, migraines, depression and anxiety are co-morbid conditions that would make treatment more difficult, because they would be factors to consider in deciding how and whether to prescribe opiates such as OxyContin, but they would not limit the amount of the dosage. (Tr. at 710-711, 714-715)

*Patient 11 (Allegation: Inappropriate and excessive OxyContin prescriptions, despite multiple positive drug screens for cannabinoids, a negative drug screen for oxycodone and diazepam which had been prescribed to Patient 11, a negative drug screen for pregabalin which had been prescribed to Patient 11, her criminal history for drug-related felonies, and a call from a pharmacist advising that she was selling drugs)*

67. Patient 11 is a 49-year old female. She began treatment with Dr. Griffin on May 9, 2008, and a number of events took place between May and September 2008. Patient 11 was diagnosed with: (a) arthrogyposis multiplex congenita, (b) amyoplasia, (c) osteogenesis imperfecta, (d) osteoarthritis, (e) scoliosis, (f) degenerative disc disease, and (g) arthritis. At the time of her first visit, Patient 11 provided pharmacy reports to Dr. Griffin indicating that she had been prescribed OxyContin, oxycodone, diazepam, Cymbalta, and Valium, as well as other medications. Dr. Griffin accepted Patient 11's statement that she was taking 320 mg of OxyContin each day, and accepted her statement regarding how much of that medication she had remaining. At the first visit, Dr. Griffin increased her prescription for OxyContin to 640 mg per day, and added Percocet 10/325 mg. At the first appointment, he prescribed 12 pills of OxyContin, 80 mg, which he believed would require Patient 11 to return in two weeks. He also prescribed diazepam (Valium). Dr. Griffin also requested an OARRS report. (Tr. at 70, 550, 552, 554, 557-558, 560, 770, 816, 838; St. Ex. 11 at 35-37, 145, 149-163, 179-191, 193)
68. During her second office visit in May 2008, Patient 11 complained of "occasional sharp pain in multiple joints, intermittent burning pain in her legs with the left being worse than the right, and constant dull aching pain in her back." Dr. Griffin noted that her pain was "relatively well controlled" with the current medications, and that she was using it appropriately. He noted her pain levels on a scale of 10, noted no evidence of side effects, and noted that she had improved function and mood. At the second office visit, a drug screen was ordered, and it was negative for benzodiazepines<sup>11</sup> and oxycodone. (St. Ex. 11 at 63-65, 69; Tr. at 773)
69. A second drug screen was ordered in early June 2008. The second screen was positive for benzodiazepines and oxycodone, and positive for cannabinoids. (St. Ex. 11 at 73)

<sup>11</sup>The State argued that this urine screen's benzodiazepine results were abnormal. The parties focused on Dr. Griffin's diazepam prescription issued during the first office visit on May 9, 2008. A pharmacy record dated May 15, 2008, reflects that Patient 11 presented that prescription to the pharmacy, but the pharmacy held Dr. Griffin's diazepam prescription because it was "early." A later OARRS report reflects that Dr. Griffin's diazepam prescription was not filled until June 6, 2008, which was after the drug screen conducted at Patient 11's second office visit. (St. Ex. 11 at 169, 193; Tr. at 771-775) In addition, Patient 11's medical record reflects that another physician had prescribed diazepam to Patient 11, and she had filled that prescription in late March 2008. According to an OARRS report, that prescription was for a 30-day supply. (St. Ex. 11 at 179, 185) That prescription, if taken properly, should not have registered on the urine screen taken at the second office visit in late May 2008.

In mid-June 2008, Dr. Griffin sent a letter to Patient 11 advising her that, as a result of the June urine screen being positive for cannabinoids, she needed to seek immediate consultation with an addiction medicine specialist. His letter also stated that, in order to continuing receiving analgesic/opioid medications, she was required to complete the consultation in a timely manner. (St. Ex. 11 at 81)

70. In mid-June 2008, Dr. Griffin's office directed Patient 11 to the emergency room due to pain. She reported that her pain medication "has not been helping x3 days." She received a single dose of Dilaudid and a single dose of Phenergan. (St. Ex. 11 at 85-93)
71. In early July 2008, Patient 11 saw Dr. Griffin for a third time. He noted that she needed her current medications in order to adequately control her pain and to function in society, and that she was having no side effects. He further stated that her pain was "relatively well controlled," and her "function remained stable since [her] last exam."<sup>12</sup> Dr. Griffin stated in his progress notes that compliance was discussed with Patient 11,<sup>13</sup> that she was seeing an addiction medicine specialist,<sup>14</sup> and another drug screen was ordered. The urine was positive for cannabinoids. (St. Ex. 11 at 95, 97, 101)

Dr. Griffin sent Patient 11 a second letter, advising her that, as a result of the July urine screen being positive for cannabinoids, she would need to obtain further counseling and attend weekly meetings.

72. At her fourth office visit in August 2008, Dr. Griffin noted that Patient 11 needed her current medications in order to adequately control her pain and to function in society, and that she was having no side effects. He also noted that her activity level had improved, and that she was seeing an addiction medicine specialist. A fourth drug screen was conducted and it was negative for pregabalin (Lyrica), which Dr. Griffin had prescribed in July 2008. Patient 11's medical record demonstrates that she filled the Lyrica prescription on July 17, 2008, the same day it was written. It was a 42-day supply. (St. Ex. 11 at 115, 119, 201)

Shortly thereafter, Dr. Griffin received notice from a pharmacist that Patient 11 had been convicted of three, drug-related felonies, and that a friend who picked up her prescriptions in May 2008 informed another pharmacist that Patient 11 would sell most of her medications and would snort the rest. Dr. Griffin testified that his staff verified that Patient 11 had three

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<sup>12</sup>Dr. Griffin explained that she had been sent to the emergency room because she could have had a fracture since she has osteogenesis imperfecta. The single dose of medication given by the emergency room was to provide relief and allow her to continue at home on her current medications. He found that, overall, her function remained stable and there was no deterioration in her condition, although she had gone to the emergency room. (Tr. at 572-573)

<sup>13</sup>Dr. Griffin explained that his reference to discussing the need for compliance meant that he had discussed the prior lab reports, and had explained to Patient 11 that she needed to be actively in compliance if she was going to continue to receive medication. He did not consider her to be noncompliant with his prescriptions at that time. (Tr. at 579-580)

<sup>14</sup>Patient 11's medical record, which covers the time period of May to September 2008, does not include any report from the addiction medicine specialist. (Tr. at 568-570)

drug-related convictions. His office also obtained a second OARRS report. (St. Ex. 11 at 127, 193-197; Tr. at 583-584)

73. At Patient 11's next office visit in September 2008, Dr. Griffin discussed urine testing, the pharmacist's note, compliance and his grave concerns. He noted that Patient 11 reported that she was seeing an addiction medicine specialist every other week. Dr. Griffin also discussed the need for Patient 11 to provide copies of her prior medical records, noting that the lack of the records could result in her discharge. His office also obtained a third OARRS report. (St. Ex. 11 at 129-131, 201-205)
74. Dr. Reddy raised two criticisms of Dr. Griffin's care and treatment of Patient 11. First, he felt that it was inappropriate to double her "already high" OxyContin prescription at the first office visit. Dr. Reddy stated that, when he increases dosages, he increases medications by 10 to 25 percent, and does not double dosages. Dr. Reddy also stated that the OxyContin prescription was prescribed to be taken every six hours, which is more frequently than the PDR allows. Second, Dr. Reddy took issue with Dr. Griffin's response to the positive urine screens and the pharmacist's letter. Dr. Reddy stated that Dr. Griffin met the standard of care when he ordered an addiction medicine consultation in June 2008.<sup>15</sup> However, Dr. Reddy stated that Dr. Griffin did not meet the standard of care because he prescribed excessive amounts of OxyContin and because he continued to prescribe opioids after notice of Patient 11's possible drug diversion, noncompliance with his instructions, and illegal drug use. Dr. Reddy also stated that he would have investigated Patient 11's noncompliances. (Tr. at 71-73, 76, 78-80, 91-92, 105, 300, 335-336; St. Ex. 18 at 12-13)

Dr. Reddy testified what he would have done the following with Patient 11:

I would be on top of this patient, number one. The issue here is the urine analysis is a major concern. We are giving high doses of medication, and the urine is showing negative, number one.

Number two, the same urine test is showing an illicit drug. Number three, a pharmacist has called saying that this patient may sell medications.

So I don't know if the patient is really selling medications or not, but putting everything together I see that there is quite a bit of drug diversion or drug abuse in this patient, and I would act on it. And I would discharge this patient from my clinic? Absolutely not.

I would - This patient is in pain, there is no question. This patient needs to be counseled, help taken from addiction medicine specialists, and she should still remain in this practice, collect the previous records and treat the patient with nondiverting drugs. That's what I would have done.

<sup>15</sup>Dr. Reddy acknowledged that Dr. Griffin responded in the following ways to the "dirty" urine screen: conducted further urine screens, sent a noncompliance letter referring Patient 11 to an addiction medicine consult, and tried to get the patient's former medical records. (Tr. at 336, 354-356)

\* \* \*

And even if I were to write controlled medications, at that point in time, I would certainly reduce the pills. And I will have a family member dispense the medications, see this patient more often, because I believe that if – because this particular pain patient is creating trouble to my practice \* \* \*.

(Tr. at 88-90)

75. Dr. Griffin stated that Patient 11 was an unusual patient because she suffered from three very rare genetic conditions. Dr. Griffin disagreed with Dr. Reddy's criticisms. He stated that he complied with the standard of care in his treatment of Patient 11. He concluded that the doses were necessary to improve Patient 11's function in society, and noted that the medical record demonstrates an improvement in her pain scores and her quality of life. (Resp. Ex. C at 10; Tr. at 542)

76. In response to the particular criticisms levied, Dr. Griffin explained that he increased the amount of OxyContin at Patient 11's first visit because she was having pain and her medical conditions were severe. He concluded that an adjustment in her medication was clinically indicated, and she needed more pain medicine. Dr. Griffin also stated that he checked into her background via the prescription services available in Ohio [OARRS], Indiana [INSPECT], and Kentucky [KASPER]. (Tr. at 527-52) He explained:

I OARRS'd her, I INSPECT'd her, I KASPER'd her that day [May 9<sup>th</sup>].

How, when I did the OARRS, I think the OARRS was a month behind. So I have no idea what happened from the 9th of April to the 9th of May. But she had been on this level of medication, and when she stated it was inadequate, I believed the patient.

(Tr. at 529) Dr. Griffin believes that he received the first set of reports from OARRS, INSPECT and KASPER on May 14, 2008, after the first appointment with Patient 11. (Tr. at 558-559)

77. In response to the comments about the drug screens, Dr. Griffin stated that he received the results of his first drug screen on May 30<sup>th</sup>.<sup>16</sup> He noted that he did not know if she had filled the prescriptions that he had written on May 9<sup>th</sup>, but he had confirmed her statements about multiple fractures and surgeries, and decided to order another drug screen. Dr. Griffin also stated that he repeatedly asked Patient 11 to provide her prior medical records, and his office made telephone calls to that physician as well. He stated that there were some understandable delays in obtaining the medical records because of the unavailability of the prior physician, and he did not want to punish Patient 11 for those difficulties. Dr. Griffin noted that Patient 11 began counseling after his instruction to do so. (Tr. at 533-535)

<sup>16</sup>Dr. Griffin noted that he currently has the ability to test urine samples in his office. However, at the time the above-noted events occurred with Patient 11 in 2008, he did not have any in-office drug screening capability. (Tr. at 412-414)

78. Dr. Griffin testified that, after receiving the letter from the pharmacist, he increased his level of concern for her, and he or his office took the following actions: his office thanked the pharmacist, he expressed his concerns with the patient (addressing the need to obtain prescriptions and to be compliant), and he shortened and varied the timing of her medication so that she had to come into his office more frequently. Dr. Griffin stated that, upon talking with Patient 11, he learned that her insurance company would not pay for the Lyrica, the medication missing from her fourth drug screen.<sup>17</sup> He switched her to Neurontin, as a result. Dr. Griffin stated that, with counseling and persistence, Patient 11 became compliant. (Tr. at 536-538, 546, 563, 581-582, 817-819, 824)

Dr. Griffin stated that drug-related felony convictions are not contraindications for pain medications. Similarly, he found that the hearsay statements and the low-level marijuana did not convince him to discontinue her pain medications. He acknowledged, however, that they raised concerns and required him to watch the patient closely. (Tr. at 540, 818; Resp. Ex. C at 10)

Dr. Griffin acknowledged that the pharmacy reports and the OARRS reports he obtained in May, August and September 2008 demonstrate that Patient 11 had received prescriptions for OxyContin and Oxycodone from multiple medical professionals shortly prior to beginning treatment with Dr. Griffin. (St. Ex. 11 at 155, 157, 171, 173, 175, 185, 193, 203)

79. Dr. Griffin concluded that he closely watched Patient 11 and appropriately responded to the red flags that developed. He noted that, by early September 2008, she was compliant. (Tr. at 540-541, 822-823; Resp. Ex. C at 10)

Dr. Griffin explained that Patient 11 is no longer a patient because, in 2009, she had an abnormal drug screen, and Dr. Griffin told her he was stopping her medicines until she saw an addictionologist. He explained that she "self-discharged." (Tr. at 567)

80. Dr. Gregg found Dr. Griffin's care and treatment of Patient 11 to be appropriate. He stated that Patient 11 "has a problem that is permanently painful and markedly debilitating." He further stated that Dr. Griffin fairly quickly addressed Patient 11's positive drug screen, and he consistently worked through that issue "to the point of possible discharge if [it] did not change." He believes that Dr. Griffin was trying to help alleviate her pain while working through her improper drug use. (Tr. at 717, 719-720)

In addition, Dr. Gregg stated that a positive drug screen does not contraindicate prescribing 640 mg of OxyContin. He stated:

The number of milligrams doesn't concern me as a physician if I was seeing this, as much as the patient still doing illegal drugs. And that needs to be addressed.

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<sup>17</sup>Dr. Griffin acknowledged that Patient 11 obtained small amounts of Lyrica by paying for it herself. (Tr. at 582)

How much you prescribe them as you're deciding to continue to treat them and trying to get them to an addiction specialist should reasonably be based on what you think is going to help their pain, rather than removing medicine from them. That will only drive them to more illicit drugs if they are using any of them for pain in the process.

(Tr. at 717-718)

81. Similarly, Dr. Gregg stated that her prior drug-related convictions were not contraindications for prescribing 640 mg of OxyContin. Moreover, Dr. Gregg concluded that the standard of care requires what Dr. Griffin did in response to the pharmacist's letter: identify the accuracy of the statements, go over the records, and further "push the issue" of an addiction specialist with the patient. (Tr. at 721, 722)
82. Dr. Gregg stated that, in his opinion, the doubling of the OxyContin prescription at Patient 11's first office visit is not automatically a deviation from the standard of care. He found that the issue is a judgment call for the physician, based on the patient's history, statements regarding what is effective, and statements regarding what is not effective. Dr. Gregg stated that, in reaching his conclusion on this point, he had not reviewed the information about prior prescriptions in the pharmacy profile that Dr. Griffin had at the time he doubled the OxyContin prescription. However, he stated that he himself had doubled dosages of opiates when he felt that was what was necessary to provide pain relief. Therefore, he concluded that it may have been appropriate for Dr. Griffin to double the OxyContin prescription. (Tr. at 723, 745, 750-752, 777-778, 799-800)
83. In addition, Dr. Gregg stated that it was not below the standard of care to prescribe OxyContin more frequently than every 12 hours. He further stated that it is done frequently. He also stated that OxyContin is supposed to last and be continuously delivered for 12 hours in most patients, but that is not the case with all patients. (Tr. at 727-728, 735) Dr. Gregg stated:

There's some range that you can give patients. I think - And for the most part, that would be associated with either - pain that changes during time so that you can adjust the dose.

There are some patients who have periods where pain markedly increases, and the ability to increase even long-acting medicine may be reasonable.

This would be a case - Osteogenesis imperfecta is a circumstance where the bones break on an inconsistent but regular basis, and the fracture itself is very painful.

Their whole body ends up being over responsive to pain because of this course, and the ability for someone in that circumstance even to be able to take medicine, if pain goes up markedly, would not be unreasonable.

(Tr. at 724-725)

*Patient 13 (Allegation: Inappropriate and excessive prescribing of a combination of OxyContin and Avinza)*

84. Patient 13 is a 46-year-old male. He began treatment with Dr. Griffin in 1983. He has been diagnosed with: (a) patellar fracture with associated crush injury from a motor vehicle accident; (b) chondromalacia, traumatic arthritis and synovitis; (c) painful right total knee; (d) synovitis right total knee; and (e) reflex sympathetic dystrophy. Between 2005 and 2007, Dr. Griffin prescribed 240 – 400 mg of OxyContin per day (20 mg, 3-5 pills, 4 times each day) and 720 mg of Avinza (120 mg, 3 pills, 2 times each day) per day. (St. Ex. 13 at 5, 761, 1301-1321; Resp. Ex. C at 13)
85. Dr. Reddy stated that, one time in July 2007, Dr. Griffin prescribed both Avinza and OxyContin to Patient 13. Dr. Reddy found that combination was inappropriate because they are both medications from the same class. However, on further questioning and review of Patient 13's medical record, Dr. Reddy stated that it appears that Dr. Griffin was attempting to transition Patient 13 from Avinza to OxyContin in the July 2007 time frame, and therefore the prescriptions were not inappropriate. (Tr. at 341-342, 351-354, 362-363, 369)
86. Dr. Griffin disagreed that he prescribed two-long acting opioids to Patient 13 simultaneously. Dr. Griffin stated that he had attempted to rotate Patient 13 to a brand name of OxyContin, and it did not work. He stated that he had documented his efforts in his progress notes. He found that his actions were within the standard of care. (Tr. at 547)
87. Similarly, Dr. Gregg disagreed that two-long acting opioids were prescribed to Patient 13 simultaneously; instead, he found that one medication was being eliminated while the other was being titrated up, in an attempt to switch medications. He concluded that the OxyContin and Avinza medications were within the standard of care. (Tr. at 707-708)

**Summary of Evidence Regarding the Remaining Eight Patients (Patients 3-8, 12 and 14)**  
(Allegations: Inappropriate and excessive prescriptions for OxyContin, Kadian, Methadone, Lyrica, and/or Neurontin)

88. The following chart summarizes the basic evidence regarding Patients 3 through 8, 12 and 14 that is contained in their medical records:

Pl. #, Age, + Sex	Year Started	Diagnoses	Medications Alleged to be Improper	Dosages	Per-Day Totals	Time Period
3  53-year- old female	1986	(a) herniated disc L4-L5 with complication (aortic perforation) (b) post-laminectomy syndrome (c) revision spine surgery, decompression laminectomy L4 and L5 with posterolateral fusion (e) cervical C4-C5 ACDF (f) multilevel cervical stenosis <sup>18</sup>	OxyContin	80 mg, 4 pills, 4 times a day	1,280 mg	1/06 - 9/07
			Methadone	10 mg, 4 pills, 4 times a day	160 mg	1/07 - 9/07
			Lyrica	100 mg, 3 pills, 4 times a day	1,200 mg	8/07 - 9/07
4  41-year- old male	2002	(a) lumbar disc herniation at L4-5 and L5-S1 (b) lumbar strain (c) thoracic strain (c) fracture of the lumbar vertebrae	Kadian	50 mg, 4-5 pills, twice a day	500 mg	3/05 - 5/05
			OxyContin	80 mg, 3-5 pills, 3 times a day	720-1,200 mg	7/06 - 9/07
			Lyrica	50 mg, 3-4 pills, three times a day	600 mg	2/06 - 9/07
5  50-year- old male	1983	(a) villonodular synovitis of the foot and ankle (b) fracture of the left tibia (c) generalized osteoarthritis (d) lumbosacral spondylosis (e) lumbar facet arthropathy <sup>19</sup>	OxyContin	80 mg, 6 pills, 3 times a day	1,440 mg	9/04 - 5/06
			Kadian	100 mg, 7 pills, 3 times a day	2,100 mg	9/06 - 10/07
			Lyrica	100mg, 3-4 pills, 4 times a day	1,600 mg	8/07 - 9/07
6  46-year- old female	2005	(a) post-laminectomy syndrome (b) two lumbar spine surgeries (c) spinal cord stimulator (d) probable epidural fibrosis secondary to smoking <sup>20</sup>	OxyContin	80 mg, 5 pills, 3 times a day, plus 6 pills at bedtime	1,680 mg	1/07 - 9/07
			Lyrica	50 mg, 1-6 pills, 3 times a day	900 mg	5/06

<sup>18</sup>Dr. Griffin also stated that Patient 3 had multiple knee surgeries and two cervical disk herniations for which she had surgery. (Tr. at 544)

<sup>19</sup>Patient 5 has co-morbidities of diabetes and hypertension, as well as exogenous obesity. (Tr. at 544)

<sup>20</sup>Patient 6 has significant lung problems, which limit her ability to function. (Tr. at 545)

Pt. #, Age, + Sex	Year Started	Diagnoses	Medications Alleged to be Improper	Dosages	Per-Day Totals	Time Period
7  52-year- old female	2002	(a) lumbar post-laminectomy syndrome (b) multilevel lumbar fusion (c) s/p femoral shaft stress fracture (d) cervical post-laminectomy syndrome (e) rheumatoid arthritis (f) blindness <sup>21</sup>	OxyContin	80 mg, six pills, 4 times a day	1,920 mg	4/06 – 9/07
			Kadian	100 mg, 10-11 pills, 2 times a day	1,000-2,200 mg <sup>22</sup>	2/05 – 6/05
			Neurontin	300 mg, 4-7 pills, 4 times a day	4,800 - 8,400 mg	6/03 – 8/07
8  52-year- old male	2002	(a) lumbar disc herniation at L5-S1 (b) retrolisthesis L5 on S1 (c) post-laminectomy syndrome (d) probable epidural fibrosis secondary to smoking	OxyContin	80 mg, 4 pills, 4 times a day	1,280 mg	1/06 – 9/07
			Neurontin	600 mg, 3 & 1/2 pills, 4 times a day	8,400 mg	6/07 – 9/07
12  52-year- old female	2004	(a) lumbar post-laminectomy syndrome (b) L3-S1 fusions (c) disc herniations L2-3 and L1-2 (d) cervical spinal stenosis C2-3, C5-6, and C6-7 (e) diabetes (f) seizure disorder (g) emphysema	OxyContin	80 mg, 5-6 pills, 4 times a day,	1,600 -- 1,920 mg	4/07 – 9/07
			Neurontin	600 mg, 4-5 pills, 4 times a day	9,600 -- 12,000 mg	5/07 – 9/07
14  48-year- old male	2002	(a) disc herniations L4-05 and L3-L4 (b) s/p L4-L5 and L3-L4 hemi-laminectomies (c) post-laminectomy syndrome	Kadian	100 mg, 7 pills, 2 times a day	1,400 mg	6/04 – 9/07

(Tr. at 545, 644; St. Ex. 3 at 991-1005; St. Ex. 4 at 1125, 1111-1117; St. Ex. 5 at 1093-1109; St. Ex. 6 at 787-793; St. Ex. 7 at 3-5, 895-911, 917; St. Ex. 8 at 5, 689-697; St. Ex. 12 at 3, 25, 525-529, 1361; St. Ex. 14 at 43, 949-961; Resp. Ex. C at 3-8, 12, 14)

89. Dr. Reddy testified that, in light of the eight patients' medical conditions, Dr. Griffin prescribed excessive amounts of OxyContin, Kadian, Lyrica, Neurontin, and Methadone during the above listed time frames. He concluded that the prescriptions were below the standard of care. (St. Ex. 18 at 4-10, 15-17; Tr. at 141-142, 159-166, 179-191)

<sup>21</sup>Patient 7 has co-morbidities of emphysema and diabetes. (Tr. at 545)

<sup>22</sup>Dr. Reddy opined that patients with lumbar post-laminectomy syndrome could be managed with ten percent of this dose of Kadian. (St. Ex. 18 at 9)

90. Dr. Griffin disagreed that his prescriptions for Patients 3-8, 12 and 14 fell below the minimum standard of care. Dr. Griffin opined that there was a rational use of the medications, and the doses of OxyContin, Kadian, Lyrica, Neurontin, and Methadone were necessary to improve the patients' function in society and their relationships with family and friends. (Resp. Ex. C at 3-8, 12, 14; Tr. at 476-477, 482-484, 486, 492-494, 502-506, 525-526)
91. Dr. Greg found that Dr. Griffin's care and treatment of Patients 3-8, 12, and 14 was appropriate. (Resp. Ex. A)

### FINDINGS OF FACT

1. During the time period of 2000 to 2008, George D.J. Griffin, III, M.D., provided care in the routine course of his practice for Patients 1-14 (as identified in a confidential Patient Key). In treating Patients 1-14:
- a. (i) Dr. Griffin inappropriately and excessively prescribed 1,600 mg of OxyContin per day and 7,200 mg of Neurontin per day for Patient 1.
- This finding is supported by the following: First, Dr. Griffin prescribed the high dose of OxyContin to be taken every six hours, even though it is a long-acting opioid and the PDR dosing interval is every 12 hours. There is insufficient justification in the hearing record to explain this very short dosing interval. Second, Dr. Griffin prescribed the high dose of OxyContin and allowed the patient to select the number of pills to take at each interval (either 3, 4, or 5 pills). Third, Dr. Griffin explored few other modalities to address Patient 1's pain between June 2005 and September 2007. Fourth, Dr. Reddy testified convincingly that the OxyContin and Neurontin amounts are excessive given Patient 1's diagnoses.
- (ii) Dr. Griffin inappropriately prescribed Ultram to Patient 1.
- This finding is supported by the following: Dr. Griffin testified that he prescribed Ultram in an off-label fashion, but the medical record suggests otherwise. First, there no direct documentation in Patient 1's medication of an off-label *prescribing* of Ultram; the medical record only refers to *discussing* off-label use of Ultram in 2005, which is nearly 10 years after he began prescribing Ultram. Second, the medical records in this proceeding reflect that Dr. Griffin had a practice of documenting, on numerous occasions, when he had prescribed medications in an off-label fashion. Third, Patient 1's medical record reflects that Dr. Griffin prescribed Ultram prior to prescribing opioids on a long-term basis, and he continuously prescribed Ultram to Patient 1 for 12 years (1995-2007) at basically

the same dosage. During that same time period, other stronger medications for Patient 1's pain were added, adjusted, and/or switched. Taken altogether, the evidence is unconvincing that Dr. Griffin prescribed Ultram to Patient 1 in an off-label fashion; instead, the evidence demonstrates that Dr. Griffin inappropriately continued to prescribe Ultram while also prescribing short-acting and long-acting opioids.

- b. (i) Dr. Griffin inappropriately and excessively prescribed 1,920 mg of OxyContin per day for Patient 2.

- This finding is supported by the following: There is insufficient justification in the hearing record to explain the high dose of OxyContin for Patient 2. Dr. Griffin explored few other modalities to address Patient 2's pain between October 2006 and October 2007. Dr. Reddy testified convincingly that the dosage amount is excessive given Patient 2's diagnoses.

- (ii) The evidence is insufficient to establish that Dr. Griffin inappropriately and excessively prescribed 1,920 mg of OxyContin per day for Patient 2 because of the June 2006 urine screen. Dr. Griffin and Dr. Gregg convincingly testified that the standard of care does not require prescription decreases or cessations when marijuana use is discovered; rather, it necessitates investigation, counseling, and referral to an addictionologist.

Furthermore, the evidence is insufficient to establish that Dr. Griffin should have referred Patient 2 for the treatment of spasticity, or should have provided and/or documented treatment to Patient 2 for spasticity.

- This finding is supported by Patient 2's medical record in which it is repeatedly documented that Dr. Griffin physically examined Patient 2 at numerous office visits. All witnesses testified that spasticity requires a physical examination to diagnose. Dr. Griffin noted many observations during Patient 2's office visits, including a number of incidents of muscle spasms. However, there is no indication in the medical record that the spasms were more severe such that a referral and/or treatment for spasticity were warranted.

- c. Dr. Griffin inappropriately and excessively prescribed 1,280 mg of OxyContin per day, 160 mg of Methadone per day, and 1,200 mg of Lyrica per day for Patient 3.

- This finding is supported by the following: First, Dr. Griffin prescribed the high dose of OxyContin to be taken every six hours, even though it is a long-acting opioid and the PDR dosing interval is every 12 hours. There is insufficient justification in the hearing record to explain this

very short dosing interval. Moreover, the short dosing period for the OxyContin continued for 20 months. Second, the Methadone and Lyrica were prescribed at the same time as the high dose of OxyContin was prescribed. Third, Dr. Reddy stated convincingly that the dosage amount is excessive given Patient 3's diagnoses.

- d. (i) Dr. Griffin inappropriately and excessively prescribed 1,200 mg of OxyContin per day at one point, and 500 mg of Kadian per day at one point for Patient 4.
- (ii) The evidence is insufficient to establish that Dr. Griffin inappropriately and excessively prescribed 600 mg of Lyrica per day for Patient 4.
- This finding is supported by the following: Dr. Reddy stated that, in general, Lyrica prescribed at 600 mg per day could be within the acceptable range, but concluded in relation to Patient 4 that that the higher dose was a violation of the standard of care. He provided no justification for that conclusion in his report or his testimony.
- e. Dr. Griffin inappropriately and excessively prescribed 1,440 mg of OxyContin per day at one point, 2,100 mg of Kadian per day, and 1,600 mg of Lyrica per day for Patient 5.
- f. Dr. Griffin inappropriately and excessively prescribed 1,680 mg of OxyContin per day and 900 mg of Lyrica per day for Patient 6.
- g. Dr. Griffin inappropriately and excessively prescribed 1,920 mg of OxyContin per day at one point, 2,200 mg of Kadian per day at one point, and 8,400 mg of Neurontin per day for Patient 7.
- h. Dr. Griffin inappropriately and excessively prescribed 1,280 mg of OxyContin per day and 8,400 mg of Neurontin per day for Patient 8.
- i. (i) Dr. Griffin inappropriately and excessively prescribed 960 mg of OxyContin per day at one point, 960 mg of Avinza per day at one point and 1,200 mg of Kadian per day at one point for Patient 9.
- (ii) The evidence is insufficient to establish that Dr. Griffin inappropriately prescribed two long acting opioids concurrently to Patient 9.
- This finding is supported by the following: Dr. Reddy originally relied on a medication listing that indicated concurrent prescribing of Kadian and Methadone. However, he altered his opinion upon reviewing the prescription log and corresponding progress notes which reflect that Dr. Griffin was actually switching medications. Dr. Griffin convincingly testified that the computer program which generates the medication

listing contains a flaw, and that no concurrent prescribing occurred with Patient 9.

- j. (i) Dr. Griffin inappropriately and excessively prescribed 1,040 mg of OxyContin per day, despite the following observations for Patient 10: depression, anxiety and migraine headaches.
- This finding is supported by the following: Dr. Griffin prescribed escalating OxyContin prescriptions even though Patient 10 had anxiety and depression issues for years, and even though he prescribed Cymbalta for Patient 10. A psychological consultation was not documented until Patient 10's June 2006 urine screen was positive for marijuana. When migraine headaches were first noted in early 2007, there are no details about them and yet the OxyContin continued to be prescribed at high doses and were further increased.
- (ii) The evidence is insufficient to establish that Dr. Griffin inappropriately and excessively prescribed 1,040 mg of OxyContin per day because of a urine drug screen was positive for illegal drugs of abuse (marijuana) or the presence of Hepatitis C. Dr. Griffin and Dr. Gregg convincingly testified that the standard of care does not require prescription decreases or cessations when marijuana use is discovered; rather, it necessitates investigation, counseling, and referral to an addictionologist. The medical record reflects that the Hepatitis C was the result of a blood transfusion, and Dr. Griffin was informed of that cause years before the urine screens began.
- k. (i) Dr. Griffin inappropriately and excessively prescribed 640 mg of OxyContin per day to Patient 11, despite the following observations: multiple positive urine drug screens for cannabinoids, a negative urine drug screen for oxycodone despite Dr. Griffin having prescribed said medications to Patient 11, a negative urine drug screen for Pregabalin (Lyrica) despite Dr. Griffin having prescribed said medication to Patient 11, Patient 11's criminal history for drug-related felonies, and a call from a pharmacist advising that Patient 11 was selling drugs.
- (ii) The evidence is insufficient to establish that Dr. Griffin inappropriately and excessively prescribed 640 mg of OxyContin per day despite a negative urine drug screen for diazepam in May 23, 2008, after Dr. Griffin had issued a prescription for that medication.
- This finding is supported by the following: the totality of the evidence demonstrates that Dr. Griffin's diazepam prescription was not filled until after that urine screen, and Patient 11's prior diazepam prescription, if taken properly, would have been fully consumed weeks before the May 2008 urine screen.

- l. Dr. Griffin inappropriately and excessively prescribed 1,920 mg of OxyContin per day and 12,000 mg of Neurontin per day for Patient 12.
- m. The evidence is insufficient to establish that Dr. Griffin inappropriately and excessively prescribed a combination of 240 mg of OxyContin per day and 720 mg of Avinza per day for Patient 13.
  - This finding is supported by the following: Dr. Reddy originally relied on a medication listing that indicated concurrent prescribing of OxyContin and Avinza. However, he altered his opinion upon reviewing the prescription log and corresponding progress notes, which reflect that Dr. Griffin was actually switching/transitioning medications. Dr. Griffin convincingly testified that the computer program which generates the medication listing contains a flaw, and that no concurrent prescribing occurred with Patient 13.
- n. Dr. Griffin inappropriately and excessively prescribed 1,400 mg of Kadian per day for Patient 14.

#### CONCLUSIONS OF LAW

1. As set forth in Findings of Fact 1(a)(f) and (ii), (b)(i), (c), (d)(i), (e), (f), (g), (h), (i)(i), j(i), (k)(i), (l), and (n), Dr. Griffin's acts, conduct, and/or omissions individually and/or collectively constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in Section 4731.22(B)(6), Ohio Revised Code.
2. As set forth in Findings of Fact 1(b)(ii), (d)(ii), (i)(ii), (j)(ii), (k)(ii), and (m), Dr. Griffin's acts, conduct, and/or omissions individually and/or collectively do not constitute "[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as set forth in Section 4731.22(B)(6), Ohio Revised Code.

Because the Board did not previously have before it all of the information that was presented during the hearing, the Board was substantially justified in pursuing the allegations in Findings of Fact 1(b)(ii), (d)(ii), (i)(ii), (j)(ii), (k)(ii), and (m), which are set forth as part of paragraphs 1(b), (d), (i), (j), (k), and (m) of the notice of opportunity for hearing.

#### RATIONALE FOR THE PROPOSED ORDER

The medical records in this matter reflect that the 14 patients are legitimate chronic pain patients, and Dr. Griffin's care and treatment of the 14 patients involved high doses of a number of medications. Dr. Griffin understood that he was prescribing high doses, often over extended periods

of time. Dr. Griffin's treatment primarily involved escalation after escalation after escalation of medications. Some other treatments were periodically tried/explored by Dr. Griffin, but his general approach with these patients was to prescribe opioids and escalate them with complaints of pain. There were not a significant number of attempts to control the dosages of opioids via switching medications, interventional procedures, other therapies, consultations or referrals over the many years he treated most of the patients. Additionally, there is *little* explanation and/or justification in his progress notes to delineate why, at the time, he continually increased dosages and why he determined that such high doses were needed or continued to be needed by each patient, especially since the dosages were so high. Across nearly all patient records, Dr. Griffin failed to include patient-specific objective data that is appropriate in prescribing opioids for chronic pain patients. Such data includes: pulse rate, blood pressure and pupil diameter. (Dr. Griffin's Exhibit P indicates that such objective data can indicate signs of excess opioid use and uncontrolled pain.)

Dr. Griffin's contention that the 14 patients' pain was intractable pain that justified his prescriptions was unconvincing. It does not appear from the medical records that Dr. Griffin performed all the necessary steps set forth in Rule 4731-21-02, Ohio Administrative Code.

With regard to Patient 11, Dr. Griffin inappropriately doubled her OxyContin prescription at her first appointment with him (as opposed to an incremental increase), inappropriately prescribed OxyContin for consumption every six hours, inappropriately continued to prescribe OxyContin to her when the first drug screen at the second office visit was negative for oxycodone, and inappropriately continued to prescribe OxyContin to her after receiving notification from the pharmacist about her prior drug-related convictions and her diversion activities.

Despite the above, it appears that Dr. Griffin seeks to care and follow his chronic pain patients in order to alleviate their pain. Dr. Griffin erred in some of his mechanisms, for which discipline is appropriate. A definite suspension of 120 days, additional education, and future monitoring of his practice are recommended. The Board is reminded that Dr. Griffin is a sole practitioner.

#### PROPOSED ORDER

It is hereby ORDERED, that:

- A. **SUSPENSION OF CERTIFICATE, STAYED IN PART:** The certificate of George D.J. Griffin, III, M.D., to practice medicine and surgery in the State of Ohio shall be **SUSPENDED** for a period of 120 days. All but 30 days of such suspension are **STAYED**.
- B. **PROBATION:** Upon reinstatement of Dr. Griffin's certificate, the certificate shall be subject to the following **PROBATIONARY** terms, conditions, and limitations for a period of at least three years:
  1. **Obey the Law:** Dr. Griffin shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

2. **Declarations of Compliance:** Dr. Griffin shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Order. The first quarterly declaration must be received in the Board's offices on or before the first day of the third month following the month in which Dr. Griffin's certificate is reinstated. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
3. **Personal Appearances:** Dr. Griffin shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which Dr. Griffin's certificate is reinstated, or as otherwise directed by the Board. Subsequent personal appearances shall occur every six months thereafter, and/or as otherwise directed by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
4. **Controlled Substances Prescribing Course(s):** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Griffin shall submit acceptable documentation of successful completion of a course or courses dealing with the prescribing of controlled substances. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Griffin submits the documentation of successful completion of the course(s) dealing with the prescribing of controlled substances, he shall also submit to the Board a written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

5. **Pharmacology Course(s):** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Griffin shall submit acceptable documentation of successful completion of a course or courses dealing with pharmacology. The exact number of hours and the specific content of the course or courses shall be subject to the prior approval of the Board or its designee. Any course(s) taken in compliance with this provision shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

In addition, at the time Dr. Griffin submits the documentation of successful completion of the pharmacology course(s), he shall also submit to the Board a

written report describing the course(s), setting forth what he learned from the course(s), and identifying with specificity how he will apply what he has learned to his practice of medicine in the future.

6. **Monitoring Physician:** Within 30 days of the reinstatement of Dr. Griffin's certificate, or as otherwise determined by the Board, Dr. Griffin shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary and Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Griffin and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. Griffin and his medical practice, and shall review Dr. Griffin's patient charts. The chart review may be done on a random basis, with the frequency and number of charts reviewed to be determined by the Board.

Further, the monitoring physician shall provide the Board with reports on the monitoring of Dr. Griffin and his medical practice, and on the review of Dr. Griffin's patient charts. Dr. Griffin shall ensure that the reports are forwarded to the Board on a quarterly basis and are received in the Board's offices no later than the due date for Dr. Griffin's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Griffin shall immediately so notify the Board in writing. In addition, Dr. Griffin shall make arrangements acceptable to the Board for another monitoring physician within 30 days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Dr. Griffin shall further ensure that the previously designated monitoring physician also notifies the Board directly of his or her inability to continue to serve and the reasons therefor.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. Griffin's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. Griffin's monitoring physician, in the event that the Secretary and Supervising Member of the Board determine that any such monitoring physician has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

7. **Controlled Substances Log:** Dr. Griffin shall keep a log of all controlled substances he prescribes, orders, administers, or personally furnishes. Such log shall be submitted in a format of Dr. Griffin's choosing and approved in advance by the Board. All such logs required under this paragraph must be received in the Board's offices no later than the due date for Dr. Griffin's

declarations of compliance, or as otherwise directed by the Board. Further, Dr. Griffin shall make his patient records with regard to such controlled substances available for review by an agent of the Board upon request.

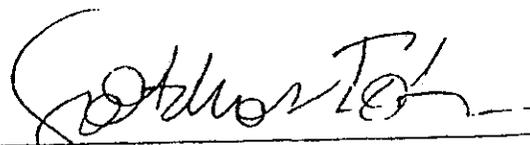
8. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Griffin is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.
- C. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. Griffin's certificate will be fully restored.
- D. **REQUIRED REPORTING AND DOCUMENTATION OF REPORTING:**
1. **Required Reporting to Employers and Hospitals:** Within 30 days of the effective date of this Order, Dr. Griffin shall provide a copy of this Order to all employers or entities with which he is under contract to provide health care services (including but not limited to third-party payors) or is receiving training, and the Chief of Staff at each hospital or healthcare center where he has privileges or appointments. Further, Dr. Griffin shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide health-care services (including but not limited to third-party payors), or applies for or receives training, and the Chief of Staff at each hospital or healthcare center where he applies for or obtains privileges or appointments. This requirement shall continue until Dr. Griffin receives from the Board written notification of her successful completion of his probation.  
  
In the event that Dr. Griffin provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical services provider in Ohio, within 30 days of the effective date of this Order, Dr. Griffin shall provide a copy of this Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. This requirement shall continue until Dr. Griffin receives from the Board written notification of her successful completion of his probation.
  2. **Required Reporting to Other State Licensing Authorities:** Within 30 days of the effective date of this Order, Dr. Griffin shall provide a copy of this Order to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Also, Dr. Griffin shall provide a copy of this Order at the time he applies for any professional license or for reinstatement of any professional license. This requirement shall

continue until Dr. Griffin receives from the Board written notification of the successful completion of his probation.

3. **Documentation that the Reporting Required by Paragraph D:** Dr. Griffin shall provide the Board with one of the following documents as proof of each required notification within 30 days of the date of each notification required above: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (c) the original facsimile-generated report confirming successful transmission of a copy of the Order to the person or entity to whom a copy of the Order was faxed, or (d) an original computer-generated printout of electronic mail communication documenting the e-mail transmission of a copy of the Order to the person or entity to whom a copy of the Order was e-mailed.

E. **VIOLATION OF THE TERMS OF THIS ORDER:** If Dr. Griffin violates the terms of this Order in any respect, the Board, after giving him notice and the opportunity to be heard, may institute whatever disciplinary action it deems appropriate, up to and including the permanent revocation of his certificate.

F. **EFFECTIVE DATE OF ORDER; NO NEW PATIENTS:** This Order shall become effective 30 days from the date of mailing of the notification of approval by the Board. In the 30-day interim, Dr. Griffin shall not undertake the care of any patient not already under his care.



Gretchen L. Petrucci  
Hearing Examiner

April 14, 2010

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The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

GEORGE D. J GRIFFIN, III, M.D.

Dr. Amato directed the Board's attention to the matter of George D. J. Griffin, III, M.D. He advised that objections were filed to Hearing Examiner Petrucci's Report and Recommendation and were previously distributed to Board members.

Dr. Amato continued that a request to address the Board has been timely filed on behalf of Dr. Griffin. Five minutes would be allowed for that address.

Dr. Griffin was accompanied by his attorney, Eric J. Plinke, Esq.

Mr. Plinke stated that the case against Dr. Griffin involves dosage amounts for pain medications. Mr. Plinke stated that the burden of proof is on the Board to support that charge by a preponderance of the evidence. Mr. Plinke argued that the evidence demonstrated that the Board cannot meet that burden.

Mr. Plinke continued that the state's expert, Yeshwant P. Reddy, M.D., admitted repeatedly that there were no maximum dosages for any pain medication. Mr. Plinke observed that Dr. Reddy admitted repeatedly that the standard of care for treatment of chronic pain is to prescribe the amount of medication necessary to treat the patient's pain, make them functional, and avoid side effects. Both Dr. Griffin and Dr. Griffin's expert, Richard V. Gregg, M.D., testified to the same standard of care.

Based on the foregoing, Mr. Plinke requested that the Board amend Ms. Petrucci's Proposed Order. Mr. Plinke opined that if this were analyzed as a medical malpractice case, it would have to be dismissed upon summary judgment based on the nature of Dr. Reddy's testimony.

Dr. Griffin stated that he is a caring and thoughtful physician and is deeply concerned about his patients and their quality of life. Dr. Griffin stated that patients come to him looking for a solution to their pain. Dr. Griffin described his job as not only pain relief, but also making his patients more functional and improving their quality of life so they can return to their families, society, and work.

Dr. Griffin continued that most of the patients in question have significant co-morbidities and were not usual pain patients. Dr. Griffin stated that his patients have had multiple injuries and have had all the surgery and alternative treatments from which they could benefit. The only remaining treatment option for these patients is medication. Dr. Griffin explained that these patients are in pain all day, every day for years.

Dr. Griffin described the circumstances of specific patients:

- Patient 10 was crushed and nearly paralyzed by a house truss. Patient 10's L1 vertebrae was heavily damaged and required removal. Hardware was inserted and portions of Patient 10's spine were fused. Patient 10 developed a chronic infection and hepatitis from blood transfusions during surgery.

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- Patient 5 had an ankle fracture which eventually required ankle fusion. Patient 5 then developed a tibial fracture on the same leg and two surgeries were required to heal the bone. Patient 5 also had a herniated disk. Vein problems in Patient 5's legs led to an infection in the fractured tibia and required the rod to be removed.
- Patient 3 has had multiple lumbar spine surgeries and two cervical disk surgeries with neurologic residuals. With the help of medication, Patient 3 is able to work every day.
- Patient 12 has cervical stenosis, has had five lumbar spine surgeries, is an insulin-dependent diabetic, and suffers from asthma and a poorly-controlled seizure disorder.

Dr. Griffin stated that the medications he has prescribed for his patients have improved their quality of life and sleep. The medications have allowed some of Dr. Griffin's patients to return to work and has helped all of his patients live full and more functional lives.

Dr. Griffin stated that an oath from the American College of Surgeons Fellowship Pledge sits on his desk, which he sees and lives every day. The oath reads in part: "I pledge myself to pursue the practice of surgery with honesty and to place the welfare and rights of my patient above all else. I promise to deal with each patient as I would hope to be dealt with were I in that patient's position."

Dr. Griffin thanked the Board for its time.

Dr. Amato asked whether the Assistant Attorney General wished to respond. Ms. Pfeiffer replied that she did wish to respond.

Ms. Pfeiffer referred to transcript testimony from Dr. Griffin's hearing. During the hearing, the Board's expert, Dr. Reddy, stated, "I have noticed one thing in Dr. Griffin's care. Reviewing the patients' records, I feel he follows his patients very regularly and provides them care. There is no question or doubt about his care. The problem is, when it comes to medications, his doses are higher than usual. He's treating usual patients with unusual doses of medications." Upon further questioning from Ms. Pfeiffer, Dr. Reddy reiterated that Dr. Griffin's patients were typical pain patients with usual painful conditions. Therefore, despite Dr. Griffin's statements, Dr. Griffin's patients were not unusual.

Ms. Pfeiffer wished to specifically address Patient 11. Patient 11 had an initial office visit with Dr. Griffin in May 2009. At the time, according to Dr. Griffin, Patient 11 was currently being treated with other medications from another physician. Dr. Griffin also had pharmacy profiles that Patient 11 had brought in. *At the time of Patient 11's initial office visit with Dr. Griffin, Dr. Griffin was aware of the following:*

- 13 days prior to the office visit with Dr. Griffin, Dr. Hamilton had prescribed 20 mg Oxycontin, quantity 90 tablets. Patient 11 filled that prescription that day.
- 11 days prior to the office visit with Dr. Griffin, Dr. Hamilton had prescribed 80 mg Oxycontin, quantity 90, to Patient 11.

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- Nine days prior to the office visit with Dr. Griffin, Dr. Hamilton had prescribed 40 mg of oxycodone ER. Patient 11 filled the prescription that day.
- Eight days prior to the office visit with Dr. Griffin, Pamela Sisney, D.P.M., had prescribed 40 mg Oxycontin, quantity 90.

Ms. Pfeiffer stated that, despite this knowledge, Dr. Griffin doubled Patient 11's Oxycontin at the initial visit from 320 mg to 640 mg. On Patient 11's second office visit, Dr. Griffin performed a urine screen which revealed no oxycodone, the base ingredient in Oxycontin. Ms. Pfeiffer stated that, despite this red flag for diversion, Dr. Griffin continued to prescribe Oxycontin to Patient 11.

Ms. Pfeiffer stated that Dr. Griffin also gave his patients improper instructions on how to take the Oxycontin he prescribed. Ms. Pfeiffer explained that Oxycontin tablets are designed to release medication in the patient's system for 12 hours. Dr. Griffin's practice was to prescribe a variable amount, like 3-5 tablets, and instruct the patient to take it every eight hours or every six hours. Dr. Reddy testified that a long-acting medication such as Oxycontin had to be given as a fixed dose in a specific time period. Dr. Reddy testified that if the patient is allowed to choose how many tablets to take, then the action of the medication may last longer than needed and potentially put the patient's health in jeopardy.

Ms. Pfeiffer stated that the Oxycontin doses prescribed by Dr. Griffin ranged from 1,000 mg to almost 2,000 mg. In contrast, Dr. Reddy stated that among his fellow practitioners from across the country whom he speaks with professionally and at national pain conferences, the maximum dosage is 320 mg.

Ms. Pfeiffer stated that the volumes of medication prescribed by Dr. Griffin, combined with other red flags, indicate that the Board has shown by preponderance of the evidence that Dr. Griffin failed to conform to and has departed from the minimal standards of care.

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. PETRUCCI'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF GEORGE D. J. GRIFFIN, III, M.D. DR. MADIA SECONDED THE MOTION.**

Dr. Amato stated that he would now entertain discussion in the above matter.

Dr. Varyani opined that Dr. Griffin's intentions were good. However, Dr. Varyani stated that he himself once practiced in pain therapy and could not see himself prescribing the doses the Dr. Griffin had prescribed. Dr. Varyani wondered how Dr. Griffin's patients functioned while taking these quantities of medication, if they were taking them.

Dr. Varyani stated that his primary concern with Dr. Griffin is the fact the he doubled Patient 11's dose of Oxycontin at the initial visit. In subsequent visits, despite suspect OARRS reports and urine screens, Dr. Griffin continued to prescribe the same amount. Dr. Varyani stated that he supports Ms. Petrucci's Proposed Order.

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Dr. Mahajan noted that Dr. Griffin prescribed Neurontin in quantities greater than 3,600 mg. However, Dr. Mahajan pointed out that Neurontin is not absorbed into the system beyond 3,600 mg. Dr. Mahajan opined that Dr. Griffin did not understand how Neurontin worked. Dr. Mahajan stated that if Dr. Griffin's patients needed that much medication, he should have conducted further investigation or use other palliative medications so that the patient could function, especially if there were indications that a patient is abusing drugs or diverting medication. Dr. Mahajan did not find Dr. Griffin to be credible.

Dr. Varyani stated that Dr. Griffin was using Neurontin to decrease patients' dose of medications. However, no decrease in medication followed the Neurontin. Dr. Varyani agreed with Dr. Mahajan that Neurontin in doses beyond 3,600-4,000 mg are not absorbed and does the patient no good.

Dr. Steinbergh opined that the Proposed Order was actually quite generous to Dr. Griffin. Dr. Steinbergh did not accept Dr. Griffin's assertion that he felt he was treating unusual patients with unusual pain which required unusual methods. Dr. Steinbergh stated that she has referred her own patients to pain specialists, but had never seen a pain specialist prescribe medications in these quantities to her patients who have very significant pain.

Dr. Steinbergh disagreed that Dr. Griffin's patients could be functional on the doses of medication prescribed. Dr. Steinbergh opined that Patient 11, in particular, was not taking the medications and was probably diverting. Dr. Steinbergh stated that this was not acceptable, considering the significant problem that diversion of medication is in Ohio and across the country.

Dr. Steinbergh felt that, in addition to the educational course in pharmacology that the Proposed Order required during Dr. Griffin's probation, a medical record-keeping course should also be required. Dr. Steinbergh stated that there were many errors across Dr. Griffin's medical records in which he did not include basic data or document his thought process.

**DR. STEINBERGH MOVED TO AMEND THE PROPOSED ORDER TO ADD THE REQUIREMENT THAT DR. GRIFFIN TAKE AN EDUCATIONAL COURSE IN MEDICAL RECORD KEEPING. DR. MAHAJAN SECONDED THE MOTION. A vote was taken:**

ROLL CALL:	Dr. Stafford	- aye
	Mr. Hairston	- aye
	Dr. Madia	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Dr. Varyani	- aye
	Dr. Talmage	- abstain
	Dr. Suppan	- aye

The motion to amend passed.

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. PETRUCCI'S FINDINGS OF**

April 14, 2010

**FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF GEORGE D. J. GRIFFIN, III, M.D. DR. VARYANI SECONDED THE MOTION.** A vote was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Madia	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Amato	- aye
	Dr. Varyani	- aye
	Dr. Talmage	- abstain
	Dr. Suppan	- aye

The motion carried.

**NARENDRA KUMAR GUPTA, M.D.**

Dr. Amato directed the Board's attention to the matter of Narendra Kumar Gupta, M.D. He advised that no objections were filed to Hearing Examiner Petrucci's Report and Recommendation.

**DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MS. PETRUCCI'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF NARENDRA KUMAR GUPTA, M.D. DR. MADIA SECONDED THE MOTION.**

Dr. Amato stated that he would now entertain discussion in the above matter.

Dr. Suppan stated that Dr. Gupta's case was brought to the Board's attention due to action taken by the Georgia Composite Medical Board [Georgia Board]. The Georgia Board has issued a Summary Suspension pending further action.

Dr. Suppan continued that in March 2009, it was alleged that Dr. Gupta conducted an examination of a female without a chaperone. Dr. Gupta was arrested for sexual assault of a female minor. In April 2009, Dr. Gupta was arrested for aggravated sexual battery of a female patient.

Dr. Suppan observed that Dr. Gupta is not currently practicing medicine and surgery in Ohio and has not done so for more than five years. There is no indication that Dr. Gupta will seek to practice medicine in Ohio again. Dr. Gupta cannot practice medicine in Ohio without filing an application to restore his license, which would be thoroughly reviewed by the Board and the outcome of Dr. Gupta's administrative proceedings with the Georgia Board and his criminal charges could be considered. For this reason, the Proposed Order states that No Further Action be taken at this time. Dr. Suppan agreed with the recommendation, but expressed concern that the term "No Further Action" could convey that the Board could never take any future action based on these allegations.

IN THE COURT OF COMMON PLEAS  
FRANKLIN COUNTY, OHIO

George D.J. Griffin, III, M.D.,

Appellant,

vs.

State Medical Board of Ohio,

Appellee.

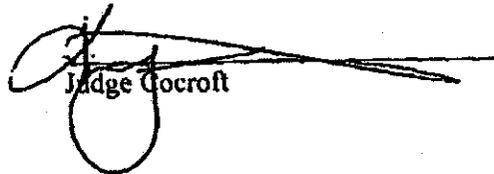
Case No. 10CVF-05-7480

Judge Cocroft

**ENTRY GRANTING APPELLANT'S MOTION SUSPENSION OF THE ORDER OF  
THE STATE MEDICAL BOARD OF OHIO PENDING APPEAL**

This matter is before the Court on Appellant's Motion for Suspension of the Order of the State Medical Board of Ohio Pending Appeal. The Court finds that an unusual hardship to the Appellant will result from the execution of the Appellee's order pending determination of the appeal and that the health, safety, and welfare of the public will not be threatened by suspension of the order. Accordingly, Appellant's Motion for Suspension of the Order of the State Medical Board of Ohio Pending Appeal is found to be well taken and is GRANTED.

IT IS SO ORDERED.

  
Judge Cocroft

Submitted by:

  
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Attorneys for Appellant, George D.J. Griffin, III, M.D.

CLERK OF COURTS  
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DEFENDANT'S  
EXHIBIT  
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IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO

George D.J. Griffin, M.D.,

Appellant,

v.

State Medical Board of Ohio,

Appellee.

Case No. 10CVF05-7480 (Cocroft, J.)

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CLERK OF COURTS

DECISION AND ENTRY DENYING THE APPELLANT'S MOTION FOR SUSPENSION  
OF THE ORDER OF THE STATE MEDICAL BOARD OF OHIO PENDING APPEAL,  
FILED FEBRUARY 9, 2011

AND

DECISION AND ENTRY DENYING APPELLANT'S MOTION TO STRIKE, FILED  
FEBRUARY 18, 2011

Rendered this 10<sup>th</sup> day of March, 2011

COCROFT, J.

This matter is before the Court upon the motion for suspension of the order of the State Medical Board of Ohio pending appeal to the Tenth District Court of Appeals, filed by the appellant, George Griffin III, MD, on February 9, 2011. The appellee, State Medical Board of Ohio, filed a memorandum contra on February 11, 2011. The appellant filed a reply and a motion to strike on February 18, 2011. The appellee filed a memorandum in opposition to the motion to strike on February 25, 2011. This matter is now ripe for decision.

On February 3, 2011, this Court rendered a decision and entry which upheld the State Medical Board of Ohio's Order imposing a 120-day suspension of the appellant's license to practice medicine, staying all but 30 days of the suspension. The appellant is now requesting that this Court stay the effect of its decision and entry pending a



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resolution to the Tenth District Court of Appeals. (Motion for Suspension, p. 1). Conversely, the appellee contends that the appellant has failed to demonstrate undue hardship that would result. (Memorandum in opposition, p. 1). Additionally, the appellee contends that the public interest is served by denying the appellant's request for a stay because of the appellant's "very poor judgments in prescribing OxyContin." (Id, p. 5).

The filing of an administrative appeal does not automatically entitle a party to a stay of execution pending judicial review. Rather, the General Assembly has given trial courts broad discretion when making such determinations, legislating that: "if it appears to the Court than an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal, the Court may grant a suspension and fix its terms." R.C. 119.12. As such, when reviewing whether a trial court properly granted or denied a motion to stay an administrative order, the standard of review employed is an abuse of discretion. *Carter Steel & Fabricating Co. v. Danis Bldg. Construction Co.* (1998), 126 Ohio App. 3d 251, 254, 710 N.E.2d 299.

When asked to stay an administrative order, courts give significant weight to the expertise of the administrative agency, as well as to the public interest served by the proper operation of the regulatory scheme. See *Hamlin Testing Labs, Inc. v. United States Atomic Energy Comm.* (1964), 337 F.2d 221. To that end, R.C. 119.12 allows the Court to grant a suspension of an agency order pending appeal if the Court determines that "unusual hardship" will result to appellant.

There are several factors that the Court considers when determining whether it is appropriate to stay an administrative order pending judicial review. *Bob Krihwan Pontiac-GMC Truck, Inc. v. GMC* (2001), 141 Ohio App. 3d 777, 783. Those factors

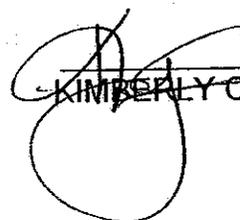
are: (1) whether appellant has shown a strong or substantial likelihood or probability of success on the merits; (2) whether appellant has shown that it will suffer irreparable injury; (3) whether the issuance of a stay will cause harm to others; and (4) whether the public interest would be served by granting a stay. *Id.*; citing *Hamlin, supra*; *Gurtzweiler v. United States* (1985), 601 F. Supp. 883; *Holden v. Heckler* (1984), 584 F. Supp. 463; *UpJohn Company v. Finch* (1969), 303 F. Supp. 241; *Friendship Materials v. Michigan Brick, Inc.* (1982), 679 F.2d 100; and *Virginia Petroleum Jobbers Assn. v. FPC* (1958), 104 U.S. App. D.C. 106, 259 F.2d 921.

Upon review, the evidence indicates that an issuance of a stay may cause harm to others and that the public interest would not be served by granting a stay. The record indicates that the appellant "inappropriately and excessively" prescribed OxyContin to a patient with a criminal history including drug-related felonies when the appellant was put on notice by a pharmacist that the patient was selling drugs. Additionally, public policy dictates that this Court takes into consideration the dangers of OxyContin and the fact that the evidence indicates that the appellant would benefit from training and supervision with regards to prescribing narcotics.

Furthermore, this Court finds that the appellant has failed to show irreparable harm. The record indicates that the appellant's suspension is 30 days. As the appellee correctly points out, the appellant's license is not being revoked permanently and there is no evidence that the 30-day suspension will be unduly burdensome to the appellant. As such, this Court finds that the appellant's arguments lack merit and, therefore, the appellant's motion to suspend the State Medical Board of Ohio's Order and the

appellant's motion to strike portions of the appellee's memorandum in opposition are not well-taken and are hereby DENIED.

IT IS SO ORDERED.

  
KIMBERLY COCROFT, JUDGE

Copies to:

Eric Plinke  
Gregory Mathews  
Counsel for Appellant

Henry Appel  
Counsel for Appellee

IN THE COURT OF APPEALS OF OHIO  
TENTH APPELLATE DISTRICT

FILED  
COURT OF APPEALS  
FRANKLIN CO. OHIO

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CLERK OF COURTS

George D. J. Griffin, III, M.D., :

Appellant-Appellant, :

v. :

State Medical Board of Ohio, :

Appellee-Appellee. :

No. 11AP-174

(REGULAR CALENDAR)

JOURNAL ENTRY

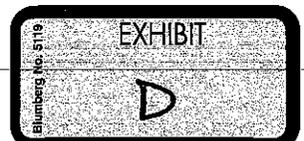
Appellant's March 15, 2011 motion for a stay of the order of the State Medical Board of Ohio, pending appeal, is granted except that the probationary terms, conditions and limitations shall be effective immediately. Furthermore, appellant shall be granted thirty (30) days from journalization of this entry to comply with the monitoring physician provision. No bond shall be required as a condition of this stay.



Judge Susan Brown



Judge Julia L. Dorian



*C. Crisp*

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IN THE COURT OF APPEALS OF OHIO  
TENTH APPELLATE DISTRICT

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COURT OF APPEALS  
FRANKLIN COUNTY, OHIO

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CLERK OF COURTS

George D.J. Griffin, III, M.D., :

Appellant-Appellant, :

v. :

State Medical Board of Ohio, :

Appellee-Appellee. :

No. 11AP-174  
(C.P.C. No 10CVG-05-7480)  
(REGULAR CALENDAR)

D E C I S I O N

Rendered on November 22, 2011

*Dinsmore & Shohl, LLP, Eric J. Plinke and Gregory P. Mathews, for appellant.*

*Michael DeWine, Attorney General, and Henry G. Appel, for appellee.*

APPEAL from the Franklin County Court of Common Pleas.

DORRIAN, J.

{¶1} Appellant, George D.J. Griffin, III, M.D., appeals the judgment of the Franklin County Court of Common Pleas, in which the trial court affirmed the order of appellee, State Medical Board of Ohio ("board"), finding departures from minimal standards of care and imposing a 120-day suspension of appellant's license to practice medicine and staying all but 30 days of the suspension. The board's order also placed appellant on probation for a period of at least three years and imposed conditions including, but not limited to, further coursework, monitoring and reporting.



{¶2} Appellant is a physician and orthopedic surgeon, practicing in the areas of orthopedic surgery, orthopedic spine surgery, arthroscopies, total joint replacement, and pain management. Appellant graduated from the University of Cincinnati Medical School in 1975 and subsequently completed a one-year internship at Cincinnati General Hospital. In 1980, appellant completed a four-year orthopedic residency at the University of Cincinnati and opened a private practice in Cincinnati, Ohio. In 1981, appellant became board certified in orthopedics and is currently a member of the Freiberg Society, the Cincinnati Academy of Medicine, the Cincinnati Orthopedic Society, the Ohio State Medical Association, the North American Arthroscopy Association, and is a diplomat of the American Pain Management Board.

{¶3} Appellant testified that, in 1981, he began treating patients for pain management as part of his regular practice. Further, appellant testified that, currently, he spends more than 50 percent of his time with chronic pain patients and the remainder in the practice of orthopedics and spine. As part of his practice, appellant prescribes pain medications, including: OxyContin, Avinza, Kadian, Methadone, Lyrica, Neurontin and Ultram.

{¶4} In a letter dated January 14, 2009, the board notified appellant that it intended to determine whether or not to discipline him for failing to provide treatment in accordance with the minimal standards of care with regard to 14 patients during the approximate time period of 2000 to 2008. The board provided examples of this conduct for each of the 14 patients as follows:

[1.] You inappropriately and excessively prescribed Schedule II narcotics and Neurontin to Patient 1, including directions to

take 1700 mg<sup>1</sup> of OxyContin per day and 7200 mg. of Neurontin per day. Further, you inappropriately prescribed Ultram to Patient 1.

[2.] You inappropriately and excessively prescribed Schedule II narcotics to Patient 2, including directions to take 1920 mg. of OxyContin per day. Further, you failed to refer, provide and/or document the treatment of Patient 2's spasticity.

[3.] You inappropriately and excessively prescribed Schedule II narcotics and Lyrica to Patient 3, including directions to take 1280 mg. of OxyContin per day, 160 mg. of Methadone per day and 1200 mg. of Lyrica per day.

[4.] You inappropriately and excessively prescribed Schedule II narcotics and Lyrica to Patient 4, including directions to take 1200 mg. of OxyContin per day at one point, 500 mg of Kadian per day at one point and 600 mg of Lyrica per day.

[5.] You inappropriately and excessively prescribed Schedule II narcotics and Lyrica to Patient 5, including directions to take 1440 mg. of OxyContin per day at one point, 2100 mg. of Kadian per day at one point and 1600 mg. of Lyrica per day.

[6.] You inappropriately and excessively prescribed Schedule II narcotics and Lyrica to Patient 6, including directions to take 1680 mg of OxyContin per day and 900 mg. of Lyrica per day.

[7.] You inappropriately and excessively prescribed Schedule II narcotics and Lyrica to Patient 7, including directions to take 1920 mg. of OxyContin per day at one point, 2200 mg. of Kadian per day at one point, and 8400 mg. of Neurontin per day.

[8.] You inappropriately and excessively prescribed Schedule II narcotics and Neurontin to Patient 8, including directions to take 1280 mg. of OxyContin per day and 8400 mg. of Neurontin per day.

[9.] You inappropriately and excessively prescribed Schedule II narcotics to Patient 9, including directions to take 960 mg. of OxyContin per day at one point, 960 mg. of Avinza per day at one point and 1200 mg. of Kadian per day at one point.

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<sup>1</sup> Should be 1600 mg. of OxyContin as pointed out by the board in its January 14, 2009 letter.

Further, you inappropriately prescribed two long acting opioids concurrently to Patient 9.

[10.] You inappropriately and excessively prescribed Schedule II narcotics to Patient 10, including directions to take 1040 [redacted] of OxyContin per day despite the following observations for Patient 10: a urine drug screen positive for illegal [redacted] of abuse; the presence of Hepatitis C; depression; anxiety and migraine headache.

[11.] You inappropriately and excessively prescribed Schedule II narcotics to Patient 11, including directions to take 640 mg. of OxyContin per day despite the following observations for Patient 11: multiple positive urine drug screens for cannabinoids, a negative urine drug screen for oxycodone and diazepam despite your having prescribed said medications to Patient 11, a negative urine drug screen for pregabalin despite your having prescribed said medication to Patient 11, Patient 11's criminal history for drug-related felonies, and a call from a pharmacist advising that Patient 11 was selling drugs.

[12.] You inappropriately and excessively prescribed Schedule II narcotics and Neurontin to Patient 12, including directions to take 1920 mg. of OxyContin per day and 12,000 mg. of Neurontin per day.

[13.] You inappropriately and excessively prescribed Schedule II narcotics to Patient 13, including directions to take a combination of 240 mg. of OxyContin per day and 720 mg. of Avinza per day.

[14.] You inappropriately and excessively prescribed Schedule II narcotics to Patient 14, including directions to take 1400 mg. of Kadian per day.

[15] In addition, the board's letter indicated that appellant's alleged acts, conduct, and/or omissions, individually and/or collectively, warrant discipline pursuant to R.C. 4731.22(B)(6) because appellant's conduct represented " [a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the

same or similar circumstances, whether or not actual injury to a patient is established.'"  
(Jan. 14, 2009, Notice of Opportunity for Hearing.)

{¶6} On February 5, 2009, appellant timely requested a hearing, pursuant to R.C. Chapter 119, in order to address the board's allegations. Further, in a letter dated June 11, 2009, the board notified appellant regarding two errors in the January 14, 2009 letter and corrected the same: (1) paragraph 1(a) should reference 1800 mg. of OxyContin, instead of 1700 mg., and (2) Patient 11's last name was misspelled on the confidential patient key.

{¶7} On October 5, 8, 9, and 13, 2009, a board-appointed hearing examiner conducted a four-day evidentiary hearing wherein Yeshwant P Reddy, M.D. ("Dr. Reddy") testified as an expert on behalf of the state, and Richard V Gregg, M.D. ("Dr. Gregg"), testified as an expert on behalf of appellant. The record further reflects that appellant also testified on his own behalf.

{¶8} Dr. Reddy, a spine physiatrist and pain consultant testified that, in managing a patient's pain, there are no limitations on maximum dosages for pure pain medications (Tr. 49-50.) He stated that, according to general literature, "the highest dose of the medication you give is the medication which keeps the patient's pain under reasonable control, makes him functional, and there are no side effects." (Tr. 49.) Dr. Reddy also stated that "[t]he side effect[s] provided for these long-acting medications are quite high, and that's the reason any literature, any pain book, states that you start low, go slow, and watch for the side effects." (Tr. 51.) Dr. Reddy explained that giving a heavy dose of pain medication to an opioid naïve patient causes respiratory depression, increasing the chances of fatal abnormalities. (Tr. 51.)

{¶9} Upon reviewing 25,000 pages of medical records, of the 14 patients at issue, Dr. Reddy concluded that the problem is not in appellant's care, or in following the due regulations, rather, "[t]he problem is giving high doses." (Tr. 300 ) In fact, Dr. Reddy testified that he can see that appellant is a compassionate and caring doctor, trying to help his patients. (Tr. 302.) Dr. Reddy also testified that, even without having personally seen these patients, based upon the descriptions in their charts, he could conclude these were "usual pain patients." (Tr. 301.) However, Dr. Reddy stated that appellant is "treating usual patients with unusual doses of medications." (Tr. 150, 290-91.) Additionally, Dr. Reddy expressed concern regarding the treatment of Patient 11 because (1) appellant doubled her dose of OxyContin at the first office visit, and (2) appellant continued prescribing OxyContin subsequent to noticing possible drug diversion, noncompliance with instructions, and illegal drug use. (Tr. 71-73, 79-80, 91-92, 300.)

{¶10} The hearing examiner issued a 43-page report and recommendation containing a patient-by-patient summary of the facts concerning appellant's treatment of the 14 patients, including medications and dosing. Also, the hearing examiner provided a detailed patient-by-patient summary of the testimony of Drs. Reddy, Gregg, and Griffin regarding whether appellant's conduct fell below the minimal standard of care. Upon consideration of the evidence, the hearing examiner found that appellant's conduct constituted a violation of R.C. 4731.22(B)(6) with respect to 13 out of 14 patients as follows:

[Patient 1] \*\*\* inappropriately and excessively prescribed 1,600 mg of OxyContin per day and 7,200 mg of Neurontin per day; \*\*\* inappropriately prescribed Ultram \*\*\*

[Patient 2] \*\*\* inappropriately and excessively prescribed 1,920 mg of OxyContin per day \*\*\*

[Patient 3] \*\*\* inappropriately and excessively prescribed 1,280 mg of OxyContin per day, 180 mg of Methadone per day, and 1,200 mg of Lyrica per day \*\*\*

[Patient 4] \*\*\* inappropriately and excessively prescribed 1,200 mg of OxyContin per day at one point, and 500 mg of Kadian per day at one point \*\*\*

[Patient 5] \*\*\* inappropriately and excessively prescribed 1,440 mg of OxyContin per day at one point, 2,100 mg of Kadian per day, and 1,600 mg of Lyrica per day \*\*\*

[Patient 6] \*\*\* inappropriately and excessively prescribed 1,680 mg of OxyContin per day and 900 mg of Lyrica per day \*\*\*

[Patient 7] \*\*\* inappropriately and excessively prescribed 1,920 mg of OxyContin per day at one point, 2,200 mg of Kadian per day at one point, and 8,400 mg of Neurontin per day \*\*\*

[Patient 8] \*\*\* inappropriately and excessively prescribed 1,280 mg of OxyContin per day and 8,400 mg of Neurontin per day \*\*\*

[Patient 9] \*\*\* inappropriately and excessively prescribed 960 mg of OxyContin per day at one point, 960 mg of Avinza per day at one point and 1,200 mg of Kadian per day at one point \*\*\*

[Patient 10] \*\*\* inappropriately and excessively prescribed 1,040 mg of OxyContin per day, despite the following observations \*\*\*: depression, anxiety and migraine headaches \*\*\*

[Patient 11] \*\*\* inappropriately and excessively prescribed 640 mg of OxyContin per day, despite the following observations: multiple positive urine drug screens for cannabinoids, a negative urine drug screen for Oxycodone despite \*\*\* having prescribed said medication, \*\*\* a negative urine drug screen for Pregabalin (Lyrica) despite \*\*\* having prescribed said medication, \*\*\* Patient 11's

criminal history for drug-related felonies, and a call from a pharmacist advising that Patient 11 was selling drugs \* \* \*

[Patient 12] \* \* \* inappropriately and excessively prescribed 1,920 mg of OxyContin per day and 12,000 mg of Neurontin per day \* \* \*

[Patient 14] \* \* \* Inappropriately and excessively prescribed 1,400 mg of Kadian per day \* \* \*

(See Report and Recommendation, p. 34-38.)

{¶11} The hearing examiner recommended that appellant's certificate to practice medicine and surgery in the state of Ohio be suspended for a period of 120 days, all but 30 days of which are stayed. Further, following appellant's suspension, the hearing examiner recommended at least three years of probation, subject to the following conditions: (1) he must obey the law; (2) he must submit quarterly declarations of compliance to the board, (3) he must personally appear before the board at designated times; (4) he must complete a course or courses regarding prescribing controlled substances and submit documentation of successful completion and a summary report of the course(s) before the end of the first year of probation; (5) he must complete a course or courses regarding pharmacology and submit documentation of successful completion and a summary report of the course(s) before the end of the first year of probation; (6) he must submit the name and curriculum vitae of a monitoring physician to the board within 30 days of reinstatement, and said physician, if approved by the board, shall monitor appellant in his medical practice, review appellant's charts and report to the board regarding the same; and (7) he must keep a controlled substances log. (See Report and Recommendation, 39-42 )

{¶12} On April 5, 2010, appellant filed objections to the hearing examiner's report and recommendation, along with a motion to appear at the April 14, 2010 meeting in order to personally address the board. On April 14, 2010, the board considered the hearing examiner's report and recommendation, appellant's personal statement, and Assistant Attorney General Pfeiffer's response. Subsequently, members of the board discussed this matter, focusing on: (1) appellant's treatment of Patient 11, wherein red flags regarding diversion were ignored; (2) appellant's propensity for prescribing unusually high doses of medication to usual pain-management patients; and (3) appellant's sub-par recordkeeping. Due to appellant's deficiencies in recordkeeping, the board amended the hearing examiner's report and recommendation in order to include a course on medical recordkeeping as a condition of appellant's probation. The board approved and confirmed the hearing examiner's amended report and recommendation. (April 14, 2010, Board Meeting Minutes.)

{¶13} On May 17, 2010, appellant appealed the board's order to the Franklin County Court of Common Pleas pursuant to R.C. 119.12. On February 4, 2011, the trial court journalized a decision and entry adopting the board's order, finding it to be supported by reliable, probative, and substantial evidence and in accordance with law. Further, on February 15, 2011, the trial court journalized a judgment entry affirming the decision of the state medical board for the reasons set forth in the February 4, 2011 decision and entry.

{¶14} On February 23, 2011, appellant filed a timely notice of appeal, setting forth seven assignments of error for our consideration:

[1.] THE COURT OF COMMON PLEAS ERRED IN FINDING THAT THE BOARD'S ORDER WAS SUPPORTED

BY RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE AND WAS IN ACCORDANCE WITH LAW BECAUSE THE BOARD RELIED ON "EXPERT" TESTIMONY THAT WAS NOT BASED ON RELIABLE SCIENTIFIC METHODOLOGY.

[2.] THE COURT OF COMMON PLEAS DEPRIVED DR. GRIFFIN OF A MEANINGFUL APPEAL UNDER R.C. 119.12 BY GIVING UNDUE DEFERENCE TO THE MEMBERS OF THE BOARD.

[3.] THE COURT OF COMMON PLEAS ERRED IN FINDING THAT THE BOARD'S ORDER WAS SUPPORTED BY RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE BECAUSE THE STATE'S EXPERT DID NOT TESTIFY THAT DR. GRIFFIN'S DOSING INSTRUCTIONS DEVIATED FROM THE STANDARD OF CARE.

[4.] THE COURT OF COMMON PLEAS ERRED IN FINDING THAT THE BOARD'S ORDER COMPLIED WITH R.C. 119.07 BECAUSE THE BOARD INAPPROPRIATELY CONSIDERED ALLEGATIONS REGARDING DOSING INSTRUCTIONS AND OTHER TREATMENT MODALITIES THAT WERE NOT IN THE NOTICE OF OPPORTUNITY FOR HEARING.

[5.] THE COURT OF COMMON PLEAS ERRED IN FINDING THAT THE BOARD'S ORDER WAS SUPPORTED BY RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE AND WAS IN ACCORDANCE WITH LAW BECAUSE THE BOARD'S ORDER WAS BASED UPON INCORRECT FINDINGS REGARDING NEURONTIN ABSORPTION.

[6.] THE COURT OF COMMON PLEAS ERRED IN FINDING THAT DR. GRIFFIN'S TREATMENT OF PATIENT 11 WAS BELOW THE MINIMUM STANDARD OF CARE.

[7.] THE COURT OF COMMON PLEAS ERRED BY INAPPROPRIATELY PLACING THE BURDEN OF PROOF ON DR. GRIFFIN.

{¶15} "In an administrative appeal pursuant to R.C. 119.12, the trial court reviews an order to determine whether it is supported by reliable, probative, and

substantial evidence, and is in accordance with the law." *Schechter v. Ohio State Med. Bd.*, 10th Dist. No. 04AP-1115, 2005-Ohio-4062, ¶55, citing *Huffman v. Hair Surgeon, Inc.* (1985), 19 Ohio St.3d 83, 87. The Supreme Court of Ohio has defined the concepts of reliable, probative, and substantial evidence as follows:

- (1) "Reliable" evidence is dependable; that is, it can be confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true.
- (2) "Probative" evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue.
- (3) "Substantial" evidence is evidence with some weight, it must have importance and value.

*Our Place, Inc. v. Ohio Liquor Control Comm.* (1992), 63 Ohio St.3d 570, 571.

{¶16} The standard of review is more limited on appeal to this court. "While it is incumbent on the trial court to examine the evidence, this is not a function of the appellate court." *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St.3d 619, 621. In reviewing the court of common pleas' determination that the board's order was supported by reliable, probative, and substantial evidence, this court's role is confined to determining whether the court of common pleas abused its discretion. *Roy v. Ohio State Med. Bd.* (1992), 80 Ohio App.3d 675, 680. "The term 'abuse of discretion' connotes more than an error of law or judgment; it implies that the court's attitude is unreasonable, arbitrary or unconscionable." *Blakemore v. Blakemore* (1983), 5 Ohio St.3d 217, 219. "On questions of law, however, the common pleas court does not exercise discretion and the court of appeals' review is plenary." *Landefeld v. State Med. Bd.* (June 15, 2000), 10th Dist. No. 99AP-812.

{¶17} For ease of discussion, we address appellant's assignments of error out of order. We begin our discussion with appellant's seventh and fourth assignments of

error because they address the standard applied by the trial court and procedure applied by the board, rather than the merits of the board's findings. In appellant's seventh assignment of error, he argues that the trial court inappropriately placed the burden of proof on appellant to "justify" his prescriptions. (Appellant's brief, 24.) Appellee contends that the trial court did not place the burden of proof on appellant by opining that appellant did not provide any reasonable explanation for prescribing up to more than six times the amount of pain medication than other practitioners. (Appellee's brief, 24.) Appellee also contends that it clearly bore the burden of proof in this matter and in doing so introduced (1) thousands of pages of patient records, and (2) Dr. Reddy's expert opinion regarding the same. (Appellee's brief, 24.)

{¶18} "[I]t is fundamental to administrative law and procedure that the party asserting the affirmative issues also bears the burden of proof." *Nuckos v. State Med. Bd.*, 10th Dist. No. 09AP-406, 2010-Ohio-2973, ¶17. In the present matter, the record clearly indicates that appellee set forth sufficient evidence to meet its burden of establishing that appellant prescribed unusually high doses of pain medication to 14 patients. In his testimony, Dr. Reddy referenced thousands of pages of medical records that he reviewed for each of the 14 patients in order to prepare his expert opinion. Dr. Reddy testified that, according to the medical records, each of the 14 patients had usual issues regarding pain management; however, appellant prescribed unusually high doses of pain medication to all 14 patients. (Tr. 149-50.) Dr. Reddy also testified that appellant's treatment of each of the 14 patients fell below the minimum standard of care. (Tr. 92 (11), 110-11 (1), 133 (2), 141-42 (3), 149 (4), 162 (5), 163 (6), 164 (7), 166 (8), 169 (9), 178 (10), 185 (12), 186 (13), 190 (14).)

{¶19} In its decision, the trial court stated that, "when the levels are far beyond what other practitioners would consider appropriate for similarly situated patients, then the appellant should have, but did not offer, some substantive basis to support the departures." (See Feb. 4, 2011 Decision and Entry, 6.) In review of the record, we agree that appellant, in response to Dr. Reddy's testimony that he prescribed unusually high doses of pain medication to address "usual" pain-management issues, did not present any contradictory evidence to explain his reasoning for prescribing such high doses of pain medication to the 14 patients. As such, the trial court's above-cited statement requires nothing more of appellant than it would of any party faced with adverse evidence during litigation. See *Smith v. Columbus*, 10th Dist. No 02AP-1219, 2003-Ohio-3303, ¶25, see also *Nucklos* at ¶17. Therefore, we find that the trial court did not shift the burden of proof to appellant, and, as such, appellant's seventh assignment of error is not well-taken.

{¶20} Appellant's seventh assignment of error is overruled.

{¶21} In his fourth assignment of error, appellant argues that the board's order failed to comply with R.C. 119.07 by considering allegations regarding dosing instructions and other treatment modalities that were not in the notice of opportunity for hearing ("notice"), consequently denying him due process. (See appellant's brief, 17) Specifically, appellant states that the board inappropriately considered allegations regarding: (1) dosing frequency, (2) practice of prescribing a range of pills to certain patients, and (3) failure to explore other modalities. (See appellant's brief, 17-18.) In response, appellee contends that the notice adequately warned appellant that the board intended to review all of his prescribing habits with respect to the 14 patients and that it

implicitly warned appellant regarding the review of other treatment modalities. (See appellee's brief, 18.) In addition, appellee contends that, even if the notice is somewhat deficient, appellant has failed to establish any prejudice because (1) he has not identified any additional evidence that would have been produced, and (2) he has not identified any additional legal arguments that would have been made. (Appellee's brief, 19.)

{¶22} "A fundamental requirement of due process, that is, notice and an opportunity to be heard, must be afforded an individual whose professional license is subject to revocation in an administrative hearing." *Johnson v. State Med. Bd. of Ohio* (Sept. 28, 1999), 10th Dist. No. 98AP-1324. Pursuant to R.C. 119.07, "[n]otice shall \* \* \* include the charges or other reasons for the proposed action, the law or rule directly involved, and a statement informing the party that the party is entitled to a hearing if the party requests it within thirty days of the time of mailing the notice." Further, "the right to a hearing includes the right to appear at the hearing prepared to defend oneself through testimony, evidence, or argument against the charges brought." *Johnson*, citing *In re Shelley* (Dec. 31, 1992), 10th Dist. No. 92AP-440. As such, "due process requires that an individual receive fair notice of the precise nature of the charges that will be raised at a disciplinary hearing." *Johnson* citing *Shelley*.

{¶23} In *Johnson*, another case involving the prescribing of controlled substances, this court stated that we have not established a bright line test regarding the sufficiency of notice of the nature of the charges forming the basis of an administrative hearing. *Id.* The *Johnson* notice accused the appellant of violating R.C. 4731.22(B)(2) and (B)(6) as to 15 patients because he:

(1) utilized controlled substances and other dangerous drugs despite his failure to conduct an appropriate physical examination and/or make objective physical findings substantiating the necessity of the medications; (2) utilized these medications in amounts and combinations which had no therapeutic value and/or were not indicated; (3) utilized multiple narcotics and/or multiple benzodiazepines, concurrently, without appropriate medical justification; and (4) routinely prescribed benzodiazepines and narcotics in treatment of injuries that occurred many years previously.

Id. Further, the *Johnson* notice included a "Patient Key," which identified, by name, patients 1 through 15. Id.

{¶24} In determining that the *Johnson* notice sufficiently apprised the appellant of the precise nature of the charges to be raised against him at the disciplinary hearing, we noted that: (1) the board's notice referenced specific sections of R.C. 4731.22 which formed the basis for the charges; (2) the notice included general allegations as to the 15 patients regarding the appellant's inappropriate use of controlled substances and dangerous drugs; (3) the notice included a "Patient Key," giving the appellant the benefit of the medical records and the "knowledge of his treatment of each of the identified patients." Id

{¶25} Here, the notice specifically references R.C. 4731.22(B)(6), advising appellant that his conduct constitutes " '[a] departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances.' " (See Jan. 14, 2009 Notice of Opportunity for Hearing, 3.) Further, the notice includes 14 specific examples of appellant's conduct and clearly states that appellant's conduct is not limited to the examples set forth in the notice. Each example of appellant's conduct, as stated in the notice, advises appellant that he "inappropriately and excessively prescribed Schedule II narcotics" and other drugs, to each of the 14

patients. (Notice of Opportunity for Hearing, 3.) The notice also specifically lists the names of the drugs, as well as the dosage amounts, for each of the 14 patients. In addition, the notice advises appellant that he failed to "refer, provide and/or document the treatment of Patient 2's spasticity," as well as failing to address certain red flags with Patient 11 regarding possible drug abuse and diversion. (See Notice of Opportunity for Hearing, 1.) Finally, the board attached to the notice a confidential "Patient Key," identifying all 14 patients by name.

{¶26} Upon review, we find that, in line with our decision in *Johnson*, the notice in the present matter sufficiently apprised appellant of the precise nature of the charges against him by: (1) specifically referencing R.C. 4731.22(B)(6), (2) including both general and specific allegations as to the 14 patients at issue, (3) listing the names of the drugs and the prescribed dosages, and (4) attaching a "Patient Key" in order for appellant to thoroughly review the 14 patients' medical records. In addition, the notice informed appellant that the board would determine whether to discipline him with regard to the 14 patients because he inappropriately or excessively prescribed Schedule II narcotics to them (See Notice of Opportunity for Hearing ) This logically includes consideration of dosage frequency, range of pills, and failure to explore other treatment modalities. Further, the record shows that, from January 15, 2009 (the date notice was mailed to appellant) to October 5, 2009 (the date evidentiary hearing commenced), appellant had approximately nine months to prepare his defense and request additional information from the board. The record does not indicate that appellant's counsel moved for a continuance of the October 5, 2009 hearing or that he was not prepared to present appellant's defense. Even if the notice contained some deficiencies, appellant

has not demonstrated any prejudice by failing to indicate what, if anything, he would have done differently in preparation of his defense. Therefore, because appellant had a full and fair opportunity to prepare and present his defense at the disciplinary hearing, we find that no violation of appellant's due process rights occurred.

{¶27} Appellant's fourth assignment of error is overruled.

{¶28} We now address appellant's sixth assignment of error regarding the trial court's finding that appellant's treatment of Patient 11 was below the minimum standard of care as required by law.

{¶29} Appellant argues that the trial court abused its discretion because the record does not support its conclusion that appellant prescribed excessive doses of medication to Patient 11 and/or ignored signs of diversion. In response, appellee argues that appellant immediately doubled Patient 11's dosage of OxyContin and continued to prescribe this high dose even after learning that Patient 11 (1) had three other prescriptions of OxyContin from two other doctors, within two weeks of her appointment with appellant, (2) tested negative for Oxycodone and positive, on two occasions, for Cannabinoids, (3) had been convicted of three drug felonies, and (4) had been suspected by family members of "sell [ing] most of her medications and snort [ing] the rest." Appellee also argues that appellant waived his argument regarding ignoring signs of diversion because he failed to raise it in the trial court.

{¶30} It is well-settled that "[a] party generally waives the right to appeal an issue that could have been, but was not, raised in earlier proceedings." *Jain v. Ohio State Med. Bd.*, 10th Dist. No. 09AP-1180, 2010-Ohio-2855, ¶10. Upon review of the record, we agree that appellant did not raise the argument regarding whether he ignored

Patient 11's possible drug diversion in the trial court; however, appellant did generally raise an argument regarding the board's findings as to Patient 11 and excessive dosing. Therefore, we will address appellant's sixth assignment of error.

{¶31} In the present matter, the board's finding that appellant's conduct fell below the minimum standard of care with respect to his treatment of Patient 11 is supported by reliable, probative, and substantial evidence. On the first office visit, Dr. Reddy testified that appellant doubled Patient 11's dosage of OxyContin from 320 milligrams to 640 milligrams, which he considered to be an "ultra high" dosage. (Tr. 90.) Further, Dr. Reddy stated that, following Patient 11's first office visit, a urine drug test ordered on May 23, 2008 was negative for Oxycodone, the active ingredient in OxyContin (Tr. 39, 72.) A second urine drug test ordered on June 6, 2008 showed positive for opioids and Cannabinoids. (Tr. 77.) A third urine drug test ordered on July 8, 2008 was also positive for Cannabinoids. (Tr. 78.) Finally, a fourth urine drug test ordered on August 6, 2008 was negative for Lyrica, one of Patient 11's prescribed medications. (Tr. 79.) In addition, Dr. Reddy testified that Patient 11's chart reflected another "red flag," in that a pharmacist sent appellant a letter to inform him that Patient 11 "is selling the drugs," and that Patient 11 had been convicted of three drug-related felonies. (Tr. 79, 80.)

{¶32} Appellant testified that he reviewed the pharmacist's letter relating to the allegation that Patient 11 had sold her medications and also verified Patient 11's convictions for possession of heroin, aggravated trafficking in drugs, and illegal processing of drug documents on the Clermont County Clerk of Courts' website. (Tr. 583) In spite of this knowledge, the record reflects that appellant did not reduce Patient 11's prescribed dosages or further investigate the possible issue of drug diversion. (Tr. 80-

81.) Based upon Patient 11's medical records, Dr. Reddy concluded that appellant's treatment methods did not meet the minimum standard of care. (Tr. 92.)

{¶33} Based upon the foregoing, we find that the board's order is supported by reliable, probative, and substantial evidence. First, the testimony of Dr. Reddy is reliable because he practices in the area of pain management, and he personally reviewed Patient 11's medical chart. Further, appellant testified that he personally reviewed the letter from the pharmacist regarding possible drug diversion and verified that Patient 11 had been convicted of three drug-related felonies.

{¶34} Second, Dr. Reddy's testimony is probative because it directly addresses the issue regarding prescribing high dosages of pain medication to Patient 11, drug diversion and drug abuse.

{¶35} Finally, Dr. Reddy's testimony is substantial because it has weight, importance, and value in determining whether appellant's treatment of Patient 11 fell below the minimum standard of care. Therefore, the trial court did not abuse its discretion in affirming the board's order suspending appellant's medical license.

{¶36} Appellant's sixth assignment of error is overruled.

{¶37} Because the board had reliable, probative, and substantial evidence for suspending appellant's license to practice medicine with respect to his treatment of Patient 11, we need not address appellant's first, second, third, or fifth assignments of error. See *D.L. Lack Corp. v. Liquor Control Comm.* (Dec. 6, 2010), 10th Dist No. 10AP-400, ¶18, citing *Our Place, Inc.* at 572. The board may revoke a physician's license for "one or more" of the reasons enumerated in R.C. 4731.22(B), and, therefore, "in a given case, the trial court would only need to find substantial, reliable and probative evidence

supporting one ground for revocation in order to uphold the board's order." *Landefeld v. State Med Bd.* (Jun 15, 2000), 10th Dist No 99AP-812.

{¶38} Appellant's first, second, third and fifth assignments of error are moot.

{¶39} Notwithstanding that appellant's first and second assignments of error are moot, we will briefly address appellant's concerns regarding whether, in reaching its decision, the board relied upon expert testimony that was not based on "reliable scientific methodology," and whether the trial court gave undue deference to members of the board. (Appellant's brief, 6, 11.)

{¶40} Appellant contends that Dr. Reddy's expert testimony should be disregarded because it was not based on reliable scientific methodology. Appellant believes that, because Dr. Reddy informally surveyed other physicians at pain conferences regarding their opinions on maximum dosages for OxyContin, Dr. Reddy's testimony regarding high dosages is unreliable. (Appellant's brief, 7.) We note that the record does contain Dr. Reddy's testimony regarding Dr. Reddy's informal surveys of other medical practitioners. However, it also contains testimony that, in reaching his conclusion, Dr. Reddy personally reviewed medical charts for each of the 14 patients, and based upon his own experience as a pain practitioner, along with the information contained in the patients' charts, Dr Reddy reached the conclusion that appellant's treatment of the 14 patients fell below the minimum standard of care. (Tr. 92 (11), 110-11 (1), 133 (2), 141-42 (3), 149 (4), 162 (5), 163 (6), 164 (7), 166 (8), 169 (9), 178 (10), 185 (12), 186 (13), 190 (14).)

{¶41} Further, regarding appellant's concern that the trial court gave undue deference to members of the board, we note as well that the record demonstrates that

Dr. Reddy's testimony, in and of itself, provides substantial, reliable, and probative evidence that appellant's practices fell below the minimum standard of care and, therefore, the trial court did not abuse its discretion in affirming the decision of the board.

{¶42} Finally, in *Goldfinger Entcs., Inc. v Ohio Liquor Control Comm.*, 10th Dist. No. 01AP-1172, 2002-Ohio-2770, ¶23, this court stated that "[a]s a practical matter, courts have no power to review penalties meted out by the commission. Thus, we have little or no ability to review a penalty even if it seems on the surface to be unreasonable or unduly harsh." See also *Staschak v. State Med. Bd.*, 10th Dist. No. 03AP-799, 2004-Ohio-4850, ¶50; *Henry's Café, Inc. v. Bd. of Liquor Control* (1959), 170 Ohio St. 233. Therefore, even if the trial court had found that only one of the board's allegations was supported by reliable, probative, and substantial evidence, this court would not modify the board's sanction to suspend appellant's medical license for 120 days, with all but 30 days stayed, and at least three years of probation.

{¶43} Based upon the foregoing, appellant's fourth, sixth, and seventh assignments of error are overruled, appellant's first, second, third, and fifth assignments of error are moot, and the judgment of the Franklin County Court of Common Pleas is affirmed.

*Judgment affirmed*

BROWN and FRENCH, JJ., concur.

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FILED  
COURT OF APPEALS  
FRANKLIN CO. OHIO

IN THE COURT OF APPEALS OF OHIO 2011 NOV 22 PM 1:03  
TENTH APPELLATE DISTRICT CLERK OF COURTS

George D.J. Griffin, III, M.D., :  
Appellant-Appellant, :  
v. :  
State Medical Board of Ohio, :  
Appellee-Appellee. :

No. 11AP-174  
(C.P.C. No. 10CVG-05-7480)  
(REGULAR CALENDAR)

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on November 22, 2011, appellant's fourth, sixth, and seventh assignments of error are overruled, appellant's first, second, third, and fifth assignments of error are moot, and it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs shall be assessed against appellant.

DORRIAN, BROWN & FRENCH, JJ.

By Julia L. Dorrian  
Judge Julia L. Dorrian

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO  
COMMON PLEAS COURT  
FRANKLIN CO. OHIO

MARK W. HAYES, D.P.M.,

Appellant,

71442A15

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CLERK OF COURTS

CASE NO. 99CVF-03-2007

v.

STATE MEDICAL BOARD OF OHIO,

Appellee.

JUDGE O'GRADY

**ENTRY**  
**ADOPTING THE MAGISTRATE'S DECISION**  
**FILED SEPTEMBER 1, 1999**

This court is in receipt of Appellee's Objection to the Magistrate's September 1, 1999 Decision, said objection having been filed on September 2, 1999. A Memorandum in Opposition was submitted on behalf of Appellant on September 3, 1999.

The Magistrate had the opportunity to review the memoranda of the parties and, indeed, to have a telephone conference with counsel for both sides prior to making her decision. This decision involves a temporary matter prior to the decision on the merits, and this court will not disturb the Magistrate's finding at this time. Therefore, the objection to the Magistrate's Decision is not well-taken.

  
JAMES J. O'GRADY, JUDGE

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Annex Barry Smith, Esq.  
Counsel for Appellee

Magistrate Browning

Blumberg No. 5714  
DEFENDANT'S  
EXHIBIT

F

71296H03

IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO  
GENERAL DIVISION

MARK W. HAYES, DPM,	]	CASE NO. 99CVF03-2007
Appellant,	]	JUDGE O'GRADY
vs.	]	MAGISTRATE BROWNING
STATE MEDICAL BOARD OF OHIO,	]	
Appellee.	]	

MAGISTRATE'S DECISION GRANTING APPELLANT'S "MOTION FOR IMMEDIATE SUSPENSION OF ORDER OF THE STATE MEDICAL BOARD OF OHIO," FILED MARCH 10, 1999

MAGISTRATE'S DECISION DENYING APPELLANT'S "MOTION TO STRIKE BRIEF OF APPELLEE STATE MEDICAL BOARD OF OHIO," FILED JUNE 30, 1999

FILED  
COMMON PLEAS COURT  
FRANKLIN CO. OHIO  
1999 SEP - 1 AM 8:19  
CLERK OF COURTS

Rendered this 1st day of September 1999.

**BROWNING, M.**

Pursuant to Civil Rule 53 and Local Rule 99, the court referred this case to this magistrate to conduct a hearing on August 31, 1999, on all pending motions. By agreement of the parties, the hearing was conducted by telephone and the parties waived the presence of a court reporter.

Having considered the pending motions, the memoranda that have been filed in support thereof and in opposition thereto, and the arguments of counsel, this magistrate renders the following decision.

Appellant's "Motion for Immediate Suspension of Order of the State Medical Board of Ohio," filed March 10, 1999

This case is a Revised Code 119.12 administrative appeal, by Mark W. Hayes, DPM, from a February 10, 1999 order in which the State Medical Board

71296H04

of Ohio permanently revoked appellant's certificate to practice podiatric medicine and surgery in Ohio. When appellant appealed the board's order to this court, he also moved the court to suspend the board's order pending the court's determination of the appeal. The board has opposed appellant's motion to suspend.

Revised Code 119.12 provides:

\*\*\* In the case of an appeal from the state medical board \*\*\*, the court may grant a suspension and fix its terms if it appears to the court that *an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal and the health, safety, and welfare of the public will not be threatened by suspension of the order.* \*\*\* (Emphasis added.)

Appellant contends that he will suffer an unusual hardship from the execution of the board's order because he is unable to earn an income from his practice and he will sustain irreparable damage to his professional reputation. In the words of his attorney, appellant is "professionally dead." The board contends that appellant's hardship does not rise to the level of "unusual" hardship. This magistrate respectfully disagrees.

The board's revocation of appellant's certificate to practice podiatry was based on his failure to establish his fitness to sit for the Ohio bar examination, and not on any failure in his practice as a podiatrist. It appears to this magistrate that, under such circumstances, appellant will suffer an unusual hardship from the execution of the board's revocation order while the court determines the appeal. It further appears to this magistrate that the health, safety, and welfare of the public will not be threatened by suspension of that order while the court determines the appeal.

In *Ohio Veterinary Med. Licensing Bd. v. Harrison*, Franklin C.P. No.

98CVF10-7821, Judge Alan Travis observed:

We normally do not execute prisoners in criminal cases before providing an opportunity for appeal. It may well be that appellant will be unsuccessful in his appeal from the order below. However, the court is satisfied that appellant has met his burden to demonstrate that "unusual hardship" will occur if the administrative revocation order is enforced before the [court] can review the proceedings of the agency.

This magistrate, likewise, is satisfied that appellant has met his burden.

Appellant's "Motion for Immediate Suspension of Order of the State Medical Board of Ohio," filed March 10, 1999, is hereby **GRANTED**.

Appellant's "Motion to Strike Brief of Appellee State Medical Board of Ohio," filed June 30, 1999

On June 30, 1999, appellant moved the court to strike the board's brief on the grounds that the brief exceeds the fifteen-page limitation of Local Rule 12.01. The board has opposed appellant's motion to strike, arguing that Local Rule 12.01 does not apply to administrative appeals.

Whether or not Local Rule 12.01 applies to administrative appeals, appellant has failed to demonstrate that he has been prejudiced by the board's three-page violation of the rule. The court's rules "are to be interpreted to achieve the prompt, efficient, and fair resolution of cases." Local R. 107.01. The board's minor infraction of the rule has not deprived appellant of his right to have his case decided promptly, efficiently, and fairly.

Appellant's "Motion to Strike Brief of Appellee State Medical Board of Ohio," filed June 30, 1999, is hereby **DENIED**.

71296H00

*Patricia Rose Browning*  
**PATRICIA ROSE BROWNING, MAGISTRATE**

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**MIKE KARN, Bailiff for Judge O'Grady**

70769J07

IN THE COURT OF COMMON PLEAS OF FRANKLIN COUNTY, OHIO

Leonard K. Smith, M.D.,

Plaintiff,

va.

State Medical Board of Ohio,

Defendant.

Case No. 99CVF07-5481

Judge Michael H. Watson

**DECISION AND ENTRY SUSTAINING THE JULY 2, 1999 MOTION OF APPELLANT FOR STAY PENDING APPEAL**

Rendered this 27<sup>th</sup> day of July, 1999.

WATSON, JUDGE

Before the Court is the July 2, 1999 Motion of Appellant Leonard K. Smith, M.D. (hereinafter "Appellant") for Stay Pending Appeal. Appellee State Medical Board of Ohio (hereinafter "Appellee") filed a Memorandum in Opposition on July 16, 1999.

Appellant seeks, pursuant to O.R.C. §119.12, a stay of Appellee's June 9, 1999 Order (hereinafter "Order") suspending his medical license for one hundred and twenty (120) days. He contends an undue hardship will result if the Order is allowed to take effect. Specifically, if a stay is not permitted, Appellant argues he will serve all, or most, of his suspension, prior to this matter being fully briefed and ready for the Court's review. Accordingly, without a stay of the suspension pending review by this Court, Appellant contends he will be deprived any effective judicial review as he is unable to be compensated for the harm he may suffer during the suspension period. Finally, Appellant maintains that a stay of the Order will not threaten the health, welfare and safety of the public.

In response, Appellee argues Appellant fails to set forth the requisite element of O.R.C. §119.12. Appellee maintains Appellant has failed to demonstrate that a denial

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IN THE COURT OF COMMON PLEAS  
FRANKLIN COUNTY, OHIO  
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Blumberg No. 5114  
DEFENDANT'S EXHIBIT  
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of the stay will result in an unusual hardship and that the public's health and safety will be protected if a stay of the Order is allowed.

O.R.C. §119.12 states, in relevant part:

... In the case of an appeal from the state medical board or chiropractic examining board, the court may grant a suspension and fix its terms if it appears to the court that an unusual hardship to the appellant will result from the execution of the agency's order pending determination of the appeal and the health, safety, and welfare of the public will not be threatened by suspension of the order. This provision shall not be construed to limit the factors the court may consider in determining whether to suspend an order of any other agency pending determination of an appeal....

Upon review, the Court concludes an unusual hardship will result if a stay of Appellee's Order is not permitted. First, Appellant is the elected Coroner of Hardin County. While Appellant may eventually serve the subject suspension, the Court is of the opinion that an interruption of his service as Coroner prior to a final resolution of the appeal imposes an undue hardship upon Appellant and the citizens of Hardin County. Second, the Court was informed that Appellant's wife is currently very ill. Again, while the suspension may ultimately be served, denial of a stay may result in an unnecessary interruption of her medical treatment at a critical stage. Finally, as argued by Appellant, if a stay is not entered, he will likely complete his entire suspension prior to a review of the Order by the Court. Accordingly, the Court concludes Appellant will suffer an unusual hardship if a stay of the Order is not entered. Furthermore, public health, safety, and welfare will not be in jeopardy if a stay is granted as the practices which have resulted in Appellant's suspension have not been committed in over three (3) years.

70769J09

Accordingly, the July 2, 1999 Motion of Appellant for Stay Pending Appeal is  
herely **SUSTAINED**.

  
MICHAEL H. WATSON, JUDGE

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