



**TABLE OF CONTENTS**

	<b>Page</b>
TABLE OF CONTENTS .....	i
TABLE OF AUTHORITIES .....	iii
INTRODUCTION .....	1
STATEMENT OF THE CASE AND FACTS .....	2
A. Dr. Griffin ignored red flags of drug diversion with “Patient 11.” .....	2
B. Dr. Griffin routinely prescribed over 1,000 mg/day of Oxycontin to patients when most pain specialists will not prescribe more than 320 mg/day .....	3
C. The trial court and court of appeals concluded that there was reliable, probative, and substantial evidence to support all the violations, and that the violation involving Patient 11 was sufficient to justify the sanction. ....	4
THIS CASE IS NOT OF PUBLIC OR GENERAL INTEREST .....	6
A. Dr. Griffin is asking this Court to revisit the discretionary decision that remand was not warranted in this case. ....	6
B. This case is a poor vehicle for addressing the mootness issue. ....	7
C. The final three propositions of law are simply challenging the Tenth District’s conclusion that the court of common pleas did not abuse its discretion in finding that an expert provided reliable, probative and substantial testimony as to the standard of care. ....	8
ARGUMENT .....	10
<u>Appellee State Medical Board’s First Proposition of Law:</u> .....	10
<i>An Ohio court need not review an assignment of error raised in an appeal under R.C. 119.12 if the court concludes (1) that the assignment of error does not challenge all agency finding of violations and (2) the sanction imposed is fully justified by the proven violation.</i>	
<u>Appellee State Medical Board’s Second Proposition of Law:</u> .....	12
<i>A licensed medical doctor who practices in pain management may rely on his own experience to opine about the minimal standards of care for prescribing narcotics.</i>	

Appellee State Medical Board’s Third Proposition of Law ..... 13

*A medical licensing agency may rely on the expertise of its members to determine the proper medical standard of care.*

Appellee State Medical Board’s Fourth Proposition of Law: ..... 15

*An agency holding proceedings under R.C. Chapter 119 to discipline a licensee will meet its burden of proof when it presents enough evidence to support all elements of a violation.*

CONCLUSION ..... 15

CERTIFICATE OF SERVICE ..... unnumbered

## TABLE OF AUTHORITIES

<b>Cases</b>	<b>Page(s)</b>
<i>Bartley v. Dep't. of Commerce</i> , 2002-Ohio-3592 (4th Dist.).....	11
<i>Burger Brewing Co. v. Liquor Control Comm.</i> , 34 Ohio St.2d 93 (1973).....	11
<i>Griffin v. State Medical Board of Ohio</i> , 2011-Ohio-6089 (10th Dist.) .....	5,9,13,14
<i>Landefeld v. State Med. Bd.</i> , 2000 Ohio App. Lexis 2556 (10th Dist. 2000).....	10,11
<i>Nuclos v. State Med. Bd.</i> , 2010-Ohio-2973 (10th Dist.).....	9
<i>Our Place, Inc. v. Ohio Liquor Control Comm.</i> , 63 Ohio St.3d 570 (1992).....	6
<i>Plain Local Sch. Bd. of Educ. v. Franklin County Bd. of Revision</i> , 130 Ohio St.3d 230, 2011-Ohio-3362 .....	10
<i>Smith v. Columbus</i> , 2003-Ohio-3303 (10th Dist.).....	9
<i>State v. Evans</i> , 113 Ohio St. 3d 100, 2007-Ohio-861.....	11
 <b>Constitutional Provisions, Statutes, and Rules</b>	 <b>Page(s)</b>
App. R 12.....	10
R.C. 119.12.....	11
 <b>Other Authorities</b>	 <b>Page(s)</b>

## INTRODUCTION

Dr. Griffin is a pain specialist who routinely prescribed shockingly high dosages of Oxycontin to his patients and ignored clear “red flags” that a patient with multiple felony drug convictions was diverting her pills. The State Medical Board of Ohio (“the Board”), concluding that Dr. Griffin’s errors were in good faith, imposed a thirty-day suspension and required additional classes and monitoring. Dr. Griffin has already completed his thirty-day suspension.

This Court should decline jurisdiction on this case because Dr. Griffin identifies no splits in authority or any overarching issues that warrant this Court’s attention.

Dr. Griffin’s main issue is that the Tenth District allegedly did not review all assignments of error because it concluded that the most serious violation was proven and fully justified the thirty-day suspension that the Board imposed on Dr. Griffin’s license. Dr. Griffin does not challenge the underlying legal principle that “remand for reconsideration of the sanction is not always mandated when one or more violations are reversed.” Memorandum in Support at 9. Instead, Dr. Griffin is challenging the Tenth District’s discretionary decision not to remand for reconsideration of Dr. Griffin’s probation and thirty-day suspension sanction because the court upheld the most serious violation.

Even if this legal issue warranted attention, this case is a poor vehicle. Although the Tenth District concluded some assignments of error were moot, the Tenth District *did* address all assignments of error that Dr. Griffin included in the Propositions of Law raised to this Court.

Moreover, Dr. Griffin raises no proposition of law in this Court to challenge what the lower courts held was the most important violation: Dr. Griffin continued to prescribe large amounts of Oxycontin to a patient with a criminal drug history despite clear “red flags” that she was diverting narcotics. The trial court and the court of appeals both concluded that this

violation, by itself, was enough to justify a thirty-day suspension. Dr. Griffin completed this suspension after this Court denied his request for a stay.

Dr. Griffin's other three propositions of law all focus on Dr. Griffin's disagreement with the expert used by the Board at the hearing. The courts below have concluded that the expert, a licensed physician who also practices in pain management, provided reliable, probative and substantial evidence as to the standards of care for prescribing narcotic pain medication. The final three propositions of law are really requests for error correction that focus on the credibility of an expert. They do not warrant this Court's attention.

This Court should decline jurisdiction.

### **STATEMENT OF THE CASE AND FACTS**

#### **A. Dr. Griffin ignored red flags of drug diversion with "Patient 11."**

The main issue before the Board related to Patient 11 – a 49 year old woman with a history of both severe medical problems and felony drug convictions. 3/18/10 Report and Recommendation ("R&R") at 25.

Dr. Griffin ignored red flags of drug diversion even when he first prescribed medication. At this initial visit, Patient 11 brought in a printout from her local pharmacy showing that she had received 180 tablets of Oxycontin from another doctor during two visits just over a week earlier, and received even more Oxycontin from yet another doctor a few days before coming to Dr. Griffin. Tr. at 553. Dr. Griffin prescribed more Oxycontin despite the fact that Patient 11 was supposed to still have pills from the previous doctor. Tr. at 555.

Dr. Griffin continued to prescribe massive doses of Oxycontin to Patient 11 despite learning of other red flags of drug diversion. At the first follow-up appointment, the patient tested negative for the active ingredient in Oxycontin – meaning that she had not taken the pain medication prescribed by Dr. Griffin and the previous doctors. R&R at 25. But she did test

positive for marijuana. R&R at 25. Dr. Griffin later learned that the patient had three felony drug convictions (possession of heroin, aggravated trafficking and deception to obtain dangerous drugs). R&R at 26. A pharmacist from Walgreens reported to Dr. Griffin that the person picking up Patient 11's medication said that Patient 11 "would sell most of her medications and snort the rest." R&R at 26; State Ex. 11, p. 127. Despite this strong evidence of diversion, Dr. Griffin continued to prescribe massive doses of opiates to a patient with a history of drug trafficking and heroin abuse without taking any significant precautions to prevent her from diverting her medication to others. R&R at 29.

The court of common pleas concluded that this was reliable, probative and substantial evidence that Dr. Griffin fell below the minimal standard of care relating to Patient 11. The Tenth District concluded that the court of common pleas did not abuse its discretion in coming to this conclusion. Although Dr. Griffin "contends that the court erred in affirming the Board's findings as to Patient 11," Dr. Griffin has not raised any specific challenges to the lower courts' conclusions regarding Dr. Griffin's failure to properly respond to Patient 11's possible drug diversion. Memorandum in Support, p. 2, n.1

**B. Dr. Griffin routinely prescribed over 1,000 mg/day of Oxycontin to patients when most pain specialists will not prescribe more than 320 mg/day.**

The other major issue at the evidentiary hearing was the amount of opiates (especially Oxycontin) that Dr. Griffin would prescribe to his patients. Dr. Reddy, a pain management expert called by the Board, concluded that the fourteen patient files he reviewed were "usual pain patients" with conditions that pain specialists address "day in and day out." Tr. at 301-02. For ten of these patients, Dr. Griffin prescribed over 1,000 mg/day of oxycodone (usually in the form of Oxycontin but sometimes also in Percocet<sup>1</sup>). Two patients received 1,920 mg/day of oxycodone. Dr. Reddy testified that these levels of oxycodone were not justified by the patients'

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<sup>1</sup> Oxycontin releases oxycodone over a 12-hour time span. Tr. at 40-41. Percocet also has oxycodone but is not time-released. Tr. at 44.

conditions as described in the patient records. Dr. Reddy explained that Dr. Griffin's patient records did not reflect any factors that would justify the huge doses of oxycodone to "usual pain patients." Tr. at 301-302. To put things in perspective, Dr. Reddy testified that the Physician's Desk Reference states that "80 and 160 milligram tablets [of Oxycontin] are for opioid tolerant patients." Tr. at 246. Dr. Reddy further explained that he does not prescribe more than 160 mg/day of oxycodone, even for the most severe pain. Tr. at 302. At a medical conference of pain specialists in 2009, the highest amount of oxycodone any doctor would acknowledge prescribing was 320 mg/day. Tr. at 310.

Members of the Medical Board were aghast at the quantities prescribed. According to the minutes of the Board meeting, "Dr. Varyani stated that he himself once practiced in pain therapy and could not see himself prescribing the doses the [sic] Dr. Griffin had prescribed. Dr. Varyani wondered how Dr. Griffin's patients functioned while taking these quantities of medication, if they were taking them." Record #12, Minutes at 19028. Dr. Steinberg was also dismayed at the dosages prescribed stating, "she has referred her own patients to pain specialists, but had never seen a pain specialist prescribe medication in these quantities to her patients who have very significant pain." *Id.* at 19028-29. Dr. Steinberg agreed that Dr. Griffin's patients could not be functional "on the doses of medication prescribed." *Id.*

**C. The trial court and court of appeals concluded that there was reliable, probative, and substantial evidence to support all the violations, and that the violation involving Patient 11 was sufficient to justify the sanction.**

After a full hearing and a review by the Medical Board itself, Dr. Griffin appealed to the Franklin County Court of Common Pleas. The court of common pleas concluded that there was reliable, probative and substantial evidence that Dr. Griffin had violated the minimal standard of care with his prescribing decisions. The court concluded that the Board had proven that the "levels [of oxycodone] are far beyond what other practitioners would consider appropriate for similarly situated patients" so Dr. Griffin "should have, but did not offer, some substantive basis

to support the departures.” Opinion & Order, 2/4/11 at 6. As a result, the court concluded that there was “substantial, reliable and probative evidence to support the Board’s findings[.]” *Id.* at 8.

The court of common pleas concluded that Dr. Griffin “ignored obvious information that [Patient 11] was ‘diverting’ medication[.]” and held that the “Board’s findings and conclusions are supported throughout the record.” Opinion & Order, 2/4/11 at 10. The court explained that the violations involving Patient 11 were sufficient to justify the sanction the Board imposed. “In addition, the Court will note that even if it were inclined to find that there was no substantial, reliable and probative evidence to find a failure to meet the minimum standards of care with respect to thirteen of the patients, the record clearly provides support that the appellant’s treatment as to Patient 11 was below minimum standards and would warrant some sanction by the Board.” Opinion & Order, 2/4/11 at 8.<sup>2</sup>

The Tenth District upheld the lower court’s decision, concluding that “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.” *Griffin v. State Medical Board of Ohio*, 2011-Ohio-6089, ¶31 (10<sup>th</sup> Dist.) As a result, “the trial court did not abuse its discretion in affirming the board’s order suspending appellant’s medical license.” *Id.* at ¶35, ¶42

The Tenth District concluded that, based on the violation involving drug diversion by Patient 11, it would not remand for reconsideration even if it found error in regards to the assignments of error that did not involve Patient 11’s diversion. As a result, the Tenth District concluded that several other assignments of error were moot. *Id.* at ¶¶37-38.

Despite this conclusion, the Tenth District went on to explain that it would still reject Dr. Griffin’s First and Second Assignments of Error because Dr. Reddy’s testimony fully supported

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<sup>2</sup> The court should have said the other twelve patients. The Board rejected all allegations involving Patient 13. R&R at 38. So, only the findings related to thirteen patients are subject to review on appeal.

the allegations. “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.” *Id.* at ¶40. The Tenth District explained 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.” *Id.* at ¶41.

Dr. Griffin has now appealed to this Court. This Court denied Dr. Griffin a stay of enforcement and Dr. Griffin has completed his thirty-day suspension.

### **THIS CASE IS NOT OF PUBLIC OR GENERAL INTEREST**

**A. Dr. Griffin is asking this Court to revisit the discretionary decision that remand was not warranted in this case.**

The first proposition of law revolves around the Tenth District’s conclusion that it would not remand for reconsideration of the sanction even if it upheld some other assignments of error because Dr. Griffin’s failure to respond to Patient 11’s possible drug diversion was so egregious that, even if the other violations were overturned, the court would still uphold the sanction. This is based on the well-established legal principle that even Dr. Griffin acknowledges: “remand for reconsideration of the sanction is not always mandated when one or more violations are reversed.” Memorandum in Support at 9. This Court recognized this principle when it applied R.C. 119.12 in the case *Our Place, Inc. v. Ohio Liquor Control Comm.*, 63 Ohio St.3d 570 (1992). “In this case the Director ... denied the permit application on two grounds. ... If either of the grounds is supported by reliable, probative and substantial evidence, then the commission’s decision must be upheld.” *Id.* at 572.

Appellate courts sometimes remand for reconsideration of the sanction when they uphold some violations and reverse others. But this is a matter of discretion and Dr. Griffin does not identify any case that compels remand. In essence, Dr. Griffin is asking this Court to second-guess the discretionary decision made by the Tenth District that no remand would be necessary even if it credited the assignments of error it deemed to be moot.

Dr. Griffin has not shown that the appellate courts have any difficulty in applying these concepts. Instead, such decisions have simply turn on the facts before each court. This is not an overarching issue that needs to be addressed by this Court at this time.

**B. This case is a poor vehicle for addressing the mootness issue.**

According to Dr. Griffin, the Tenth District should have reviewed *all* the assignments of error even if those other assignments of error would not have made a difference in his case. Even assuming that Dr. Griffin is right about this legal concept (which he is not), this “error” would not make a difference in this case for two reasons.

First, Dr. Griffin does not include a proposition of law to challenge the Board’s conclusion that Dr. Griffin failed to heed the “red flags” involving Patient 11. The four propositions of law address other supposed errors. So even if this Court takes all four propositions of law, there will be no challenge to the Board’s conclusion that Dr. Griffin prescribed Oxycontin to a convicted drug trafficker with a history of heroin abuse without taking proper precautions. The Tenth District can hardly be faulted for refusing to remand for reconsideration where there is only a thirty-day suspension in light of such a serious violation.

The second problem is that Dr. Griffin’s propositions to this Court offer no arguments that the Tenth District did not address. Although the Tenth District stated that the first, second, third and fifth assignments of error were moot, it ruled on the first and second assignments of

error. “Notwithstanding that appellant’s first and second assignments of error are moot, we will briefly address appellant’s concerns” regarding Dr. Reddy’s testimony. *Griffin*, 2011-Ohio-6089, ¶39. The Tenth District concluded that the first and second assignments of error were supported by reliable, probative and substantial evidence – specifically, Dr. Reddy’s testimony. *Id.* at ¶40.

So, as a practical matter, the only assignments of error not addressed were the third and fifth assignments of error.<sup>3</sup> Dr. Griffin has not included these arguments as separate propositions of law to this Court.

**C. The final three propositions of law are simply challenging the Tenth District’s conclusion that the court of common pleas did not abuse its discretion in finding that an expert provided reliable, probative and substantial testimony as to the standard of care.**

Dr. Griffin’s final three propositions of law are quintessential requests for error-correction in *this* Court. Dr. Griffin does not identify any splits in the courts or any controversies that will have any broader implications. Although cloaked as legal questions, all three propositions of law ask for this Court to step in and decide whether Dr. Reddy’s testimony should have been believed.

In the Second Proposition of Law, Dr. Griffin asks this Court to state that, when reviewing an agency decision pursuant to R.C. 119.12, “it is incumbent on reviewing courts, when called upon to do so, to examine closely the soundness of the methodology of the expert.” Memorandum in Support at 11. Both the court of common pleas and the Tenth District *did this analysis* and concluded that Dr. Reddy’s testimony provided reliable, probative and substantial evidence that Dr. Griffin’s prescribing habits fell below minimal standards of care. The Tenth

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<sup>3</sup> These alleged errors turn on technical medical questions: (1) is it proper to have patients take Oxycontin every six hours rather than every twelve hours, and (2) at what dosage does the medication Neurontin cease to be absorbed.

District included extensive citations to the record to support this analysis. *Griffin*, 2011-Ohio-6089, ¶40. Dr. Griffin is not raising a significant dispute about a principle of law. Dr. Griffin is just saying that the courts below did the right analysis but came to the wrong answer.

Dr. Griffin claims in his Third Proposition of Law that the Board gave undue deference to Dr. Reddy's testimony. The problem is that the Tenth District concluded that it did not need to rely on the Board's independent medical expertise because it concluded 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[.]" *Id.* at ¶41. So this is a very poor vehicle to address the amount of deference that courts should give to the Board's own expertise on medical issues.

Dr. Griffin's Fourth Proposition of Law – although called a burden of proof claim – is just another way of claiming that the Board should not have relied on Dr. Reddy. The Tenth District concluded that the Board made its *prima facie* case by introducing (1) over twelve-thousand pages of patient records to document Dr. Griffin's care and (2) Dr. Reddy's testimony to show the minimal standard of care. As a result, the Tenth District held that the courts and the Board "require[d] nothing more of appellant than it would of any party faced with adverse evidence during litigation." *Id.* at ¶19 (citing *Smith v. Columbus*, 2003-Ohio-3303, ¶25 (10<sup>th</sup> Dist.) and *Nuclos v. State Med. Bd.*, 2010-Ohio-2973, ¶17 (10<sup>th</sup> Dist.)). There was no shifting of the burden of proof.

Dr. Griffin challenges this conclusion by repeating his earlier claim that Dr. Reddy's testimony was not reliable: "the Board did not satisfy its burden by showing that Dr. Griffin's prescriptions were 'unusually high.'" Memorandum in Support at 15. This quote demonstrates

that Dr. Griffin's "burden of proof" claim is, in actuality, simply an evidentiary challenge to the Board's finding of facts.

## ARGUMENT

### Appellee State Medical Board's First Proposition of Law:

*An Ohio court need not review an assignment of error raised in an appeal under R.C. 119.12 if the court concludes (1) that the assignment of error does not challenge all agency findings of violations and (2) the sanction imposed is fully justified by the proven violation.*

This Court has concluded that in applying R.C. 119.12 on appeal, a court can uphold a sanction against a licensee or applicant if only one ground for relief is upheld. In *Our Place, Inc.*, 63 Ohio St.3d 570, this Court relied on the fact that the agency had sought to deny an application for two reasons. This Court explained that "If either of the grounds is supported by reliable, probative and substantial evidence, then the commission's decision must be upheld." *Id.* at 572. It is also well-established that a court does not need to remand for reconsideration of the sanction if it upholds some violations and concludes that those violations fully support the sanction. *See e.g. Landefeld v. State Med. Bd.*, 2000 Ohio App. Lexis 2556, \*18-20 (10<sup>th</sup> Dist. 2000). The converse is also true – a court has discretion to remand for reconsideration of the sanction. This Court has also found propositions of law to be moot in administrative appeals when the circumstances warranted it. *Plain Local Sch. Bd. of Educ. v. Franklin County Bd. of Revision*, 130 Ohio St.3d 230, 2011-Ohio-3362, ¶30 n.3 (proposition of law that testimony about a report was "incompetent" rendered moot when Court determined that agency could rely on data from the report without testimony.)

The Tenth District has taken the next logical step in applying these concepts. If a reviewing court upholds one or more violations found by an agency, the court need not waste its scant judicial resources evaluating other assignments of error that will not impact the outcome of the case. It is well-established that, under App. R 12(A)(1)(c), an appellate court need not

review any assignments of error that have been rendered moot by a ruling on another assignment of error. *State v. Evans*, 113 Ohio St.3d 100, 2007-Ohio-861, syllabus paragraph 2.

If a court upholds some of an agency's findings but rejects other findings, the court has the *option* of remanding for the agency to reconsider its sanction. This often occurs when a court reverses the most serious finding, but upholds other violations. *See e.g. Bartley v. Dep't. of Commerce*, 2002-Ohio-3592, ¶52 (4<sup>th</sup> Dist.) (remand was appropriate because "appellant's violations now differ from the scope and the type of violations determined during the administrative process.") But, if the court concludes the agency would not change its sanction, the court does not always have to remand even if it overrules some of the agency's findings. For example, in *Landefeld*, the Tenth District upheld the Board's conclusion that a doctor repeatedly failed to meet the minimal standard of care, but rejected violations related to "billing and fee splitting issues." *Landefeld*, 2000 Ohio App. Lexis 2556, \*19. The court explained that "we are unable to conclude that a remand to the board for reconsideration, based on the trial court's disposition of the billing and fee splitting issues, would change the result." *Id.*

This is entirely appropriate. The General Assembly has granted considerable discretion to appellate courts in administrative cases to remand or not remand. When an appellate court finds error, "it may reverse, vacate, or modify the order or make such other ruling as is supported by reliable, probative, and substantial evidence and is in accordance with law." R.C. 119.12.

If a court determines that it will not remand for reconsideration of the sanction because it has upheld the most serious charge, the court may do so. Once this finding has taken place, nothing compels the court to review the remaining assignments of error. That is, ruling on additional assignments of error will not "have a direct and immediate impact on the parties." *Burger Brewing Co. v. Liquor Control Comm.*, 34 Ohio St.2d 93, 98 (1973). Put another way,

even if the appellant wins on every other assignment of error, the result will be the same – the appellate court will affirm the decision of the agency to impose the sanction at issue.

In this case, the Board imposed a thirty-day suspension on Dr. Griffin for, *inter alia*, failing to take proper steps when there were obvious signs that Patient 11 was diverting her drugs. Both courts below concluded that this violation, by itself, would have earned Dr. Griffin probation and a thirty-day suspension. The Tenth District did not err by concluding that upholding this violation alone rendered the remaining assignments of error moot.

**Appellee State Medical Board's Second Proposition of Law:**

*A licensed medical doctor who practices in pain management may rely on his own experience to opine about the minimal standards of care for prescribing narcotics.*

The court of common pleas did not abuse its discretion when it concluded that Dr. Reddy's testimony provided reliable, probative and substantial evidence regarding the minimal standard of care for prescribing Oxycontin.

Dr. Reddy, the Board's expert, has credentials and expertise in this specific practice area. He is a physician licensed in five states whose "current practice is devoted to pain management, mostly involving spine pain." R&R at 4. Dr. Reddy was board certified "in the subspecialty of pain medicine in 2000" by the American Board of Physical Medicine and Rehabilitation. R&R at 5.

Dr. Reddy testified in detail about each patient's diagnoses to determine whether the twelve thousand pages of patient records submitted as exhibits justified Dr. Griffin's prescriptions of Oxycontin and other opiates. Dr. Reddy concluded that each patient was a "usual pain patient." Tr. at 301. Dr. Reddy evaluated what alternative treatments were available

and, for thirteen of the fourteen patients, concluded that the massive dosages of opiates were simply not justified.<sup>4</sup>

In each of the cases, he found that the patients were similar to those typically found at pain clinics and that no reasonable practitioner would have prescribed so much. For example, Dr. Reddy opined that 1,680 mg/day of Oxycontin (plus another 120 mg/day of Percocet) was excessive for Patient 6 who had a failed back surgery because “it is very rare that a non cancer patient requires such a high dose of Oxycontin. ... One could have managed this patient with much less doses of Oxycontin.” State Ex. 18, p. 8. To put this into context, Dr. Reddy testified that the most amount of Oxycontin that any pain specialist at a conference would admit to was 320 mg/day. Tr. at 310.

In rejecting this claim below, the Tenth District correctly relied on Dr. Reddy’s expertise and the fact that he “personally reviewed medical charts for each of the 14 patients” and opined specifically about each patient. *Griffin*, 2011-Ohio-6089, ¶40. Notably, the Tenth District pinpointed pages of the transcript where Dr. Reddy came to his conclusions about each patient. *Id.* The court of common pleas did not abuse its discretion in finding that Dr. Reddy’s testimony was reliable, probative and substantial evidence of the minimal standards of care for the prescribing of Oxycontin and other opiates.

The Tenth District properly rejected this claim.

**Appellee State Medical Board’s Third Proposition of Law:**

*A medical licensing agency may rely on the expertise of its members to determine the proper medical standard of care.*

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<sup>4</sup> Dr. Reddy concluded that Dr. Griffin should not have prescribed two long-acting opiates at the same time to Patient 13. The Hearing Examiner concluded that Dr. Reddy misread the patient records regarding Patient 13 and found no deviation from the standard of care.

The Tenth District rightly concluded that Dr. Griffin's challenge to the Board's reliance on its own expertise was immaterial because it already concluded that Dr. Reddy's testimony constituted reliable, probative and substantial evidence regarding the minimal standard of care. *Griffin*, 2011-Ohio-6089, ¶41.

To suggest that the Board went astray, Dr. Griffin relied on carefully edited statements by Board members when they were in deliberation. Dr. Griffin edited out any mention that specific Board members had personal experience with chronic pain patients – even when they are in the same sentence with the supposedly erroneous statement. Dr. Griffin criticized Dr. Viryani but omitted that “Dr. Varyani stated that he himself once practiced in pain therapy[.]” Record #12, Minutes at 19028. Likewise, Dr. Griffin omitted that Dr. Steinbergh prefaced her criticisms of Dr. Griffin's prescribing habits with her statement that “she has referred her own patients to pain specialists” so she was well aware of what doctors typically prescribe. *Id.* at 19028-29.

Dr. Griffin criticizes the Board members for their “hardly scientific” discussions in determining an appropriate penalty to be meted out to him. Dr. Griffin identifies no statutes or case law that has ever imposed any “scientific” standard when Board members are in deliberation to determine an appropriate penalty.

The Board overwhelmingly consists of medical professionals appointed specifically because of their understanding of the minimal standard of care. The Board's deliberations are not testimony – they are freewheeling discussions about these standards and the appropriate sanction if there are violations. There is no requirement that the Board's deliberations (which are held in public and on the record) comply with evidentiary standards found in federal court for expert testimony.

There was nothing improper here.

**Appellee State Medical Board's Fourth Proposition of Law:**

*An agency holding proceedings under R.C. Chapter 119 to discipline a licensee will meet its burden of proof when it presents enough evidence to support all elements of a violation.*

Dr. Griffin's "burden of proof" challenge is really just another attack on Dr. Reddy's testimony. Dr. Griffin argues that the Board did not meet its burden of proof because Dr. Reddy's testimony should not be believed. Memorandum in Support at 15.

This claim can be easily rejected because the Board introduced over 12,000 pages of patient records to identify what treatment Dr. Griffin provided to the fourteen patients at issue. The Board introduced the expert report of a doctor who practices in the same field as Dr. Griffin. This written report concluded that Dr. Griffin fell below the standard of care because of his prescribing habits and his failures to respond to red flags of drug diversion by Patient 11. *See* State Ex. 18. Dr. Reddy testified at length as to Dr. Griffin's failures.

The Board understood that it bore the burden of proof and introduced evidence that the courts below have concluded was reliable, probative and substantial to support its allegations.

This claim should be rejected.

**CONCLUSION**

Dr. Griffin wants this Court to reverse the Tenth District's conclusion that four assignments of error were moot – despite the fact that the court below ruled on two assignments and Dr. Griffin does not include the other two assignments of error in his Proposition of Law to this Court. He also wants this Court to engage in pure error-correction that hinges on whether the court of common pleas abused its discretion in concluding that the state's expert provided reliable, probative and substantial evidence about the minimal standard of care.

None of the propositions of law warrant jurisdiction.

Respectfully submitted,

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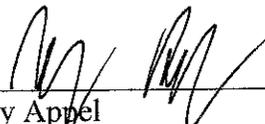
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### CERTIFICATE OF SERVICE

I certify that a copy of the foregoing Memorandum in Opposition was served by U.S. mail  
this 3<sup>rd</sup> day of February, 2012, upon the following counsel:

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