

# State Medical Board of Ohio

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Executive Director

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March 9, 2011

Patrick Kelley McGriff, D.O.  
8291 Tegmen Street  
Columbus, OH 43240

RE: Case No. 09-CRF-157

Dear Doctor McGriff:

Please find enclosed certified copies of the Entry of Order; the AMENDED Report and Recommendation of Gretchen L. Petrucci, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on March 9, 2011, including motions approving and confirming the AMENDED Report and Recommendation and Order as the Findings and Order of the State Medical Board of Ohio.

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 must be commenced by the filing of a Notice of Appeal with the State Medical Board and the Franklin County Court of Common Pleas. The Notice of Appeal must set forth the Order appealed from and state that the State Medical Board's Order is not supported by reliable, probative, and substantive evidence and is not in accordance with law. The Notice of Appeal may, but is not required to, set forth the specific grounds of the appeal. 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.*

Lance A. Talmage, M.D. *rw*  
Secretary

LAT:jam  
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3938 3049 8035  
RETURN RECEIPT REQUESTED

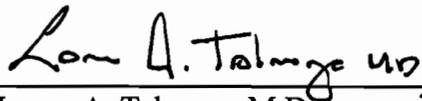
Cc: James M. McGovern, Esq.  
CERTIFIED MAIL NO. 91 7108 2133 3938 3049 8042  
RETURN RECEIPT REQUESTED

*Mailed 3-22-11*

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio (Board); AMENDED Report and Recommendation of Gretchen L. Petrucci, Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on March 9, 2011, including motions approving and confirming the Findings of Fact and Conclusions of Law of the Hearing Examiner, and Final Order of the Board, as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Patrick Kelley McGriff, D.O., Case No. 09-CRF-157, 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.

  
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Lance A. Talmage, M.D. *rw*  
Secretary

(SEAL)

March 9, 2011  
\_\_\_\_\_  
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

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CASE NO. 09-CRF-157

PATRICK KELLEY MCGRIFF, D.O.

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ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on March 9, 2011.

Upon the AMENDED 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 AMENDED Report and Recommendation is attached hereto and incorporated herein, and upon the 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.

**Rationale for disapproving the proposed order and adopting the order below:**

Based on the evidence in the hearing record, it is determined that Dr. McGriff did not engage in predatory behavior, is remorseful for his behavior, has engaged in appropriate practice in recent years, and will be able to be remediated.

It is hereby ORDERED that:

- A. **PERMANENT REVOCATION, STAYED; SUSPENSION:** The certificate of Patrick Kelley McGriff, D.O., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such revocation is STAYED, and Dr. McGriff's certificate shall be SUSPENDED for an indefinite period of time, but not less than one year.
- B. **INTERIM MONITORING:** During the period that Dr. McGriff's certificate to practice medicine and surgery in Ohio is suspended, Dr. McGriff shall comply with the following terms, conditions, and limitations:
  - 1. **Obey the Law:** Dr. McGriff shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
  - 2. **Personal Appearances:** Dr. McGriff shall appear in person for an interview before the full Board or its designated representative during the

third month following the month in which this Order becomes effective, 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.

3. **Declarations of Compliance:** Dr. McGriff 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 this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
4. **Required Reporting of Change of Address:** Dr. McGriff shall notify the Board in writing of any change of address and/or principal practice address within 30 days of the change.

C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. McGriff's certificate to practice medicine and surgery until all of the following conditions have been met:

1. **Application for Reinstatement or Restoration:** Dr. McGriff shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.
2. **Compliance with Interim Conditions:** Dr. McGriff shall have maintained compliance with all the terms and conditions set forth in Paragraph B. of this Order.
3. **Controlled Substances Prescribing Course(s):** At the time he submits his application for reinstatement or restoration, Dr. McGriff shall submit acceptable documentation of successful completion of a controlled substance prescribing course or courses. 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. However, documentation of successful completion of the November 10-12, 2010, course on "Prescribing Controlled Drugs" at Vanderbilt University in Nashville, Tennessee, may be submitted to satisfy this course requirement. 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. McGriff 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 this practice of medicine in the future.

4. **Physician/Patient Boundaries Course(s)**: At the time he submits his application for reinstatement or restoration, Dr. McGriff shall submit acceptable documentation of successful completion of a course or courses on maintaining physician/patient boundaries. 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. However, documentation of successful completion of the September 2-3, 2010, "Medical Ethics, Boundaries and Professionalism" course at Case Western Reserve University in Cleveland, Ohio, may be submitted to satisfy this course requirement. 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. McGriff submits the documentation of successful completion of the course(s) on maintaining physician/patient boundaries, 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. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, Dr. McGriff shall submit acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. 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. McGriff submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, 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. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. McGriff has not engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under

Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

D. **PROBATION:** Upon reinstatement or restoration, Dr. McGriff's certificate shall be subject to the following PROBATIONARY terms, conditions and limitations for a period of at least four years:

1. **Terms, Conditions, and Limitations Continued from Suspension Period:** Dr. McGriff shall continue to be subject to the terms, conditions and limitations specified in Paragraph B. of this Order.
2. **Practice Plan:** Within 30 days of the date of Dr. McGriff's reinstatement or restoration, or as otherwise determined by the Board, Dr. McGriff shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. McGriff's activities will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. McGriff shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. McGriff submits his practice plan, he shall also 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. McGriff and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. McGriff and his medical practice, and shall review Dr. McGriff'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. McGriff and his medical practice, and on the review of Dr. McGriff's patient charts. Dr. McGriff 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. McGriff's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. McGriff shall immediately so notify the Board in writing. In addition, Dr. McGriff 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. McGriff 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 therefore.

The Board, in its sole discretion, may disapprove any physician proposed to serve as Dr. McGriff's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. McGriff'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.

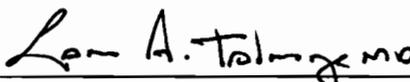
3. **Tolling of Probationary Period While Out of Compliance:** In the event Dr. McGriff is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.
- E. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. McGriff's certificate will be fully restored.
- F. **VIOLATION OF THE TERMS OF THIS ORDER:** If Dr. McGriff 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.
- G. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**
  1. **Required Reporting to Employers and Others:** Within 30 days of the effective date of this Order, Dr. McGriff shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare 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 appointment. Further, Dr. McGriff shall promptly provide a copy of this order to all employers or entities with which he contracts in the future to provide healthcare 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. McGriff receives from the Board written notification of the successful completion of his probation.

In the event that Dr. McGriff provides any healthcare services or healthcare direction or medical oversight to any emergency medical services organization or emergency medical provider in Ohio, within 30

days of the effective date of this Order, he 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. McGriff receives from the Board written notification of the successful completion of his probation.

2. **Required Reporting to Other State Licensing Authorities:** Within 30 days of the effective date of this Order, Dr. McGriff 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 professional license or certificate. Also, Dr. McGriff shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This requirement shall continue until Dr. McGriff receives from the Board written notification of this successful completion of his probation.
  
3. **Required Documentation of the Reporting Required by Paragraph G:** Dr. McGriff shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (a) the return receipt of certified mail within 30 days of receiving that return receipt, (b) an acknowledgment of delivery bearing the original ink signature of the person to whom a copy of the 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.

**EFFECTIVE DATE OF ORDER:** This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

  
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Lance A. Talmage, M.D. RW  
Secretary

(SEAL)

March 9, 2011  
\_\_\_\_\_  
Date

STATE MEDICAL BOARD  
OF OHIO

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**BEFORE THE STATE MEDICAL BOARD OF OHIO**

**In the Matter of**

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**Case No. 09-CRF-157**

**Patrick Kelley McGriff, D.O.,**

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**Hearing Examiner Petrucci**

**Respondent.**

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**AMENDED REPORT AND RECOMMENDATION**

Basis for Hearing

By letter dated December 9, 2009, the State Medical Board of Ohio [Board] notified Patrick Kelley McGriff, D.O., that it had proposed to take disciplinary action against his certificate to practice osteopathic medicine and surgery in Ohio. The Board based its proposed action on allegations that in treating and caring for Patient 1 as identified on a patient key, Dr. McGriff engaged in sexual intercourse with her, exposed her breasts at a concert, and sent/received sexually explicit emails to/from her. Additionally, the Board alleged that, in treating and caring for Patient 1, Dr. McGriff failed to enforce and/or document enforcement of a medication management agreement with her, failed to properly follow and/or document a follow-up to unusual medication utilization reports and/or unacceptable urine screens, prescribed high levels of acetaminophen, did not address the high use of acetaminophen even after an abnormal liver test, failed to document any follow-up to the abnormal liver function, and failed to complete and/or maintain any medical record for a controlled substance prescription he issued. Moreover, the Board alleged that Dr. McGriff's documentation in Patient 1's chart was inadequate, poorly legible and/or generally illegible.

The Board alleged that Dr. McGriff's acts, conduct, and/or omissions constitute:

- A violation of Section 15 of the Code of Ethics of the American Osteopathic Association and are a basis for discipline per Section 4731.22(B)(18), Ohio Revised Code.
- A departure from or failure to conform to, minimal standards of care of similar practitioners and are a basis for discipline per Section 4731.22(B)(6), Ohio Revised Code.
- Violating, attempting to violate, assisting in or abetting the violation of, or conspiring to violate Rule 4731-11-02(D),<sup>1</sup> Ohio Administrative Code, and are a basis for discipline per Section 4731.22(B)(20), Ohio Revised Code.

<sup>1</sup>Rule 4731-11-02(D), Ohio Administrative Code, states in relevant part: "Patient medical records shall accurately reflect the utilization of any controlled substances in the treatment of a patient and shall indicate the diagnosis and purpose for which the controlled substance is utilized, and any additional information upon which the diagnosis is based."

Accordingly, the Board advised Dr. McGriff of his right to request a hearing in this matter. (State's Exhibit [St. Ex.] 1A) On December 30, 2009, Dr. McGriff requested a hearing. (St. Ex. 1B)

#### Appearances at the Hearing

Mike DeWine, Attorney General, and Katherine J. Bockbrader and Kyle C. Wilcox, Assistant Attorneys General, on behalf of the State of Ohio. James M. McGovern, Esq., on behalf of Dr. McGriff.

Hearing Dates: September 13, 14, and 15, and November 22 and 30, 2010

### **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.

#### **Background**

1. Patrick Kelley McGriff, D.O., is a family-medicine physician. He graduated in 1990 from Ohio State University. In 1994, Dr. McGriff earned a medical degree from the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri. In 1994, Dr. McGriff entered a one-year rotating internship at Grandview Hospital in Dayton, Ohio. He left the internship after several months because of his fear of injuring patients. Dr. McGriff explained that he became depressed and began seeing a psychiatrist who treated him for his depression and attention deficit hyperactivity disorder. He also saw a therapist. In 1995, Dr. McGriff entered another rotating internship at Selby General Hospital in Marietta, Ohio, and completed it. In early 1997, he entered an osteopathic residency in general surgery at Grandview Hospital in Dayton, Ohio, with the hope of entering its neurosurgery residency program a few months later. However, the neurosurgery residency position was given to another resident, and Dr. McGriff then switched to the family-medicine residency at Grandview Hospital. He completed that residency in 1999. (Hearing Transcript [Tr.] at 560-568, 571; St. Ex. 10 at 6-7, 15-17)
2. Between 1999 and 2010, Dr. McGriff held a number of positions, as follows:
  - He held a position at Swope Family Practice in Springboro, Ohio, which was affiliated with Grandview Hospital, for approximately one year. He was terminated when Kettering Hospital purchased Grandview Hospital and physicians in duplicate satellite offices were eliminated.
  - In December 2000, he took a position with the Ohio Institute of Cardiac Care with offices in Springfield and New Carlisle, Ohio. He worked there for approximately one year and was let go when the offices were restructured.
  - Next, he worked for four months in 2002 at a family practice owned by Licking County Memorial Hospital. He was let go because of financial solvency concerns.

- Between mid-2002 to mid-2003, he held a position with United Medical Corporation in Columbus, Ohio. He voluntarily resigned from that position.
- In 2003, he took a position with Ohio Health Center in Columbus. He remained there until October 2006, when he was terminated due to productivity concerns.
- In November 2006, he took a position with America's Urgent Care in central Ohio. In December 2006, he was asked to leave because he had difficulty with "moving patients" in/out and had difficulty with the company's voice-activated, medical record system.
- He then held a position at Doctor's Urgent Care in the Cincinnati area for several months between December 2006 and April 2007. He left that position when he was offered the next position.
- From May 2007 to the date of the hearing, he has held a position at Columbus Southern Medical Center in Columbus.

(Tr. at 571, 575-585, 608; St. Ex. 10 at 9-14, 85-88)

3. Dr. McGriff has an active medical license in Ohio. In 2000, he became certified by the American College of Osteopathic Family Physicians in family practice. (Tr. at 572; St. Ex. 10 at 6, 8)

#### **Expert Witnesses**

4. The State presented the testimony of Martha A. Simpson, D.O. Dr. Simpson earned her osteopathic medical degree in 1978 from Kirksville College of Osteopathic Medicine, in Kirksville, Missouri. She earned a master's degree in 1993 from the University of Southern Maine, in Portland, Maine, and another master's degree in 2000 from Ohio University in Athens, Ohio. Dr. Simpson practices medicine at a walk-in urgent care clinic in Athens, Ohio, and at an inpatient psychiatric facility in Athens. Additionally, she is a member of the faculty at the Ohio University College of Osteopathic Medicine. Dr. Simpson is licensed in Ohio. She is certified by the American College of Osteopathic Family Physicians in family medicine. (Tr. at 19-21, 113-114; St. Ex. 2)

Dr. Simpson reviewed the medical records related to Patient 1 and a deposition of Dr. McGriff. She concluded, in general, that he had failed to meet the minimal standard of care in his care and treatment of Patient 1. (Tr. at 24, 127; St. Ex. 3) The details of her opinions is set forth later in this Report and Recommendation

5. Respondent presented the testimony of Matthew M. Shatzer, D.O. Dr. Shatzer earned his medical degree from New York College of Osteopathic Medicine in 1998. He completed a rotating internship at Long Beach Medical Center in New York in 1999, and a three-year residency at Johns Hopkins Sinai Hospital in Baltimore, Maryland. Additionally, in 2003, he completed a fellowship in spinal cord injury medicine at the Kessler Institute for Rehabilitation in Chester, New Jersey. He is Chief of Physical Medicine and Rehabilitation at North Shore University Hospital in Manhasset, New York. He also practices at Long Island Jewish Hospital. Moreover, he is the Director of the Physical Medicine and Rehabilitation Residency Program

at North Shore University Hospital. He is licensed to practice medicine in New York, and is board-certified both in physical medicine and rehabilitation medicine and in spinal cord injury medicine. (Tr. at 309-314; Respondent's Exhibit [Resp. Ex.] B)

Dr. Shatzer reviewed the medical records related to Patient 1 and a coroner's report.<sup>2</sup> He agreed that Dr. McGriff had failed to meet the minimal standard of care in his care and treatment of Patient 1 in several respects, but did not fully agree with all of Dr. Simpson's opinions. His opinions are detailed later in this Report and Recommendation.

### **Patient 1**

6. Patient 1 was a female born in 1975. Patient 1 was a police officer. She suffered from degenerative disk disease in her lower back. In September 2004, she underwent a fusion of the L4-L5 and L5-S1 disks. Post-surgery, she continued to experience back pain, with pain radiating down her legs. In November 2004, she underwent a second surgery during which hardware was added to further stabilize her lower back. Immediately following that surgery, she was experiencing "very little back pain." (St. Ex. 4 at 303, 307, 309, 317, 321, 325-331; Tr. at 632-636, 766-767)
7. On November 30, 2004, Patient 1 met with William Miely, M.D., the neurosurgeon who conducted the surgeries. He included the following in his progress note:

She was phoned in a prescription \* \* \* over the weekend for Lortab<sup>3</sup> for some complaints of pain in her right leg in a diffuse distribution, not necessarily in a radicular pattern. \* \* \* We had a long discussion with her. We will discontinue her narcotics. She was given Toradol 30 mg, #15 dispensed, for pain. She is not to phone in for narcotics at this point.

(St. Ex. 4 at 303)

### **Ohio Health Center [OHC]**

8. On December 4, 2004, Patient 1 went to OHC as a new patient. OHC is a walk-in, family-practice clinic in Columbus. It is owned by Ralph Newman, M.D. It has a "first-come, first-serve" format. Between December 2004 and October 2006, Dr. McGriff was one of two physicians who worked there, along with two nurse practitioners and some medical assistants. (Tr. at 155, 466, 587, 589, 598, 600, 744-745; St. Ex. 10 at 11)
9. Dr. McGriff stated that he was expected to see more than 40 patients each day. He was also expected to generate as much revenue as he could, and supervise the nurse practitioners. (Tr. at 589-591, 599)

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<sup>2</sup>Patient 1 died on February 9, 2009, from an overdose of Fentanyl. (St. Ex. 9)

<sup>3</sup>Lortab is a combination of hydrocodone and acetaminophen. It is a Schedule III controlled substance and a narcotic pain medication. (Tr. at 41, 60; St. Ex. 10 at 98)

10. Dr. McGriff stated that the patient base at OHC was not always cooperative. He also stated that “[a]lmost without fail, whatever’s written as the chief complaint or the subjective reason the patient’s there was not really why they were there. Almost without fail, you – you could count on there being a different issue that would arise while you were seeing the patient.” Moreover, Dr. McGriff testified that he had disagreements with patients and they threatened him. (Tr. at 590, 592-593)
11. Dr. McGriff testified that OHC had an in-house pharmacy. The patients taking controlled substances were “highly encouraged” to go to the in-house pharmacy for those prescriptions. (Tr. at 454-455, 605, 606-607)

**Overview of Patient 1’s Care and Treatment by Dr. McGriff, December 2004-October 2006**

12. At Patient 1’s first visit to OHC on December 4, 2004, she presented with complaints of low-back pain. She did not see Dr. McGriff at this visit. Patient 1 was initially diagnosed with: (a) lumbar myofascial syndrome with lumbar spondylosis, (b) degenerative disk disease at L4-5 and L5-S1, (c) L4-5 broad-based disk bulge, and (d) L5-S1 broad-based disk bulge.<sup>4</sup> She was given samples of Ultracet, Celebrex, and Lidoderm patches, and told to return in two weeks or as needed. The Ultracet samples were a 4.5- to 6.5-day supply. (St. Ex. 4 at 5, 15, 267, 416-417; Tr. at 621, 623-655)

Four days later, Patient 1 requested more Ultracet, and was given a 7.5- to 11.25-day supply. (St. Ex. 4 at 15, 416)

13. Patient 1 returned to OHC on December 15, 2004, and Dr. McGriff treated her at that appointment. He had not met Patient 1 prior to this office visit. Dr. McGriff testified that Patient 1 was different from the walk-in clientele at OHC because she was a 30-something, female police

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<sup>4</sup>Dr. McGriff explained the diagnoses as follows:

Well, the bottom three, the -- the two that say, "broad-based disk bulge", as I've said, the patient more than likely has pain that's resulting from a disk that's bulging. The disks are the cushions that ride between the -- the vertebrae in the spine -- in the spinal column. If these disks push out, they can push either backwards, directly into the spinal cord, which would cause pain and neurologic changes; and they can also push to the side, either the left or right side or both. And in that case, you would see specific deficits depending on where they're pushing.

Degenerative disk disease L4-5 and L5-S1, degenerative disk disease means that the disk itself isn't actually herniated or bulging, but it has changed. It's not the way it should -- It isn't normal. The disk is somewhat broken down. Most of the time when you look at -- when you see any kind of an imaging with this, the actual space itself will be decreased. And kind of the same thing, that's going to cause problems with any of the nerves that are in that area.

The top one, the lumbar myofascial syndrome with the lumbar spondylosis, the myofascial syndrome, that refers more to probably the pain that you would have from perhaps a procedure that you underwent or that the patient underwent. And the spondylosis is the actual wearing down of the vertebrae themselves, the actual bones, which can cause pain, also.

(Tr. at 832-834)

officer. Furthermore, he stated that she was well spoken. He prescribed Ultracet and Lortab. On that same day, Patient 1 executed a medication management agreement [MMA] “due to the nature of her complaints” and her receipt of controlled substances. (Tr. at 470-471, 622, 665-671, 1161; St. Ex. 10 at 20)

14. Patient 1 had office visits regularly with Dr. McGriff at OHC over the next 22 months, typically two to three times per month. He prescribed pain medications to her the entire time. (Tr. at 328; St. Ex. 4)
15. Also, during this 22-month period, Dr. McGriff had a personal and sexual relationship with Patient 1. He admitted that he exposed Patient 1’s breasts at a concert, exchanged sexually explicit e-mails with her, and engaged in sexual intercourse with her. (Tr. at 440, 443, 445-446; St. Ex. 10 at 29-30, 34-36, 54; St. Ex. 12)
16. Dr. McGriff was fired from OHC on October 20, 2006. Dr. McGriff stated that he was terminated because he did not see enough patients each day, and because Dr. McGriff’s dating relationship with Dr. Newman’s stepdaughter had ended. (Tr. at 465-467, 507, 591-592, 602, 604; St. Ex. 10 at 76, 80-81)

#### **Enforcement of the Medical Management Agreement [MMA]**

17. Patient 1 executed a MMA at her first appointment with Dr. McGriff in December 2004. Among other things, the MMA contained the following requirements:

- Not to share, sell, or trade medications for money, goods, or services.
- Not to attempt to get pain medications from any other health care provider without telling them of the pain medication prescribed by Dr. McGriff.
- To safeguard medications from loss or theft.
- To use the OHC Pharmacy and, if the pharmacy is changed for any reason, to notify Dr. McGriff at the time of receipt of a prescription.
- Not to use the medication at a rate greater than the prescribed rate.

(St. Ex. 4 at 293-299) Patient 1 executed a second MMA in May 2006. (St. Ex. 4 at 47-53)

18. Between December 2004 and October 2006, Patient 1 continually received pain medications from Dr. McGriff. During the same time period, Patient 1 obtained other pain medications from many other physicians, received pain medications from various emergency rooms, did not honestly disclose information about the pain medications that she was receiving from OHC, reported on one occasion that her medications had been stolen, filled prescriptions at numerous pharmacies, and returned early on many occasions to OHC for her pain medication refills. (Tr. at 33, 40, 63-64, 70, 89, 91-92, 199, 266-267, 270, 375-376, 473-474, 497-498, 506-507; St. Ex. 4)
19. Patient 1 was noncompliant with the MMAs and exhibited possible drug-seeking behavior. Several examples as identified in the OHC medical record and the testimony are listed.

- a. Within the first two months of Dr. McGriff treating Patient 1, he received the following information:
- Patient 1's neurosurgeon concluded in late November 2004 that, after Patient 1 had called the neurosurgeon's office on a weekend and obtained Lortab and the neurosurgeon had a "long discussion with her," the neurosurgeon would not prescribe narcotics to her. Dr. McGriff initialed receipt of those records. (St. Ex. 4 at 301; Tr. at 1163-1164)
  - Patient 1 returned early after her first visit with Dr. McGriff and requested more pain medication because she was going out of town. Dr. McGriff prescribed Lortab, a 4.5- to 5-day supply, and instructed her to take 1 tablet every six to eight hours. (St. Ex. 4 at 4, 415)
  - At her next office visit eight days later, Patient 1 reported that the Lortab relieves her pain when taken every four hours. Thus, she disclosed that she was not taking the Lortab according to his instructions. (St. Ex. 4 at 414)
  - In January 2005, Dr. McGriff reviewed an "unusual utilization report" from her insurance provider, Blue Cross/Blue Shield. The report included a list of 27 prescriptions that Patient 1 had received between October and December 2004 from 14 different physicians. Seventy-four percent of those prescriptions were for oxycodone, hydrocodone/APAP, and Ultracet. (St. Ex. 4 at 263-267)
- b. Dr. McGriff referred Patient 1 to a chronic pain specialist on April 7 and 14, 2005, and his office contacted a pain control office for a "lumbar MRI" for Patient 1. The medical record does not reflect that she went to that pain control office. (St. Ex. 4 at 403-404)
- c. In May 2005, when Patient 1 reported an exacerbation of her low back pain and reported that the Lortab was not helping her, Dr. McGriff instructed Patient 1 to obtain the MRI, and to return the remainder of her Lortab medication, after which she could receive a Percocet prescription. Nothing in the medical record reflects that Patient 1 obtained the MRI in that timeframe or that Patient 1 returned the Lortab,<sup>5</sup> and Patient 1 did not obtain a Percocet prescription in that timeframe. (St. Ex. 4 at 13, 399)
- d. Patient 1 presented early for a Lortab prescription on June 10 and 17, 2005.<sup>6</sup> (St. Ex. 4 at 13, 395, 396)

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<sup>5</sup>On June 3, 2005, Patient 1 reported that she had an MRI appointment scheduled for June 6, 2005. Dr. McGriff noted that she "needs to keep appointment." It is presumed that he was referring to the MRI appointment. The medical record indicates that Patient 1 did not obtain an MRI until July 21, 2005. (St. Ex. 4 at 251, 257, 397)

<sup>6</sup>Dr. McGriff reflected in his progress note for June 17 that Patient 1 was early for her Lortab prescription, and he stated with regard to the medications that she would "need to pick up next week." However, the prescription log reflects that Patient 1 obtained a prescription for Lortab on that date. Dr. McGriff testified that his note reflects that he sent the Lortab prescription to the in-house pharmacy and Patient 1 was instructed to pick the Lortab up on a later date because

- e. On June 30, 2005, Patient 1 reported that her Lortab and Klonopin<sup>7</sup> were stolen. She obtained new prescriptions for both from Dr. McGriff. (St. Ex. 4 at 11, 394)
- f. Between August 2005 and January 2006, Patient 1 had seven visits to several different emergency rooms [ERs] at the same time she regularly saw Dr. McGriff. He received copies of the ER reports. Most of the ER visits were for neck or back pain. (St. Ex. 4 at 169-173, 175-179, 181, 183-187, 189-191, 205-207, 229) Moreover, the following excerpts from the ER reports during this time frame reflect that Patient 1 was not truthful and reflect that one ER physician questioned her need for pain medication:
- “This is a 30-year-old female with a history of intermittent back pain in the past. She has had back surgery in 2004 times two. **She really has not had much pain since then.**” (St. Ex. 4 at 229, emphasis added.)
  - “She has a significant underlying history of a back disorder. She had Dr. Miely do a fusion 09/04 and then a re-do with some screws on 11/04. She subsequently has been doing very well. She has to follow up with \_\_\_\_\_ medicine on Monday but is in severe pain and presents to the ED. \* \* \* **MEDS: None.**” (St. Ex. 4 at 205, emphasis added.)
  - “The patient is a 30-year-old, white female who has a history of back problems. She was a riding a motorcycle yesterday and now has back pain. \* \* \* **MEDS: Toradol and iron.**” (St. Ex. 4 at 189, emphasis added.)
  - “This is a 30 year-old white female who has had a lot of spine problems. \* \* \* **She is followed by Dr. Mahmoud**, her neurosurgeon, who is currently having her undergo physical therapy, but if she does not respond, he may have to do surgery in that region as well.”<sup>8</sup> (St. Ex. 4 at 181, emphasis added.)

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she was early for that medication. However, Patient 1’s medical record reflects that Dr. McGriff prescribed Lortab to Patient 1 on three different occasions (June 10, 17, and 27) during this same time period that she twice requested early refills. Dr. McGriff could not say whether Patient 1 had received three different Lortab prescriptions on those three dates. (St. Ex. 4 at 11, 13, 395, 876-879)

<sup>7</sup>Klonopin is a benzodiazepine prescribed to treat anxiety. (Tr. at 44, 50, 842, 1175; St. Ex. 10 at 45)

<sup>8</sup>Patient 1 did see Dr. Mahmoud one time in October 2005, after Dr. McGriff referred her to him for consultation purposes. The OHC medical record does not reflect that Dr. Mahmoud treated her thereafter or otherwise followed her care and treatment. (St. Ex. 4 at 193-195)

- “The patient is a 30-year-old white female with a history of fixation fusion at L4, L5, L5-S1 levels a couple years ago, presenting to the emergency department for evaluation of low back pain. Patient states she has been experiencing low back pain for the last two days. \* \* \* **She reports that she has had similar episodes** in the past due to her musculoskeletal back pain. **She states she has taken ibuprofen as well as Ultram without relief of her symptoms.**” (St. Ex. 4 at 177, emphasis added.)
- “The patient is a 30-year-old female who had an L4-L5-S1 discectomy and fusion done approximately two years ago. This was done by Dr. Miely. I actually saw the patient in May 2005 at which time I spoke with Dr. Miely. There was some concern about pain medication use at that point. She, since that time, has been seen on 09/18/05, 11/12/05, 11/30/05 and 12/18/05. She each time was given prescriptions for narcotic pain medications. Her complaint today is that of low back pain with some radiation down the upper part of her left leg. Her current medications are contraceptives and Ultram. \* \* \* I spelled out very clearly, her visits, the questionable need of pain medication this far out from her surgery, suggested that she needs to follow up with Dr. Miely to determine why she is having pain.” (St. Ex. 4 at 171)

20. Dr. McGriff acknowledged that, between December 2004 and October 2006 when Patient 1 was his patient at OHC, he was aware of the following, and that they are “red flags” for drug-seeking behavior:

- On many occasions, Patient 1 asked him to prescribe controlled substances before the use period of the earlier prescription had expired.
- On many occasions, he issued prescriptions to Patient 1 before the use period of the earlier prescription had expired.
- Patient 1 got many controlled substances from other physicians.
- Patient 1 had abnormal drug screens.
- Patient 1 had multiple visits to ERs for back pain.
- Patient 1 had reported that her medications were stolen on one occasion.

(Tr. at 1175-1180)

21. Dr. McGriff responded to Patient 1’s noncompliance and drug-seeking behavior, and he documented several actions in OHC’s medical record for Patient 1:

- Dr. McGriff discussed the January 2005 unusual utilization report with Patient 1 in February 2005. (St. Ex. 4 at 409)

- He told Patient 1 that, on a one-time only basis, he would refill her medications, after she reported that they had been stolen in June 2005. (St. Ex. 4 at 394; See, also, Tr. at 881-882)
  - Dr. McGriff conducted three urine drug screens, all of which had abnormal results. (St. Ex. 4 at 55, 107, 255, 392; See, also, Tr. at 488, 889-890, 953-954, 957-958, 977, 1183-1184)
  - He counseled Patient 1 regarding the importance of taking medications as ordered and not asking early for new prescriptions. (St. Ex. 4 at 365, 392; See, also, Tr. at 885, 967-968)
  - He refused on one occasion to refill medications until she obtained an MRI. (St. Ex. 4 at 392; See, also, Tr. at 886)
  - He prescribed non-narcotic medications to Patient 1 for her chronic pain, but the non-narcotic medications were prescribed at the same time he prescribed narcotic medications. (St. Ex. 4 at 7-15; See, also, Tr. at 383)
  - In July 2005, Dr. McGriff referred Patient 1 to a psychiatrist, a chronic pain specialist and a neurosurgeon. His office established appointments with a chronic pain specialist and a neurosurgeon. (St. Ex. 4 at 391, 453-457, 461; See, also, Tr. at 896-898)
  - He counseled Patient 1 to fill her narcotic prescriptions at OHC's in-house pharmacy. (St. Ex. 4 at 365, 367; See, also, Tr. at 960, 966-967)
22. Dr. McGriff did not undertake several initiatives in treating and caring for Patient 1. For example, Dr. McGriff did not require Patient 1 to provide her medication for a pill count. He did not refer her to an addictionologist or suggest chemical dependency rehabilitation. He did not obtain any pharmacy reports ("OARRS" reports). He did not prescribe the medications in smaller amounts. Moreover, after Patient 1 met with Dr. McGriff's recommended chronic pain specialist, Dr. McGriff did not follow that pain specialist's recommendation to continue nonsteroidal anti-inflammatory medications, prescribe Lortab only on an as-needed basis, prescribe narcotics only for short periods during periods of exacerbation, and try Neurontin and/or low-dose Elavil. (Tr. at 52, 54-55, 203, 474-475, 178-179, 215-217, 233-235, 255, 276-278, 290-293, 296, 391, 453-457, 461, 676; 1168-1170, 1174; St. Ex. 4; Tr. at 55)

Moreover, Dr. McGriff was not aware whether Patient 1 was counseled to contact OHC, instead of visiting ERs. (Tr. at 1163)

23. Dr. Simpson opined that Patient 1 was non-compliant with the MMA, exhibited drug-seeking behavior, and enforcement of the MMA should have occurred. Dr. Simpson discussed three specific time periods:
- First, she stated that the January 2005 utilization report would "cause a reasonable physician to be concerned, especially if you had a pain management agreement with the patient where they had agreed not to get drugs from other physicians, [and] to only go to one pharmacy. There's clearly evidence that this patient has been getting drugs from multiple physicians, [and] going to multiple pharmacies." (Tr. at 35-36; See, also, Tr. at 156, 173-174)

- Second, Dr. Simpson stated that Patient 1's early request for refills and abnormal drug screen in July 2005 are "red flags" for misuse or diversion of the medications. (Tr. at 45, 50-51, 172-173)
- Finally, Dr. Simpson pointed to Dr. McGriff's actions on December 9, 2005. Dr. McGriff included in his plan "return to office next week for medications." However, he prescribed Lortab that same day. The December 9 Lortab prescription was written early – it was eight days after he had prescribed a 10- to 15-day supply of Lortab on December 1, 2005. Additionally, it was written early despite the fact that Dr. McGriff had noted in July 2005 that he had discussed "no more early prescriptions" with Patient 1. (St. Ex. 4 at 11, 377, 392; Tr. at 70-71; Resp. Ex. H at 19)

Dr. Simpson acknowledged that Dr. McGriff made some attempts to enforce the MMA (such as, ordering urine drug screens and consulting with the patient), but found those actions insufficient. Dr. Simpson concluded that Dr. McGriff failed to take *sufficient* action for Patient 1's noncompliance with the MMA, which amounts to a violation of the minimal standard of care. (Tr. at 65, 236-239, 265, 270-271, 281-282)

24. Dr. Shatzer disagreed in part with Dr. Simpson. Dr. Shatzer stated that Dr. McGriff prescribed medications that were medically necessary for Patient 1's chronic pain, and execution of the MMA was appropriate. Dr. Shatzer opined that, upon violation of a MMA, the key for the physician is to discuss what happened, why it happened, and how to avoid it from occurring again. Dr. Shatzer pointed out that there is documentation in Patient 1's medical record that Dr. McGriff had such conversations with Patient 1 on July 13, 2005, and March 21, 2006. As a result, Dr. Shatzer concluded that Dr. McGriff met the standard of care in regard to enforcing the MMA. (Tr. at 331-337)

Moreover, Dr. Shatzer stated that the three urine drug screens were required by the standard of care and Dr. McGriff complied with the standard in conducting the screens and in responding to the results. (Tr. at 345-347, 388-389)

25. Dr. McGriff explained his care and treatment of Patient 1 from December 2004 to October 2007. He identified the objective findings, his subjective thoughts, assessments, and plans. (Tr. at 665-677, 809-1100)

McGriff repeatedly testified that the medications that he had prescribed to Patient 1 while treating her at OHC were medically necessary and appropriate for Patient 1's conditions at the time.<sup>9</sup> (Tr. at 668-669, 813, 821-822, 824-826, 828-829, 836, 842, 845, 847, 848, 855, 864-865, 866, 869, 872, 879-880, 882, 895, 896, 900, 910, 914, 916, 917-918, 920, 921, 923,

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<sup>9</sup>However, Dr. McGriff acknowledged that, when he increased oxycodone to 10 mg every 4-6 hours on March 2, 2006, and continued at that prescription level, he had prescribed too much oxycodone to Patient 1, although oxycodone was a medically necessary medication for Patient 1. (Tr. at 956, 959, 963, 968, 971, 977, 979, 980, 981, 982, 987, 989)

925, 927, 929, 930, 932, 934, 935, 939, 941, 943, 944, 947, 959, 963, 968, 971, 977, 979, 980, 981, 982, 987, 989, 1038, 1040, 1041)

26. Moreover, Dr. McGriff explained that in January 2005 he did not consider Patient 1 to be drug seeking. First, Dr. McGriff testified that, when he had reviewed the January 2005 unusual utilization report with Patient 1, the report did not indicate to him possible drug-seeking behavior. However, in retrospect, he agrees that the report absolutely indicated possible drug-seeking behavior. (Tr. at 476, 479, 480; St. Ex. 4 at 409; St. Ex. 10 at 28)

Second, Dr. McGriff noted that, in January 2005, Patient 1 had been prescribed Percocet by another practitioner at OHC, but she said that Percocet was too strong and asked to switch back to Lortab. Dr. McGriff stated that drug seekers do not typically seek weaker medications and therefore he had not considered her actions to be possible drug-seeking behavior. (Tr. at 819-820)

27. Dr. McGriff admitted that, by July 2005, he had less confidence in Patient 1, which is set forth in the following exchange:

[I'm thinking this] is becoming tedious; the early visits, different presentations. I think this is the second or third time that she didn't follow up for the imaging that we have scheduled. So I think this -- I'm frustrated with this patient.

I'm trying to get to the bottom of the problems that she's presenting to me and I am meeting resistance with trying to do what she needs to have done.

\* \* \*

Well, the fact that she had been early several times, I wanted to know exactly what's going on. Was she taking the medications? Is she trading the medications for other drugs or prescriptions?

(Tr. at 884-885)

Yet, in this same time period, a July 2005 MRI of the lumbar spine demonstrated that Patient 1 had postsurgical changes at the L4-L5 and L5-S1 levels, and L5-S1 narrowing of the neural foramen bilaterally secondary to facet arthropathic changes. Moreover, in August 2005, an MRI of Patient 1's cervical spine demonstrated that she had ventral sac effacement at C6-7.<sup>10</sup> Dr. McGriff testified that these MRI findings were consistent with the pain that Patient 1 was experiencing. (St. Ex. 4 at 209, 251, 257; Tr. at 888-889, 912, 913)

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<sup>10</sup>Dr. McGriff explained the ventral sac effacement at C6-7 as follows: "The sac effacement is in the cervical region. The spinal cord as it moves down the back, it's located behind the bony structures, the vertebrae. And if there's a disk herniation, it can push back directly onto the sac that the spinal cord is located in. So that means at the front of the sac where the spinal cord is, there's a disk herniation that's actually pushing onto it, which could be a reason for pain." (Tr. at 913)

28. By late 2005 or early 2006, Dr. McGriff had other thoughts. He testified that, in late 2005 or early 2006 after his relationship with Patient 1 had become personal, he had suspected that Patient 1 was not compliant with her MMA and was either addicted or getting too much pain medication. Dr. McGriff stated that he had tried to convince himself that “everything was okay.” He also stated that he responded to those concerns by ordering urine drug screens, ordering a chronic pain consult, and discussing/documenting his concerns with Patient 1. Dr. McGriff stated that he did enforce or attempt to enforce the MMA, and thus disagrees with Dr. Simpson’s criticism. Moreover, Dr. McGriff stated that the standard of care allows physicians discretion to continue prescribing medications after receiving information of unusual medication utilization. (Tr. at 674-675, 1048, 1051-1053, 1171, 1173; St. Ex. 10 at 22-25; Resp. Ex. A at 2)

However, later in his testimony, Dr. McGriff acknowledged that his response to Patient 1’s violations of the MMA was not adequate and “amounts to a failure to enforce that [MMA].” He also stated that his response to the unusual medication utilization reports, assuming he saw the second one, was inadequate. In addition, Dr. McGriff testified that his response to the second and third urine screens was not adequate. (Tr. at 1181-1184)

#### **Excessive Prescribing of Acetaminophen**

29. Dr. McGriff continually prescribed Lortab 5/500 to Patient 1 for 15 months, between December 2004 and February 2006. As noted earlier, Lortab includes acetaminophen. Between December 2004 and January 2006, Dr. McGriff directed Patient 1 to take two Lortab tablets, every four to six hours, for a total daily dose of 4,000 mg to 6,000 mg of acetaminophen. In January 2006, he increased the Lortab dosage, directing her to take two tablets every four hours, for a total daily dose of 6,000 mg of acetaminophen. Moreover, on February 10, 2006, Dr. McGriff *added* a prescription for Percocet 5/325 mg, one tablet to be taken every four to six hours. Percocet also includes acetaminophen, and that prescription added 1,300 mg to 1,950 mg of acetaminophen on a daily basis. As a result of this additional prescription, Dr. McGriff ordered Patient 1 on February 10, 2006, to consume between 7,300 mg to 7,950 mg of acetaminophen each day. (St. Ex. 4 at 9-15; Tr. at 72, 75-76, 299; St. Ex. 3 at 2)
30. Between February 19 and March 1, 2006, Patient 1 was hospitalized with liver failure secondary to chronic acetaminophen toxicity.<sup>11</sup> Patient 1 was placed on the transplant list for an emergency liver transplant, but ultimately she did not require a transplant. Her liver function returned to normal. (St. Ex. 6 at 69, 73-75; Tr. at 78-79, 216)
31. After Patient 1’s hospitalization for acetaminophen toxicity, Dr. McGriff ceased prescribing Lortab. Instead, he prescribed oxycodone 5mg, which is a stronger medication than Lortab but contains no acetaminophen. The initial oxycodone prescription was for 60 tablets, with instructions to take one tablet every six hours. In April 2006, Dr. McGriff increased the

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<sup>11</sup>Dr. McGriff testified that the records from University Hospital in Cincinnati, where Patient 1 was transferred for treatment during this time, did not reflect that Patient 1 had elevated acetaminophen levels and he questioned whether she really experienced acetaminophen toxicity. However, her admission history as recorded in that medical record reflects that her initial liver enzymes levels were elevated, AST 1724 and ALT 1334. (Tr. at 1138-1141; St. Ex. 6 at 99)

dosage (to two tablets every four to six hours) and increased the number of pills to 120 tablets. From May 2006 to the time Dr. McGriff left OHC in October 2006, he maintained the dosage, but increased the number of pills to 150. (St. Ex. 4 at 7-9; Tr. at 295, 353 503, 504)

32. Dr. Simpson explained that one of the primary cautions with taking acetaminophen on a regular basis and in high doses is liver toxicity. The toxicity causes the liver to be overwhelmed so that it is not able to metabolize the acetaminophen, which causes the acetaminophen to build up in the liver, causes the liver to cease functioning, and damages the liver. Additionally, she stated that the maximum daily recommended amount of acetaminophen is 4,000 mg for *episodic* use. Dr. Simpson concluded that Dr. McGriff fell below the minimal standard of care by prescribing more than 4,000 mg of acetaminophen per day to Patient 1 and by prescribing it continuously. (Tr. at 72-73, 76-77, 194-195; St. Ex. 3 at 2)

Additionally, Dr. Simpson stated that the standard of care “should expect a physician, when giving a medication for a long period of time, to monitor for end organ damage, to monitor for drug levels if they’re available.” (Tr. at 304)

33. Dr. Shatzer stated that, between 2004 and 2006, Dr. McGriff, as a primary care physician, was expected to understand the potential hepatotoxic effects of acetaminophen, including the specific daily limit.<sup>12</sup> (Tr. at 348) In the following exchange, Dr. Shatzer explained what Dr. McGriff should have done, given that he had prescribed acetaminophen at those levels:

Q. Because he chose to prescribe the pain medication that he did in -- from '04 to '06, should Dr. McGriff have also tested Patient 1's acetaminophen levels and/or her liver?

A. I mean, I would -- I wouldn't have prescribed that amount of medication. But assuming for some reason you're pushing the envelope and sometimes you do prescribe a higher dose than is, you know, reported allowable, you would want to test -- you should test. In this case, I would test liver function.

\* \* \*

Q. Should he have been testing Patient 1 to see the effect of that pain medication on her on a certain interval during that same time period?

A. Again, I can't speak from experience. It's not something I would do. But assuming you were going to do that, you would want to test -- you know, get a baseline liver function, and then test at least every few weeks, knowing that you're prescribing a high dose of this medication that could potentially be toxic to the liver.

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<sup>12</sup>Dr. Shatzer noted that the daily limit of acetaminophen (4,000 mg) has not changed over time. (Tr. at 348)

Q. Okay. And you said earlier that the test to do that is that AST/ALT?

A. Yeah. You could do a Tylenol -- You could do a liver function test, yeah. That would be ideal.

(Tr. at 387-388)

34. Dr. Shatzer further stated that, after Patient 1's hospitalization, Dr. McGriff's prescriptions to Patient 1 complied with the standard of care because he ceased prescribing excessive amounts of acetaminophen, he subjected her to urine screens, and he addressed issues that came up. (Tr. at 353-354)
35. Dr. McGriff testified that, during the time that he treated Patient 1, he was aware that acetaminophen could be potentially harmful to the liver, but he was not aware of a specific number or maximum dosage. He is aware now. (Tr. at 502-503, 1053-1054; Resp. Ex. A at 2)
36. The University Hospital record reflects that Patient 1 had stated that she had been taking eight tablets of Lortab and four to eight tablets of Tylenol Extra Strength prior to her hospitalization.<sup>13</sup> Dr. McGriff noted that he was not aware that Patient 1 was taking other amounts of acetaminophen prior to her hospitalization. He stated that, had he known this and the acetaminophen limit, he would have adjusted his prescriptions. Dr. McGriff noted that, after learning of Patient 1's liver problem, he tried to avoid prescribing any acetaminophen to her. (St. Ex. 6 at 99, 421; Resp. Ex. A at 2; Tr. at 1054-1055, 1059)

#### **May 2005 Liver Function Test Results**

37. On May 24, 2005, Patient 1 visited Dr. McGriff and brought results from a physical examination completed as part of her employment. Dr. McGriff noted the hemoglobin and hemacrit counts, and ordered further testing related to anemia. Additionally, the progress note from this office visit includes "AST/ALT ↑," which refers to a liver function test. Dr. McGriff did not order any further testing to assess that issue.<sup>14</sup> (St. Ex. 4 at 398; Tr. at 869-872)
38. Dr. Simpson and Dr. Shatzer explained that AST and ALT are two liver enzymes evaluated to gauge the liver's functionality. When the enzymes levels are elevated, there is toxicity and the liver is not working well. (Tr. at 80, 350)

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<sup>13</sup>The University Hospital record does not include any mention of the Percocet prescription issued by Dr. McGriff in February 2006.

<sup>14</sup>Patient 1's medical record at OHC does not include the documentation that Patient 1 brought with her on May 24, 2005. However, in May 2005, Patient 1 was sent a letter regarding the physical examination conducted as part of her employment. The letter and accompanying blood test results reflect the same hemoglobin and hemacrit counts reflected in Dr. McGriff's progress notes from May 24, 2005. Moreover, the accompanying blood test results reflect that Patient 1's AST and ALT levels were elevated. The letter, however, does not reflect that the levels were elevated; rather the letter states that the liver function test was "okay." (St. Ex. 14 at 2-4, 10; Tr. at 1153-1161, 1186-1188)

39. Dr. Simpson stated that “AST/ALT ↑” appears to be written in Dr. McGriff’s handwriting on the progress note. Dr. Simpson and Dr. Shatzer opined that, upon seeing an elevated AST/ALT ratio, the standard of care would have required Dr. McGriff to order follow-up tests, and perhaps switch the patient’s medications to ones containing no acetaminophen, at least while he was investigating the cause of the elevated ratio. Dr. Shatzer added that, if Dr. McGriff was not comfortable in handling the issue, the standard of care would require him to obtain a consultation from a specialist. Dr. Simpson further opined that, even if Dr. McGriff did not write that note in Patient 1’s medical record, the standard of care required him to address the issue if he had been aware of it. (Tr. at 81, 201, 275, 288-289, 350-351; St. Ex. 13 at 398)
40. Dr. McGriff acknowledged that Patient 1 had had a physical examination, and “had shared with me – if I recall, she did have an actual printout.” However, Dr. McGriff testified that he did not write “AST/ALT ↑” on the progress note. Additionally, he testified that he was not certain that test was part of her employment physical. Dr. McGriff acknowledged that, except the introductory information and “AST/ALT ↑,” he had written all other information on the progress note. Additionally, Dr. McGriff stated that if he had seen “AST/ALT ↑” on the progress note he would have changed his prescription and ordered testing. (Tr. at 481-486, 870, 1055-1056; Resp. Ex. A at 2)

Dr. McGriff acknowledged that, if he had been aware of the increased AST/ALT ratio and had failed to respond to that knowledge, his inaction would be a violation of the standard of care. (Tr. at 1057-1058)

#### **Exposing Patient 1’s Breasts at a Concert**

41. Dr. McGriff admitted that, while attending a concert in November 2005, he saw Patient 1 there and lifted her shirt and exposed her breasts. (Tr. at 439-440, 1060, 1069-1070; St. Ex. 10 at 34, 36)
42. Dr. Simpson stated that lifting Patient 1’s shirt at the concert was sexual contact with her, and a violation of Section 15 of the American Osteopathic Association’s Code of Ethics. That section states: “It is considered sexual misconduct for a physician to have sexual contact with any current patient whom the physician has interviewed and/or upon whom a medical or surgical procedure has been performed.” Dr. Simpson also stated that Dr. McGriff should have stopped treating Patient 1 at that time. (Tr. at 25, 278-279; St. Ex. 3 at 1; St. Ex. 11 at 3)
43. Dr. Shatzer was not asked to express an opinion as to whether Dr. McGriff’s conduct in this regard was appropriate. (Tr. at 354-355)
44. Dr. McGriff admitted that he violated the Osteopathic Code of Ethics and the minimal standard of care when he lifted Patient 1’s shirt at the concert. He further stated that, after the concert, he should have stopped treating Patient 1. (Tr. at 439-440, 1175)

**E-Mails between Dr. McGriff and Patient 1**

45. In May 2008, Joe DePolo, a Board Investigator, received a call from the Mount Vernon Police Department and was invited to interview Patient 1. Mr. DePolo stated that he understood that she had been instructed by the Mount Vernon Police Department to be open and honest with him. During the interview with Patient 1, Mr. DePolo learned that Patient 1 had engaged in conversations by e-mail and text messages with Dr. McGriff. Mr. DePolo asked to see them and she accessed her Yahoo e-mail account from a police department computer. Patient 1 identified the folder in which the items were located, and Mr. DePolo reviewed and printed the e-mails that day. Mr. DePolo stated that he believes that he printed all of the items in the identified folder, and the paper copies presented at the hearing, as State's Exhibit 12, are mostly in the same condition as when he printed them. Mr. DePolo stated that he was under the impression that Patient 1 was trying to cooperate with him at the May 2008 meeting. (Tr. at 396-399, 402, 406-415, 418-419, 423, 432-433, 434)
46. Mr. DePolo stated that on June 2, 2008, he met a second time with Patient 1. Mr. DePolo stated that she only briefly spoke of the e-mails during this meeting because "if we dwelled on them too much, she might become reluctant to speak to me about her relationship with the doctor." (Tr. at 402, 405)
47. In the following exchange, Mr. DePolo testified about the content of the e-mails:
- Q. [Mr. McGovern:] Okay. Do you have any way of knowing whether the e-mails that you printed from Patient No. 1's Yahoo account are true and accurate copies of e-mails that were actually transmitted back and forth between she and Dr. McGriff?
- A. [Mr. DePolo:] No, sir, I do not.
- Q. Okay. So you would -- you would agree with me that there is the possibility that Patient No. 1 could have edited those e-mails or even created those e-mails prior to allowing you access to them?
- A. Yes, sir.
- Q. Okay. Thank you.
- A. Uh-huh.
- Q. So as you sit here today, that's another thing that you don't know; that being whether these are true and accurate copies of e-mail communications that actually occurred between Dr. McGriff and Patient No. 1; am I correct?
- A. You are correct.

(Tr. at 429-430)

48. Dr. McGriff admitted that he sent e-mails to Patient 1 and also received e-mails from Patient 1 that were sexually explicit. (Tr. at 443, 447-448, 468, 1060, 1174-1175; St. Ex. 10 at 54, 97) Dr. McGriff testified that he sent sexually explicit e-mails for the following reason:

After the incident at the concert I felt I had put myself in a – I had basically compromised my role in the patient/doctor relationship and at that point I felt pressured to basically keep her happy or quiet about what had happened and still, you know, treat her.

(St. Ex. 10 at 97)

49. Dr. Simpson and Dr. Shatzer did not express opinions regarding Dr. McGriff's conduct in this regard. (Tr. at 314, 354-355; St. Ex. 3)
50. Dr. McGriff acknowledged that e-mails were sent back and forth with Patient 1, and that the e-mail exchange was improper. He also acknowledged that the e-mails in State's Exhibit 12 contain factual information that is true. However, he stated that he has no record of the e-mails that were exchanged, and he has "no proof that these [e-mails in State's Exhibit 12] are the actual e-mails that we exchanged." Moreover, with regard to the sexual material and sexual conversations in the e-mails, Dr. McGriff added that he "cannot say that these [e-mails] have not been altered." Additionally, Dr. McGriff did not recall some of the events referenced in the e-mails. However, Dr. McGriff stated that the tone of the e-mails that were exchanged is the same as the tone of the e-mails in State Exhibit 12. (Tr. at 443, 446, 449, 453, 461, 463, 464, 468-469, 1175-1175; St. Ex. 10 at 57-63, 65, 68-71, 74-76)

Dr. McGriff admitted that he had violated the Osteopathic Code of Ethics and the minimal standard of care when he engaged in the e-mail relationship with Patient 1. (Tr. at 439-441, 446, 469-470; St. Ex. 10 at 96-97)

### **Sexual Intercourse with Patient 1**

51. Dr. McGriff admitted that, despite his on-going physician-patient relationship with Patient 1, he engaged in sexual intercourse with Patient 1 in October 2006. (Tr. at 440, 507, 1060, 1070; St. Ex. 10 at 29-30, 35)
52. Dr. Simpson found that the sexual intercourse with Patient 1 violates Section 15 of the American Osteopathic Association's Code of Ethics. (Tr. at 25; St. Ex. 3 at 1; St. Ex. 11 at 3)
53. Dr. Shatzer was not asked to express an opinion as to whether Dr. McGriff's conduct in this regard was appropriate. (Tr. at 354-355)
54. Dr. McGriff admitted that he violated the Osteopathic Code of Ethics and the minimal standard of care when he engaged in sexual intercourse with Patient 1. (Tr. at 439-441, 446, 469-470; St. Ex. 10 at 96-97)

**Dr. McGriff's Documentation at OHC**

55. Dr. McGriff used a "SOAP" format for the OHC medical records. He also wrote his notes on progress note forms. (Tr. at 592, 657; St. Ex. 4)
56. Dr. Simpson stated that she could not read the photocopies of Dr. McGriff's progress notes from OHC. She explained that she had to review the original OHC medical record and, even then, still had difficulty reading the progress notes because Dr. McGriff's handwriting is poor. Dr. Simpson concluded that Dr. McGriff's handwritten records fell below the standard of care because of the legibility. (Tr. at 47-48, 68, 107-109, 146-148, 170, 264-265)
57. Additionally, Dr. Simpson found further flaws in Dr. McGriff's documentation. For instance, she stated that Dr. McGriff did not document on certain visits that he had conducted an examination of Patient 1's back when she had presented with back pain. Dr. Simpson stated that, in her opinion, such documentation is necessary "especially since we're giving out narcotics." Moreover, Dr. Simpson added, "[i]f I were to pick up this chart and try to come after him and take care of this patient, it would be very difficult for me to understand what his long-term goal was for the management of this patient, [and] how she was doing this week as compared to when she had been there before. It's just not really what I would call adequate documentation to provide continuity of care for this patient." (Tr. at 68, 82-83, 102-103; 265; St. Ex. 4 at 383, 398, 402; See, also, Tr. at 223-224)
58. In summary, Dr. Simpson stated as follows:

The medical office visit notes contain minimal medical information. While there is evidence of a physical exam on the standardized form, there is no detail to the exam. When reading from note to note, there is little change in the actual documentation from visit to visit. \* \* \* With respect to Dr. McGriff's notes, there is no clear assessment and plan. The diagnoses are referenced by number to the problem list and the plan frequently reads: "1. Meds 2. f/u as directed" handwritten on the office visit sheet. Even when there has been a change in medication, as noted on the medication flow sheet, there is little or no information in the progress note.

Overall I found the office visit notes in general to be poorly legible, and parts were illegible. They were generally unrevealing in nature as to the care that was received, and the overall plan for treatment of Patient 1. It is my opinion to a reasonable degree of medical probability that the medical record was not clear, concise or complete.

(St. Ex. 3 at 2)

59. Dr. Simpson agreed that the "problem sheet" and medication list in the OHC medical record were helpful because both provide a snapshot of the continuity of care for the patient. (Tr. at 223-224, 239-240)

60. Dr. Shatzer stated that Dr. McGriff's use of the SOAP note method complies with the standard of care. Dr. Shatzer explained that the medical record is intended to communicate with the physician and with other physicians. He stated that Dr. McGriff's OHC medical record for Patient 1 "probably satisfies the purposes with communication with himself because, you know, if you look from note to note, he – you know, he does, at times, comment on what he said previously from a previous note. Probably not regarding communication with others because of certain issues with the notes." (Tr. at 316-317)
61. Dr. Shatzer identified several deficiencies with Dr. McGriff's notes, namely: poor legibility, a special numbering system for the diagnoses that was hard to follow, inconsistent documentation of test results for tests referenced in a previous note, the plans often only included "medications" without further detail, and the objective and subjective information was intermixed. He concluded that the documentation was not perfect and had weaknesses, but Dr. Shatzer concluded that it minimally met the standard of care. (Tr. at 320-324)
62. Dr. McGriff stated that, in his opinion, his documentation in the OHC records met the standard of care. He acknowledged that, in spots, his handwriting may not be perfectly legible, but he does not believe his documentation fell below the standard of care.<sup>15</sup> He noted that Dr. Newman did not complain about the legibility of his progress notes at OHC. (Tr. at 594, 656, 659-660, 663)

#### **Dr. McGriff's Care and Treatment of Patient 1 in December 2006**

63. After his termination at OHC, Dr. McGriff took a position with America's Urgent Care, working in several urgent care facilities in central Ohio. While employed there, Dr. McGriff received a telephone call from Patient 1. He recalled that she said she was unable to see her then-current physician and needed medication. She asked Dr. McGriff to prescribe her medication. Dr. McGriff called in prescriptions for a sleep aid and two pain medications: Ambien 10 mg (15 tablets, to take one tablet at bedtime), Ultram 50 mg (45 tablets, to take one tablet every six to eight hours), and Lortab 5/500 (20 tablets, to take one tablet every six to eight hours). (Tr. at 507-509, 584, 1082-1083; St. Exs. 7, 8; St. Ex. 10 at 20-21, 39, 50)
64. Dr. McGriff did not see Patient 1 and did not examine her. Dr. McGriff did not document this telephone call with Patient 1, although he knew it was required. (Tr. at 508, 509, 1083; St. Ex. 10 at 20, 38, 50-51)
65. Dr. Simpson stated that Dr. McGriff's failure to document his prescriptions to Patient 1 in December 2006 was below the standard of care. (Tr. at 30-31)
66. Dr. Shatzer testified that it was inappropriate and below the standard of care for Dr. McGriff to have prescribed medications to Patient 1 in December 2006 and to not document it. Dr. Shatzer felt that the situation would be "somewhat mitigated" if Dr. McGriff had felt he was in a compromised situation and he only prescribed short-term amounts of medications. (Tr. at 360-362, 378-379)

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<sup>15</sup>At the hearing, Dr. McGriff provided a transcription of his progress notes at OHC. (Resp. Ex. H)

67. Dr. McGriff admitted that, in December 2006, he knew it was a violation of the standard of care to prescribe medication to Patient 1 after he had engaged in sexual intercourse with her. He also admitted that it was a violation of the standard of care to not document the telephone call. (Tr. at 509, 1083, 1090) He chose to issue the prescriptions because he had felt trapped, as he explained below:

Using the leverage she had obtained following our sexual encounter, she persuaded me to call in medications. I did so against my better judgment. I did, however, make it clear to her that she would need to be assessed the following day and she agreed to be evaluated the following day at the urgent care center where I was working. I was not scheduled to work the date she agreed to be evaluated and I had no intention of ever re-establishing a doctor-patient relationship with her. My intention was to address Patient 1's acute pain needs until she was able to be evaluated and treated by another physician at the urgent care.

(Resp. Ex. A at 1; See, also, St. Ex. 10 at 39-40)

68. Dr. McGriff stated that he had agreed to prescribe the medications expressly with the caveat that Patient 1 would follow up with the urgent care within one to two days. Patient 1 did not follow up at the urgent care. (Tr. at 1083)

#### **Dr. McGriff's Care and Treatment of Patient 1 in October 2007**

69. Dr. McGriff began working at Columbus Southern Medical Center [CSMC] in May 2007. CSMC is a family-medicine practice in Columbus, Ohio. It is run by Kevin Lake, D.O. Two physicians currently work there, along with two physician assistants and some medical assistants. Appointments and walk-ins are accepted. Electronic record-keeping is used at CSMC. (Tr. at 585, 608-610, 616, 793, 795-796, 801, 1090)
70. On October 26, 2007, Patient 1 came to CSMC and saw Dr. McGriff. She complained of low-back syndrome and myositis. Dr. McGriff prescribed Darvocet, Robaxin and Ultram. She executed a MMA at that appointment as well. (St. Ex. 5 at 9-11, 37-39; St. Ex. 10 at 19; Resp. Ex. L at 4)
71. Patient 1 returned four days later, complaining of left clavicle fracture pain. Dr. McGriff saw her and prescribed a Medrol dosepak. (St. Ex. 5 at 13-15)
72. A colleague of Dr. McGriff ordered an OARRS report of Patient 1's prior prescriptions. Dr. McGriff stated that the OARRS report covered the first 10 months of 2007. A summary of the OARRS report was included in CSMC's medical record for Patient 1 on October 31, 2007. (Tr. at 512-516; St. Ex. 10 at 26-27, 32) That summary states as follows:

This patient has a bad pharm report with innumerable narcotic and benzo

prescriptions (188 over the last yr) from 64 different providers. She should receive no controls including tramadol from us.

(St. Ex. 5 at 17)

73. Patient 1 next returned to CSMC on November 21, 2007. Dr. McGriff's colleague saw her, and diagnosed her with drug dependency, among other things. That physician noted that she refused non-narcotic medication and a referral to treatment. (St. Ex. 5 at 19-21; St. Ex. 10 at 27-28, 32; Resp. Ex. A at 2)
74. Dr. Simpson opined that it was a violation of the Code of Ethics for Dr. McGriff to have treated Patient 1 at CSMC on October 26 and 30, 2007, because he had had a sexual relationship with her. Since neither office visit involved an emergency, Dr. Simpson noted that there was time to have had another practitioner see Patient 1. (Tr. at 96-99, 205-206, 208, 218-219)
75. Dr. Simpson agreed that the electronic records at CSMC were legible and improved in substance as compared to those at OHC, but found inaccuracies. Dr. Simpson opined that Dr. McGriff's documentation from the October 30, 2007 office visit was substandard. (Tr. at 215) She stated:

Well, initially when you look at it, it says, "Chief Complaint: Clavicle fracture/Left." And if you go back to the Page 9, the 10-26 [sic] visit -- excuse me -- Page 11, in his diagnosis he talks about a clavicle fracture. But that's nowhere else in the -- in the progress note.

So it looks to -- here originally, at first glance, you'd think, well, she's here because she's fallen and broken her clavicle; but apparently this started several years ago, as well. So she has some old clavicle problems. \* \* \*

And, again, on our -- on our physical exam, he is talking about the lumbar spine and the lumbar spine, but her chief complaint was a fractured clavicle on the left and she's here for clavicle, I find no evidence of examination of the clavicle. So there's not a great documentation here; it doesn't all mesh together nicely.

(Tr. at 99) Similarly, Dr. Simpson stated that Dr. McGriff incorrectly noted in the medical record that Patient 1 had an acetaminophen allergy. Lastly, Dr. Simpson stated that the pharmacy report referenced in the medical record should have been included in her medical record. (Tr. at 215-217, 221; St. Ex. 5 at 9)

76. Dr. Shatzer agreed that it was inappropriate for Dr. McGriff to have seen Patient 1 at CSMC because of the prior sexual relationship. Moreover, Dr. Shatzer admitted that, on the first visit at CSMC, Dr. McGriff should have conducted a physical examination of Patient 1's back and documented it. However, he concluded that the overall medical care provided to her appeared to be appropriate care. (Tr. at 363-365, 385-386, 389-390)

77. Additionally, Dr. Shatzer found that Dr. McGriff's medical record at CSMC met the minimal standard of care. He stated that the record-keeping clearly improved, as compared to the OHC records. Additionally, he stated that the medical record at CSMC was legible and contained adequate communications. Dr. Shatzer stated that the only shortcoming with the CSMC medical records was that the plan section could be more specific. (Tr. at 362-363)
78. Dr. McGriff admits that it was a violation of the standard of care to have seen Patient 1 on October 26, 2007. Dr. McGriff testified that he had considered having another physician see Patient 1 in October 2007, but he felt that it would have "more than likely ended [his] employment" at CSMC. (Tr. at 512, 1089-1090) Dr. McGriff stated that, in October 2007, he felt trapped again by Patient 1:

When she presented to me without any advance notice, I felt trapped by my past mistakes. At that time, I was in a relationship with a wonderful woman, whom I met in late December 2007, and eventually married in March 2009. I was finally practicing medicine at a facility where I was happy. I had been working at CSMC for 5 months and I was aware that my employer, Dr. Kevin Lake[,] was solely interested in providing appropriate medical care to patients. I also knew that he was quick to nip any potential problems by making staff changes. From my perspective, this meant that I would most assuredly be fired if I refused to see a new patient with whom I had a sexual encounter at a previous office. Once again, against my better judgment, I chose to remain quiet and see her. At no time during Patient 1's two visits with me at CSMC were any nonmedical matters discussed.

(Resp. Ex. A at 1)

79. Dr. McGriff further stated that the medications that he had prescribed to Patient 1 while at CSMC were medically necessary and appropriate for Patient 1's conditions at the time. Dr. McGriff stated that he was surprised by Patient 1's OARRS report and he had felt manipulated by her. (Tr. at, 1096, 1101, 1111)
80. Dr. McGriff stated that he believes Patient 1's medical record at CSMC meets the standard of care because the documentation is appropriate and there is no legibility issue. Additionally, Dr. McGriff stated that Dr. Lake has not ever raised concerns about the quality of Dr. McGriff's electronic medical records. (Tr. at 615, 1110)

#### **Summary of the Expert Witnesses' Opinions Regarding Care and Treatment of Patient 1**

81. In summary, Dr. Simpson reached the following conclusions regarding Dr. McGriff's care and Treatment of Patient 1:
- The lifting of Patient 1's shirt and exposing her breasts, and the sexual intercourse with Patient 1 both violate Section 15 of the American Osteopathic Association's Code of Ethics. (Tr. at 25; St. Ex. 3 at 1; St. Ex. 11 at 3)

- Dr. McGriff's admitted sexual contact with Patient 1 was below the standard of care. (St. Ex. 3 at 1)
  - Dr. McGriff's treatment and care of Patient 1 was below the standard of care inasmuch as he did not enforce the MMA with Patient 1, he prescribed high amounts of acetaminophen, and he did not follow up on an "AST/ALT" test result. (St. Ex. 3 at 2)
  - Dr. McGriff's documentation in the OHC medical record was below the standard of care. (St. Ex. 3 at 3; Tr. at 47-48)
  - Dr. McGriff failed to document prescriptions issued to Patient 1 in December 2006. (Tr. at 30-31)
82. Dr. Shatzer acknowledged that Dr. McGriff had failed to meet the minimal standard of care in his care and treatment of Patient 1 in several respects, namely: the sexual relationship, prescribing high doses of acetaminophen, prescribing medication after the sexual relationship, and failing to document the December 2006 prescriptions. However, he disagreed with some of Dr. Simpson's conclusions. First, Dr. Shatzer stated that Dr. McGriff did enforce the MMA, pointing to several notes in the medical record in which Dr. McGriff had discussions with Patient 1. Second, Dr. Shatzer found that the documentation was not below the standard of care; rather, he admitted that it had poor legibility. Third, Dr. Shatzer found that Dr. McGriff's care of Patient 1 improved in two respects: he properly prescribed medications after Patient 1's February 2006 hospitalization and his documentation improved at CSMC. (Tr. at 377-378, 381-382; Resp. Ex. C)

**Dr. McGriff's Testimony Regarding the Change in His Relationship with Patient 1**

83. Dr. McGriff explained that his relationship with Patient 1 became personal in late 2005, before the concert. He stated that he had opened up to Patient 1 about difficulties at OHC because at the time he was dating Dr. Newman's stepdaughter, spending time with that family, and had no one else to turn to. (Tr. at 1062-1063, 1071-1072)
84. Dr. McGriff explained why he believes the relationship with Patient 1 became a personal relationship:

She presented as a different client than what we normally have. And I found myself needing someone, I guess, to talk to. And at some point during our conversation, more than likely during a visit, I probably shared some personal information about my life stressors.

And kind of from that point on, I actually crossed the boundary where you don't share any personal information with a patient. And it just kind of went from there. I mean, at the time when it started, I – I'm sure I didn't think like, oh, this is going to lead to where I -- where I am today, but it did, nonetheless.

(Tr. at 1061)

85. Dr. McGriff admitted that his personal and sexual relationship with Patient 1 had an impact on his medical care and treatment of Patient 1, clouding it. (Tr. at 442-443, 1060, 1194-1196) He explained as follows:

A. [Dr. McGriff:] Because I found myself to be in a very painful situation. I feared that, worst case, what would happen would be why we're all here today. I had originally crossed the boundary and put myself into this position. I didn't know how I could possibly extricate myself from that situation. I felt it best to try to keep it quiet and keep her placated and hope and pray that it would just go away.

Q. [Ms. Bockbrader:] So your -- the sexual contact that you had with Patient 1 impacted with your judgment and what you did on that day?

A. If by "sexual contact" you mean intercourse, or the incident at the concert?

Q. Either/or.

A. When the event at the concert happened, it was at that moment my medical judgment was clouded, that I realized that I had made a grievous error. I had no idea how to extricate myself from -- from that point forward. I felt as if she had me.

Q. And that was after the concert, November 2005?

A. That was at the concert in 2005, yes, ma'am.

Q. And it was after that that she sent you pictures via e-mail?

A. Yeah, it would appear that way; yes, ma'am.

Q. And it was almost a year later that you had sex with the patient?

A. Yes, ma'am.

(Tr. at 510-511; See, also, Tr. at 1063-1066)

#### **Other Information Regarding Patient 1's Narcotics Use and Actions**

86. Chief Richard Zitzke of the Whitehall Police Department testified that Patient 1 worked for the Whitehall Police Department. (Tr. at 762, 766, 789)

87. Chief Zitzke stated that, in July 2006, a sheriff with the Knox County Sheriff's Department stopped Patient 1. The sheriff drove her to her destination because she was driving poorly, and then the sheriff notified the Whitehall Police Department. The Whitehall Police

Department conducted an internal affairs investigation and determined that Patient 1 had a substance abuse problem. She underwent drug and alcohol treatment and entered into an aftercare program, but did not cooperate. Patient 1 was suspended and referred to the employee assistance program. Additionally, Patient 1 entered into a "Last Chance Discipline Abeyance Agreement." However, Patient 1 was involved in an impairment-related automobile accident in December 2006. Thereafter, Patient 1 resigned from the Whitehall Police Department. (Tr. at 768, 771, 773-775, 777-785, 789; Resp. Ex. K)

88. Detective Craig Feeney with the Mount Vernon Police Department testified that he became involved in a criminal investigation of Patient 1 after her automobile accident in December 2006. At the time of that accident, the police discovered several prescriptions in Patient 1's automobile. Also, the police obtained an OARRS report and interviewed Patient 1 in December 2006. Detective Feeney stated that Patient 1 intended, at that time, to seek rehabilitation. (Tr. at 680, 684-685, 691-692, 709, 722; Resp. Ex. M)
89. Detective Feeney testified that, later, Patient 1 came voluntarily to him to talk. In the following exchange, he explained their second conversation:

A. [Det. Feeney:] Well, yeah. She said she had a -- a narcotic problem; that she was taking 15 to 20 oxycodone at a time twice a day. And during that conversation, she said that -- that she was having sexual relations with the doctor to obtain more drugs.

Q. [Mr. McGovern:] Okay. Did she, during the course of that interview, admit to what you have described as deception to obtain drugs from multiple prescribing physicians?

A. Yes.

Q. Okay. And was one of those physicians the physician that she referenced having sexual relations with?

A. Yes.

Q. Okay. When she offered you the information regarding having sexual relations with -- with one of her physicians, what was your response to obtaining that information?

A. Well, we talked a little bit. And, basically, at that point I told her, you know, I was thinking that -- at that point that the Medical Board should be in, and then contacted Joe DePolo of the Medical Board and advised him of the situation.

And in that same time frame, I also contacted Jennifer Springer, Assistant Prosecutor, Common Pleas Prosecutor Jennifer Springer, and -- and referenced the material or the information that I got to her.

\* \* \*

Q. Did you ever have a meeting with Mr. DePolo and Patient No. 1?

A. Yes. Mr. DePolo came in. I called him. She was in my office, he came in. Briefly discussed with him what we had. She said that there were -- that she had saved e-mails that were back and forth from the said doctor, and -- and then provided those or -- or used my computer to pull her e-mail account up so she could show Mr. DePolo those e-mails.

Q. Okay. And what, if anything, did Mr. DePolo do while he was reviewing the e-mails?

A. I know he just reviewed some of the e-mails. During their conversation, I left. And then when I came back, he told me that he was going to go ahead and -- and further the investigation and handle that side of it.

(Tr. at 694-696)

90. In June 2008, Detective Feeney brought the case to Jennifer Springer in the Knox County Prosecutor's Office. The Prosecutor's Office elected to pursue criminal charges. In August 2008, a criminal indictment was filed in *State of Ohio v. [Patient 1]* in the Knox County Court of Common Pleas, alleging numerous counts of deception to obtain a dangerous drug. (Tr. at 705, 720, 722; Resp. Ex. J)

A plea agreement was agreed upon in the criminal matter, but Patient 1 was not sentenced. She died on February 9, 2009, from a Fentanyl overdose. The criminal case was dismissed after Patient 1's death. (Tr. at 706, 731; St. Ex. 9; Resp. Ex. J at 1-5)

91. Detective Feeney and Ms. Springer described Patient 1's actions as one of the worst/biggest cases of deception to obtain a dangerous drug.<sup>16</sup> They acknowledged that any cooperation by Patient 1 with the Board was going to be taken into consideration for sentencing in the criminal matter. (Tr. at 695-696, 700, 702, 723, 730)

#### **Testimony of Michael S. Schottenstein, M.D.**

92. Dr. Schottenstein is Dr. McGriff's psychiatrist.<sup>17</sup> He has been in private practice since 1997 in the Columbus area. He provides psychotropic medication management, as well as counseling, for children, adolescents and adults. (Tr. at 994)

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<sup>16</sup>Additional confirmation of Patient 1's "doctor shopping" activities during this time period is set forth in Respondent Exhibits L and M at 16-19.

<sup>17</sup>Dr. Schottenstein's education and background are set forth in the transcript. (Tr. at 993-994)

(There is no allegation of impairment in the Notice of Opportunity for Hearing in this matter. Accordingly, impairment is *not* at issue in this case. Dr. Schottenstein's testimony relates to Dr. McGriff's disclosure of the events involving Patient 1, Dr. McGriff's understanding of what led to the events with Patient 1, and his current well-being. Dr. Schottenstein also expressed his own opinion as to what led to the events with Patient 1.)

93. Dr. Schottenstein first saw Dr. McGriff in August 2004, and thereafter continually treated Dr. McGriff's ADHD and depression.<sup>18</sup> Dr. Schottenstein testified that his care and treatment of Dr. McGriff appeared to be going well and that Dr. McGriff seemed stable, overall. In October 2008, Dr. McGriff disclosed to Dr. Schottenstein that he had exchanged e-mails with a patient, had sexual relations with that patient, and that she had followed him in order to get medications. Dr. Schottenstein stated that Dr. McGriff was remorseful. (Tr. at 994, 1006-1007, 1015) Dr. Schottenstein described Dr. McGriff's demeanor at that time:

It was sort of a kicking himself kind of remorseful. Almost like the situation had gotten out from under him and he -- you know, he was a bit bewildered by it all, I think. And certainly regretful that -- that things had come to that.

I think there was, you know, especially looking back, I think there was an element of wishful thinking on his part, just sort of hoping it would all go away. And definitely a feeling on his part like he had made an error in judgment.

(Tr. at 1007-1008)

94. Dr. Schottenstein noted that he was surprised by Dr. McGriff's disclosure. He evaluated Dr. McGriff and determined that no underlying psychiatric condition contributed to Dr. McGriff's actions. He did not find that any predatory actions on Dr. McGriff's part were involved. Dr. Schottenstein concluded that Dr. McGriff had not maintained a strong boundary with Patient 1. (Tr. at 1008-1011)
95. Dr. Schottenstein noted that Dr. McGriff has personally and professionally handled the disclosure of the events with Patient 1. He considers the events with Patient 1 to be isolated behavior. He further believes that Dr. McGriff has the necessary tools to deal with any future problems. (Tr. at 1012-1014, 1019-1022) Dr. Schottenstein testified as follows:

And I think that when we had that conversation, he expressed a very substantial amount of regret and remorse. He indicated that, you know, when I -- when I had that conversation with him, he felt very badly about that to the effect that there was the possibility that returning someone else's affections that way in the professional setting could actually make somebody feel badly. I -- I don't think he really fully appreciated the nature of the behavior that he was engaging in in that respect.

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<sup>18</sup>Dr. Schottenstein diagnosed ADHD inattentive type, and episodic major depression in late partial remission. He prescribed Effexor, Concerta and counseling. Dr. Schottenstein stated that Dr. McGriff has complied with his treatment recommendations (Tr. at 997-998, 1003-1005, 1035)

And so what I -- what I tried to do was help provide some insight and some food for thought in terms of why it's never okay, essentially, to engage in that kind of behavior. Unfortunately, it's always possible for emotions to cloud the judgment.

I think that Dr. McGriff had the sense that, you know, it was okay on some level because the patient, Patient No. 1, potentially had a lot to lose if there was discovery of this relationship, and -- and that that on some level sort of made it okay, it sort of made it their -- you know, their mutual secret. And what we -- you know, what I tried to convey to him and help him understand, and I think he did, I think he got it, is that it's just never okay under any circumstances whatsoever.

\* \* \*

In that respect, I really don't -- and, of course, I can't make any guarantees, but I really don't foresee a future problem in terms of, again, there being any kind of predatory aspect of his behavior. It seemed very much more like a boundary issue.

It seemed as we continued to explore the boundary issue and as Dr. McGriff continued to take his courses, that it very much sank in in terms of -- in terms of what he was learning in terms of the propriety of those kinds of behaviors.

In addition, being married now, I don't think that that is activity that he would engage in just by virtue of his -- of his current marriage.

(Tr. at 1015-1018)

#### **Courses Taken**

96. Dr. McGriff attended a course entitled "Medical Ethics, Boundaries and Professionalism" on September 2-3, 2010, at Case Western Reserve University, in Cleveland, Ohio. Dr. McGriff presented a summary of the course and its agenda. He noted that he is very aware of the boundaries with patients and appropriate documentation. Moreover, Dr. McGriff stated that his practice of medicine has already benefitted as a result of taking the course. (Tr. at 1117-1119; Resp. Ex. F; Resp. Ex. P at 1)
97. Dr. McGriff attended a course entitled "Prescribing Controlled Drugs" on November 10-12, 2010, at Vanderbilt University in Nashville, Tennessee. Dr. McGriff presented a summary of the course and its agenda. He explained that, among other things, he learned the importance of making the plan of treatment clear, setting forth the reasons for prescribing medications, and ensuring that the documentation is in the chart. Dr. McGriff noted that this course also was helpful for distinguishing between medication-tolerant patients and addicted patients. Additionally, he believes this course will benefit his practice of medicine. (Tr. at 1117, 1120, 1192-1193; Resp. Ex. G; Resp. Ex. P at 2)

98. Dr. Shatzer stated that Dr. McGriff should benefit from attending the controlled substances and boundaries courses that he attended. He further stated that the courses will help provide Dr. McGriff to avoid similar problems in the future. (Tr. at 368-369)

**Testimony of Ann M. Urbank, CNP**

99. Ann M. Urbank, CNP, was employed at OHC at the same time as Dr. McGriff. She stated that, at the time, the patients requested the provider that they wanted to see. (Tr. at 744, 745, 750)
100. Ms. Urbank stated that Dr. McGriff was very helpful to her clinically. Ms. Urbank noted that she turned to Dr. McGriff regularly for assistance and she would rate him, as a physician, as an “eight out of ten.” She noted that the patients and staff liked him too. (Tr. at 754-756)
101. Ms. Urbank opined that the record-keeping at OHC allowed for good continuity of care, and stated that she did not have trouble following Dr. McGriff’s records “once I got to understand and decrypt his writing.” (Tr. at 751)

**Testimony of Amber Yelder**

102. Amber Yelder is a medical assistant at CSMC. She is currently Dr. McGriff’s assistant and works side-by-side with him. Ms. Yelder stated that she has not ever observed Dr. McGriff having inappropriate communications or interactions with any of his patients. Ms. Yelder noted that Dr. McGriff has refused to prescribe certain medication without proof of a diagnosis that supports the medication, which has angered some patients. She believes that the patients, colleagues and staff at CSMC respect and like Dr. McGriff. She described him as very professional, intelligent and thorough. She also noted that Dr. McGriff is kindhearted and humorous. Ms. Yelder stated that she is not aware of any performance concerns with Dr. McGriff, and she has recommended him as a physician to family and friends. (Tr. at 793, 798-802)

**Additional Testimony**

103. Dr. Simpson, Dr. Shatzer, Detective Feeney and Ms. Springer acknowledged that Patient 1 was a deceptive patient who obtained numerous drugs from numerous providers and used numerous pharmacies. Dr. Simpson agreed that it was reasonable to find that Dr. McGriff was deceived by Patient 1. Dr. Shatzer noted that Patient 1 did not accurately describe her medications and “doctor-shopped.” (Tr. at 252-253, 293, 366-367, 376, 702, 724)
104. Detective Feeney noted that it was easier for Patient 1 to deceive physicians in 2004 and 2005 because the OARRS reports were not available until 2006. (Tr. at 707-708)
105. Both Dr. Shatzer and Dr. McGriff stated that there was no connection between Dr. McGriff’s prescribing to Patient 1 and her death in 2009. (Tr. at 367, 1116; Resp. Ex. A at 3)
106. Mr. DePolo interviewed Dr. McGriff. Mr. DePolo explained that he confronted Dr. McGriff with information regarding the relationship with Patient 1. Mr. DePolo and Dr. McGriff both

stated that, at first, Dr. McGriff “beat around the bush,” but quickly cooperated with Mr. DePolo and “came clean” regarding his relationship with Patient 1. (Tr. at 431, 1135)

107. Dr. McGriff expressed his remorse for his actions. He noted that he has learned a great deal from the entire experience. Dr. McGriff believes that the events with Patient 1 were an isolated occurrence, and stated that he will not do those things in the future. He explained that his current employer, wife and Dr. Schottenstein are available supports for him. Also, Dr. McGriff testified that he has learned a great deal from the two classes that he attended and from discussions with Dr. Schottenstein. (Tr. at 1117, 1127-1129, 1133-1134, 1145-1146)
108. Dr. McGriff stated that he hopes to be able to continue to practice medicine. (Tr. at 1136)

### FINDINGS OF FACT

1. From December 2004 to October 2007, Patrick Kelley McGriff, D.O., undertook the care of Patient 1.
2. In October 2008, Dr. McGriff stated under oath that: (a) despite his on-going physician-patient relationship with Patient 1, he had engaged in sexual intercourse with Patient 1 in October 2006; (b) while attending a concert, he had lifted up Patient 1’s shirt and had exposed her breasts; and (c) he had sent e-mails to Patient 1 and also received e-mails from Patient 1 that were sexually explicit.
3. In the regular course of clinical treatment of Patient 1, Dr. McGriff did the following:
  - a.
    - i. Although Patient 1 had signed a medication management agreement in December 2004, Dr. McGriff failed to enforce and/or failed to document enforcement of that agreement.
    - ii. Dr. McGriff failed to properly follow-up and/or document proper follow-up regarding unusual medication utilization reports and/or unacceptable urine screens. For example, at the time Dr. McGriff was prescribing narcotic medications to Patient 1, the patient was also obtaining narcotic medications from other sources, and Dr. McGriff also received several notices from an insurance provider that noted unusual utilization patterns by the patient in receiving narcotic medications. In addition, while Dr. McGriff had Patient 1 provide drug screens, those screens revealed that no narcotic medications were in the patient’s system even though Dr. McGriff was prescribing such medications to her, and/or showed evidence of a medication other than that prescribed by Dr. McGriff.
  - b. In February 2006, Patient 1 had a near-fatal liver failure. During the course of Dr. McGriff’s treatment of Patient 1, he regularly prescribed Lortab 5/500, and if Patient 1 took the medication as prescribed, the patient would have been

taking 4,000 mg to almost 8,000 mg of acetaminophen per day. However, Patient 1's medical records do not indicate that this high use of acetaminophen was adequately addressed by Dr. McGriff. Further, while Dr. McGriff's progress note of May 24, 2005, mentions the AST/ALT ratio with an arrow pointing up, no further mention of the abnormal liver test is noted in the chart, and there is no documentation that the abnormal liver function was further followed-up.

The preponderance of the evidence supports a finding that Dr. McGriff wrote "AST/ALT ↑" in the May 24, 2005, progress note, and was aware at the time of the elevated liver enzymes. The handwriting for "AST/ALT ↑" is consistent with Dr. McGriff's handwriting, the progress note (after the medical assistant's introductory information) is written entirely in the same ink, and there is no explanation for why "AST/ALT ↑" would have been inserted in that progress note at a later time.

- c. Dr. McGriff's medical documentation in the OHC patient chart was generally inadequate, as the records were not clear, concise or complete. For example, the office visit notes generally were unrevealing in nature as to the care that was received, and the overall plan for treatment of Patient 1. Even when there was a change in medication, as noted on the medication flow sheet, there is little or no information in the progress note. In addition, the office visit notes were poorly legible.
4. In December 2006, Dr. McGriff prescribed and/or called in a prescription for a controlled substance for Patient 1, but he failed to complete and/or maintain any medical records of the same.

#### CONCLUSIONS OF LAW

1. The acts, conduct, and/or omissions of Patrick Kelley McGriff, D.O., as set forth in Findings of Fact 1 and 2, individually and/or collectively, constitute "[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association \* \* \*," as set forth in Section 4731.22(B)(18), Ohio Revised Code, to wit: American Osteopathic Association of Ethics, Section 15.
2. Dr. McGriff's acts, conduct, and/or omissions, as set forth in Findings of Fact 1 through 4, 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.

This conclusion is based on the following: Dr. McGriff admitted that the sexual intercourse, exposing Patient 1's breasts, and e-mails were violations of the standard of care. Although he responded to an extent to Patient 1's noncompliance with the medication management

agreements, he admitted that his actions nevertheless amounted to a failure to enforce the agreements. He agreed that his response to the second utilization report, if he had seen it, was inadequate, and his response to two urine screens was inadequate. In addition, Dr. Simpson testified convincingly that Dr. McGriff's failure to enforce the medication management agreements amounted to a failure to conform to the standard of care. Drs. Simpson and Shatzer both agreed that Dr. McGriff excessively prescribed acetaminophen to Patient 1, and Dr. McGriff did not adequately address the acetaminophen prescriptions. OHC's medical record establishes that Dr. McGriff did not follow up on the May 2005 elevated liver enzymes. Next, the OHC chart has poor legibility, was not clear regarding the nature of care provided, was not clear regarding the overall plan for treatment for Patient 1 and was not clear regarding changes in treatment, particularly medication changes. Drs. Simpson and Shatzer both testified that the OHC chart did not adequately communicate the care and treatment of Patient 1. Finally, Drs. Simpson, Shatzer and McGriff testified that it was below the standard of care for Dr. McGriff to have prescribed to Patient 1 in December 2006. Drs. Simpson and Shatzer also testified that his failure to document the prescriptions issued to Patient 1 in December 2006 was a violation of the standard of care as well.

3. Dr. McGriff's acts, conduct, and/or omissions, as set forth in Finding of Fact 4, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of [Chapter 4731] or any rule promulgated by the board," as set forth in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also constitutes violation of Sections 4731.22(B)(2) and (B)(6), Ohio Revised Code.

### **Rationale for the Proposed Order**

On many levels, Dr. McGriff did not provide minimal care and treatment of Patient 1 between December 2004 and October 2007. His argument that his errors amount to one isolated incident is not convincing. Although this matter involved only one patient, Dr. McGriff made *numerous* errors morally, ethically and professionally over the course of Patient 1's treatment. Moreover, Dr. McGriff testified that he understood at the time that a number of his actions with Patient 1 were inappropriate and he nonetheless acted inappropriately. Plus, his errors occurred over a lengthy period of time and over the course of his treatment of Patient 1. The evidence strongly demonstrates that this is not a "physician as predator" situation. However, among other things, there was a failure on Dr. McGriff's part to maintain an appropriate physician-patient boundary. Therefore, disciplinary action by the Board is warranted.

In this matter, there are a number of aggravating factors: a pattern of sexual misconduct, knowing misconduct, reckless misconduct (particularly with regard to the failure to enforce the MMA and the failure to follow-up on an unusual medication utilization report, the urine screens, and the AST/ALT levels), multiple different violations, selfish motives, and an adverse impact on Patient 1, who was a vulnerable person.

The mitigating factors include: (1) Dr. McGriff has no prior disciplinary record; (2) Dr. McGriff has great remorse for his errors; (3) Dr. McGriff has taken two courses specifically designed to improve his understanding of boundary issues and controlled substance prescribing, and both courses have been approved by the Board in the past; (4) Dr. McGriff currently has a personal support system in place to help him avoid recurrences of any of these issues; (5) Dr. McGriff was cooperative with the Board investigation; and (6) Dr. McGriff was one of many medical professionals deceived and manipulated by Patient 1.

Dr. McGriff's professional knowledge and judgment are questionable. Although education would improve Dr. McGriff and he has already demonstrated that he is receptive to further education, his professional judgment and decision-making cannot be trusted. Accordingly, permanent revocation is recommended.

**PROPOSED ORDER**

It is hereby ORDERED, that:

The certificate of Patrick Kelley McGriff, D.O., to practice osteopathic medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

  
Gretchen L. Petrucci  
Hearing Examiner

# State Medical Board of Ohio

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

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## EXCERPT FROM THE DRAFT MINUTES OF MARCH 9, 2011

### REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Suppan announced that the Board would now consider the Reports and Recommendations, and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Suppan asked whether each member of the Board had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law, Proposed Orders, and any objections filed in the matters of: Hany Ezzat Hannallah, M.D.; Dominic Joseph Maga, D.O.; Patrick Kelley McGriff, D.O.; Pedro S. Montano, M.D.; Christina E. Noga; and Ernesto Compendio Tan, M.D. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Mr. Albert	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Amato	- aye
	Dr. Ramprasad	- aye

Dr. Suppan asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Mr. Albert	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Amato	- aye
	Dr. Ramprasad	- aye

Dr. Suppan noted that, in accordance with the provision in section 4731.22(F)(2), Ohio Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in

further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member. In addition, Dr. Amato served as Acting Supervising Member in the cases of Pedro S. Montano, M.D., and Christina E. Noga. Therefore, Dr. Amato cannot vote in those matters. However, all Board members may vote on the matter of Hany Ezzat Hannallah, M.D., as that case is not disciplinary in nature and only involves the respondent's qualifications for licensure.

Dr. Suppan reminded all parties that no oral motions may be made during these proceedings.

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

.....  
PATRICK KELLEY MCGRUFF, D.O., Case No. 09-CRF-157  
.....

**Dr. Madia moved to approve and confirm Ms. Petrucci's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Patrick Kelley McGriff, D.O. Mr. Hairston seconded the motion.**

.....  
A vote was taken on Dr. Madia's motion to approve:

ROLL CALL:	Dr. Strafford	- nay
	Mr. Hairston	- aye
	Dr. Stephens	- nay
	Dr. Mahajan	- nay
	Dr. Steinbergh	- nay
	Dr. Suppan	- aye
	Mr. Albert	- abstain
	Dr. Madia	- aye
	Dr. Talmage	- abstain
	Dr. Amato	- abstain
	Dr. Ramprasad	- nay

The motion to approve did not carry. The Proposed Order was disapproved.

**Dr. Steinbergh moved to adopt the Findings of Fact and Conclusions of Law contained in Ms. Petrucci's Report and Recommendation. Dr. Steinbergh moved to approve the following Order:**

It is hereby ORDERED that:

- A. **PERMANENT REVOCATION, STAYED; SUSPENSION:** The certificate of Patrick Kelley McGriff, D.O., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such revocation is STAYED, and Dr. McGriff's certificate shall be SUSPENDED for an indefinite period of time, but not less than one year.
- B. **INTERIM MONITORING:** During the period that Dr. McGriff's certificate to practice medicine and surgery in Ohio is suspended, Dr. McGriff shall comply with the following terms, conditions, and limitations:
1. **Obey the Law:** Dr. McGriff shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
  2. **Personal Appearances:** Dr. McGriff shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, 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.
  3. **Declarations of Compliance:** Dr. McGriff 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 this Order becomes effective. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
  4. **Required Reporting of Change of Address:** Dr. McGriff shall notify the Board in writing of any change of residence address and/or principal practice address within 30 days of the change.
- C. **CONDITIONS FOR REINSTATEMENT OR RESTORATION:** The Board shall not consider reinstatement or restoration of Dr. McGriff's certificate to practice medicine and surgery until all of the following conditions have been met:
1. **Application for Reinstatement or Restoration:** Dr. McGriff shall submit an application for reinstatement or restoration, accompanied by appropriate fees, if any.

2. **Compliance with Interim Conditions**: Dr. McGriff shall have maintained compliance with all the terms and conditions set forth in Paragraph B. of this Order.
  
3. **Controlled Substances Prescribing Course(s)**: At the time he submits his application for reinstatement or restoration, Dr. McGriff shall submit acceptable documentation of successful completion of a controlled substances prescribing course or courses. 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. However, documentation of successful completion of the November 10-12, 2010 course on “Prescribing Controlled Drugs” at Vanderbilt University in Nashville, Tennessee, may be submitted to satisfy this course requirement. 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. McGriff 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.

4. **Physician/Patient Boundaries Course(s)**: At the time he submits his application for reinstatement or restoration, Dr. McGriff shall submit acceptable documentation of successful completion of a course or courses on maintaining physician/patient boundaries. 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. However, documentation of successful completion of the September 2-3, 2010 “Medical Ethics, Boundaries and Professionalism” course at Case Western Reserve University in Cleveland, Ohio, may be submitted to satisfy this course requirement. 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. McGriff submits the documentation of successful completion of the course(s) on maintaining physician/patient boundaries, 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. **Medical Records Course(s)**: At the time he submits his application for reinstatement or restoration, Dr. McGriff shall submit acceptable documentation of successful completion of a course or courses on maintaining adequate and appropriate medical records. 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. McGriff submits the documentation of successful completion of the course(s) on maintaining adequate and appropriate medical records, 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. **Additional Evidence of Fitness To Resume Practice**: In the event that Dr. McGriff has not been engaged in the active practice of medicine and surgery for a period in excess of two years prior to application for reinstatement or restoration, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of his fitness to resume practice.

D. **PROBATION**: Upon reinstatement or restoration, Dr. McGriff's certificate shall be subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least four years:

1. **Terms, Conditions, and Limitations Continued from Suspension Period**: Dr. McGriff shall continue to be subject to the terms, conditions, and limitations specified in Paragraph B of this Order.
2. **Practice Plan**: Within 30 days of the date of Dr. McGriff's reinstatement or restoration, or as otherwise determined by the Board, Dr. McGriff shall submit to the Board and receive its approval for a plan of practice in Ohio. The practice plan, unless otherwise determined by the Board, shall be limited to a supervised structured environment in which Dr. McGriff's activities will be directly supervised and overseen by a monitoring physician approved by the Board. Dr. McGriff shall obtain the Board's prior approval for any alteration to the practice plan approved pursuant to this Order.

At the time Dr. McGriff submits his practice plan, he shall also 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. McGriff and who is engaged in the same or similar practice specialty.

The monitoring physician shall monitor Dr. McGriff and his medical practice, and shall review Dr. McGriff'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. McGriff and his medical practice, and on the review of Dr. McGriff's patient charts. Dr. McGriff 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. McGriff's declarations of compliance.

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. McGriff shall immediately so notify the Board in writing. In addition, Dr. McGriff 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. McGriff 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. McGriff's monitoring physician, or may withdraw its approval of any physician previously approved to serve as Dr. McGriff'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.

3. **Tolling of Probationary Period While Out of Compliance:** In the event Dr. McGriff 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.

- E. **TERMINATION OF PROBATION:** Upon successful completion of probation, as evidenced by a written release from the Board, Dr. McGriff's certificate will be fully restored.
- F. **VIOLATION OF THE TERMS OF THIS ORDER:** If Dr. McGriff 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.
- G. **REQUIRED REPORTING WITHIN 30 DAYS OF THE EFFECTIVE DATE OF THIS ORDER:**

- 1. **Required Reporting to Employers and Others:** Within 30 days of the effective date of this Order, Dr. McGriff shall provide a copy of this Order to all employers or entities with which he is under contract to provide healthcare 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. McGriff shall promptly provide a copy of this Order to all employers or entities with which he contracts in the future to provide healthcare 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. McGriff receives from the Board written notification of the successful completion of his probation.

In the event that Dr. McGriff 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, he 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. McGriff receives from the Board written notification of the successful completion of his probation.

- 2. **Required Reporting to Other State Licensing Authorities:** Within 30 days of the effective date of this Order, Dr. McGriff 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 professional license or certificate. Also, Dr. McGriff shall provide a copy of this Order at the time of application to the proper licensing authority of any state or jurisdiction in which he applies for any professional license or reinstatement/restoration of any professional license. This

requirement shall continue until Dr. McGriff receives from the Board written notification of the successful completion of his probation.

3. **Required Documentation of the Reporting Required by Paragraph G:**  
Dr. McGriff shall provide this Board with **one** of the following documents as proof of each required notification within 30 days of the date of each such notification: (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 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.

**EFFECTIVE DATE OF ORDER:** This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

**Dr. Mahajan seconded the motion.**

.....  
A vote was taken on Dr. Steinbergh's motion to approve:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- nay
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Suppan	- aye
	Mr. Albert	- abstain
	Dr. Madia	- nay
	Dr. Talmage	- abstain
	Dr. Amato	- abstain
	Dr. Ramprasad	- aye

The motion to approve carried.



# State Medical Board of Ohio

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

Richard A. Whitehouse, Esq.  
Executive Director

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December 9, 2009

Case number: 09-CRF- 157

Patrick Kelley McGriff, D.O.  
8291 Tegmen Street  
Columbus, OH 43240

Dear Doctor McGriff:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) From in or around December 2004 to in or around October 2007, you undertook the care of Patient 1, as identified in the attached Patient Key (Key is confidential and shall be withheld from public disclosure).
- (2) Despite your on-going physician-patient relationship with Patient 1, in or around October 2008, you stated under oath that you engaged in sexual intercourse with Patient 1 in or around October 2006. You also stated under oath that while attending a concert in early 2006, you lifted up Patient 1's shirt and exposed her breasts. You further stated under oath that you sent e-mails to Patient 1 and also received e-mails from Patient 1 that were sexually explicit.
- (3) Further, in the regular course of your clinical treatment of Patient 1, you practiced below minimal standards of care, including, but not limited to, the following:
  - (a) Although Patient 1 signed a medication management agreement in or around December 2004, you failed to enforce and/or failed to document enforcement of that agreement. In addition, you failed to properly follow-up and/or document proper follow-up regarding unusual medication utilization reports and/or unacceptable urine screens. For example, at the time you were prescribing narcotic medications to Patient 1, the patient was also obtaining narcotic medications from other sources, and you also received several notices from an insurance provider that noted unusual utilization patterns by the

*Mailed 12-10-09*

patient in receiving narcotic medications. In addition, while you had Patient 1 provide drug screens, those screens revealed that no narcotic medications were in the patient's system even though you were prescribing such medications to her, and/or showed evidence of a medication other than that prescribed by you.

- (b) In or around February 2006, Patient 1 had a near-fatal liver failure. During the course of your treatment of Patient 1, you regularly prescribed Lortab 5/500, and if Patient 1 took the medication as prescribed, the patient would have been taking up to almost 8000 mg of acetaminophen per day. However, Patient 1's medical records do not indicate that this high use of acetaminophen was adequately addressed by you. Further, while your progress note of May 24, 2005 mentions the AST/ALT ratio with an arrow pointing up, no further mention of the abnormal liver test is noted in the chart, and there is no documentation that the abnormal liver function was further followed-up.
  - (c) Your medical documentation in the patient chart was generally inadequate, as the records were not clear, concise or complete. For example, the office visit notes generally were unrevealing in nature as to the care that was received, and the overall plan for treatment of Patient 1. Even when there was a change in medication, as noted on the medication flow sheet, there is little or no information in the progress note. In addition, the office visit notes were poorly legible and/or generally illegible.
- (4) In or around December 2006, you prescribed and/or called in a prescription for a controlled substance for Patient 1, but you failed to complete and/or maintain any medical records of the same.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[v]iolation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule," as that clause is used in Section 4731.22(B)(18), Ohio Revised Code, to wit: American Osteopathic Association, Code of Ethics, Section 15.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) through (4) above, 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 that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraph (4) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Rule 4731-11-02(D), Ohio

Administrative Code. Pursuant to Rule 4731-11-02(F), Ohio Administrative Code, violation of Rule 4731-11-02(D), Ohio Administrative Code, also constitutes violation of Sections 4731.22(B)(2) and (B)(6), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice osteopathic medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that “[w]hen the board refuses to grant a certificate to an applicant, revokes an individual’s certificate to practice, refuses to register an applicant, or refuses to reinstate an individual’s certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate.”

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.  
Secretary

LAT/MRB/flb  
Enclosures

CERTIFIED MAIL #91 7108 2133 3936 3072 2514  
RETURN RECEIPT REQUESTED

Patrick Kelley McGriff, D.O.

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cc: James M. McGovern, Esq.  
Graff & Associates, LPA  
604 East Rich Street  
Columbus, Ohio 43215

CERTIFIED MAIL #91 7108 2133 3936 3070 9003  
RETURN RECEIPT REQUESTED

**IN THE MATTER OF  
PATRICK KELLEY MCGRIFF, D.O.**

**09-CRF-158**

**DECEMBER 9, 2009 NOTICE OF  
OPPORTUNITY FOR HEARING  
PATIENT KEY**

**SEALED TO  
PROTECT PATIENT  
CONFIDENTIALITY AND  
MAINTAINED IN CASE  
RECORD FILE.**