

**STEP II
CONSENT AGREEMENT
BETWEEN
BRIAN FREDERIC GRIFFIN, M.D.,
AND
THE STATE MEDICAL BOARD OF OHIO**

This Consent Agreement is entered into by and between Brian Frederic Griffin, M.D., [Dr. Griffin], and the State Medical Board of Ohio [Board], a state agency charged with enforcing Chapter 4731., Ohio Revised Code.

Dr. Griffin enters into this Consent Agreement being fully informed of his rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

BASIS FOR ACTION

This Consent Agreement is entered into on the basis of the following stipulations, admissions and understandings:

- A. The Board is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for violation of Section 4731.22(B)(26), Ohio Revised Code, for “[i]mpairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice;” and/or Section 4731.22(B)(15), Ohio Revised Code, for “[v]iolation of the conditions of limitation placed by the board upon a certificate to practice.”
- B. The Board enters into this Consent Agreement in lieu of formal proceedings based upon the violation of Sections 4731.22(B)(15) and (B)(26), Ohio Revised Code, as set forth in Paragraph E below, and expressly reserves the right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Consent Agreement.
- C. Dr. Griffin is seeking reinstatement of his certificate to practice medicine and surgery, License Number 35.044328, which was indefinitely suspended, but not less than 90 days, pursuant to the Step I Consent Agreement between Brian Frederic Griffin, M.D. and the State Medical Board of Ohio, effective June 13, 2012 [June 2012 Step I Consent Agreement], a copy of which is attached hereto and incorporated herein.
- D. Dr. Griffin states that he is not licensed to practice in any other state or jurisdiction.

STATE MEDICAL BOARD
OF OHIO
2013 JAN -8 AM 11:08

- E. Dr. Griffin admits that after entering residential treatment for chemical dependency on or about May 24, 2012, at Glenbeigh Hospital, a Board-approved treatment provider in Rock Creek, Ohio, he was discharged, residential treatment complete, on or about June 21, 2012. Dr. Griffin states, and the Board acknowledges receipt of information to support, that since being discharged from residential treatment, he completed 72 sessions of intensive outpatient treatment with Cornerstone of Recovery in Columbus, Ohio, and furthermore, entered into a physician's aftercare contract with Glenbeigh Hospital on or about June 19, 2012. Dr. Griffin admits that the aforementioned physician's aftercare contract remains in effect.

Dr. Griffin states, and the Board acknowledges, that Nykolai V. Pidhorodeckyj, M.D., Medical Director at Glenbeigh Hospital, has provided a written report indicating that Dr. Griffin's ability to practice has been assessed and that he has been found capable of practicing according to acceptable and prevailing standards of care, so long as certain treatment and monitoring conditions are in place.

Dr. Griffin further states, and the Board acknowledges, that Harry P. Nguyen, M.D., a physician knowledgeable in the area of addictionology and approved by the Board to conduct an assessment of Dr. Griffin, has provided a written report indicating that Dr. Griffin's ability to practice has been assessed and that he has been found capable of practicing according to acceptable and prevailing standards of care, so long as certain treatment and monitoring conditions are in place.

Accordingly, Dr. Griffin states, and the Board acknowledges receipt of information to support, that Dr. Griffin has fulfilled the conditions for reinstatement of his certificate to practice medicine and surgery in the State of Ohio, as established in the above-referenced June 2012 Step I Consent Agreement between Dr. Griffin and the Board.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, the certificate of Dr. Griffin to practice medicine and surgery in the State of Ohio shall be REINSTATED, and Dr. Griffin knowingly and voluntarily agrees with the Board to the following PROBATIONARY terms, conditions and limitations:

1. Dr. Griffin shall obey all federal, state, and local laws, and all rules governing the practice of medicine in Ohio.
2. Dr. Griffin shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with the conditions of this Consent Agreement. The first quarterly declaration must be received in the Board's offices on the date his quarterly declaration would have been due pursuant to his June 2012 Consent Agreement with the Board, or as otherwise

2013 JAN -8 AM 11:08
STATE MEDICAL BOARD
OF OHIO

requested by the Board. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.

3. Dr. Griffin shall appear in person for an interview before the full Board or its designated representative. The first such appearance shall take place on the date his appearance would have been scheduled pursuant to his June 2012 Step I Consent Agreement with the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested by the Board. If an appearance is missed or is rescheduled for any reason, ensuing appearances shall be scheduled based on the appearance date as originally scheduled.
4. Dr. Griffin shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the probationary terms set forth in this Consent Agreement for occasional periods of absence of fourteen days or less. In the event that Dr. Griffin resides and/or is employed at a location that is within fifty miles of the geographic border of Ohio and any of its contiguous states, Dr. Griffin may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Griffin is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Consent Agreement.
5. In the event Dr. Griffin is found by the Secretary of the Board to have failed to comply with any provision of this Consent Agreement, 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 Consent Agreement.

MONITORING OF REHABILITATION AND TREATMENT

Drug Associated Restrictions

6. Dr. Griffin shall keep a log of all controlled substances prescribed. Such log shall be submitted, in the format approved by the Board, on the date upon which Dr. Griffin's quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Griffin shall make his patient records with regard to such prescribing available for review by an agent of the Board immediately upon request.
7. Dr. Griffin shall not, without prior Board approval, administer, personally furnish, or possess (except as allowed under Paragraph 8 below) any controlled substances as defined by state or federal law. In the event that the Board agrees at a future date to modify this Consent Agreement to allow Dr. Griffin to administer or personally

2013 JAN 28 AM 11:08

STATE MEDICAL BOARD
OF OHIO

furnish controlled substances, Dr. Griffin shall keep a log of all controlled substances prescribed, administered or personally furnished. Such log shall be submitted in the format approved by the Board and shall be submitted to the Board no later than the date upon which Dr. Griffin's quarterly declaration is due, or as otherwise directed by the Board. Further, Dr. Griffin shall make his patient records with regard to such prescribing, administering, or personally furnishing available for review by an agent of the Board immediately upon request.

Sobriety / Approval of Primary Care Physician

8. Dr. Griffin shall abstain completely from the personal use and/or personal possession of drugs, except those prescribed, dispensed or administered to him by Dr. Griffin's Board-approved primary care physician (as further described herein) who is so authorized by law; who has full knowledge of Dr. Griffin's history of chemical dependency, relapse, and current recovery status; and who shall agree to be responsible for coordinating Dr. Griffin's overall medical care as it relates to his personal use and/or personal possession of drugs. Additionally, should Dr. Griffin require healthcare services from any provider(s) other than his approved primary care physician, Dr. Griffin shall abstain completely from the personal use and/or personal possession of drugs, except those prescribed, dispensed or administered to him by another healthcare practitioner so authorized by law who has full knowledge of Dr. Griffin's history of chemical dependency, relapse, and current recovery status.

Prior to engaging in any medical practice, Dr. Griffin shall submit to the Board for its prior approval the name and curriculum vitae of a primary care physician of his choice, and concurrently shall provide the Board documentation, signed by both himself and the individual proposed to serve as Dr. Griffin's approved primary care physician, stating that such individual has: (1) received and reviewed a copy of this Consent Agreement; (2) understands the requirements pursuant to this Consent Agreement of serving as Dr. Griffin's primary care physician; and (3) agrees to serve as Dr. Griffin's primary care physician contingent upon approval by the Board. Dr. Griffin and the Board expressly agree that any physician who has been the subject of a disciplinary action by the Board is disqualified from serving as the approved primary care physician, and Dr. Griffin hereby acknowledges that any such attempted nomination shall be considered null and void and shall not be processed by the Board.

In order to ensure appropriate monitoring and coordination of all information concerning Dr. Griffin's sobriety and personal use and/or personal possession of drugs, in the event that Dr. Griffin is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol by his approved primary care physician, Dr. Griffin shall notify the Board in writing within seven days, stating that the drug was provided by his approved primary care physician; the name of the drug Dr. Griffin received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed,

STATE MEDICAL BOARD
OF OHIO
2013 JAN 8 8:31 AM EST

dispensed, or administered to him, Dr. Griffin shall provide the Board with either a copy of the written prescription or other written verification from the approved primary care physician, including the dosage, amount, number of refills, and directions for use. Furthermore, in the event that Dr. Griffin is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol by any healthcare practitioner other than his approved primary care physician, Dr. Griffin shall notify both the Board and his approved primary care physician in writing within seven days, providing the identity of the prescriber; the name of the drug Dr. Griffin received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him by any healthcare practitioner other than his approved primary care physician, Dr. Griffin shall provide both the Board and his approved primary care physician with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.

In addition, Dr. Griffin shall ensure that his approved primary care physician immediately notifies the Board of any failure by Dr. Griffin to comply with his treatment plan; of any use by Dr. Griffin of medications not prescribed, administered, or dispensed by the Board-approved primary care physician or another healthcare practitioner; and/or any excessive use or abuse of medications by Dr. Griffin, including any use not in conformance with the prescribing instructions and/or any use for a condition or purported condition other than the specific condition for which the drug was originally issued.

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

9. Dr. Griffin shall abstain completely from the use of alcohol.

Drug and Alcohol Screens/Drug Testing Facility and Collection Site

10. Dr. Griffin shall submit to random urine screenings for drugs and alcohol at least two times per month, or as otherwise directed by the Board. Dr. Griffin shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Griffin's drug(s) of choice.

2013 JAN -8 AM 11:08

STATE MEDICAL BOARD
OF OHIO

Dr. Griffin shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Griffin acknowledges that he understands that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Consent Agreement.

All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph 11 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

Dr. Griffin shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Griffin shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Consent Agreement. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Consent Agreement.

Further, within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Consent Agreement. Further, Dr. Griffin shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Griffin and the Board-approved drug testing facility and/or collection site. Dr. Griffin's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Consent Agreement. However, Dr. Griffin and the Board further agree that in the event Dr. Griffin previously entered into the aforementioned financial and contractual agreements pursuant to the requirements of a prior consent agreement with the Board under which Dr. Griffin is currently participating in an ongoing urine screening process, then this requirement shall be waived under the instant consent agreement.

2013 JAN 28 AM 11:08

STATE MEDICAL BOARD
OF OHIO

Dr. Griffin shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Griffin and the Board-approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Griffin shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Consent Agreement, Dr. Griffin must immediately notify the Board in writing, and make arrangements acceptable to the Board pursuant to Paragraph 11 below, as soon as practicable. Dr. Griffin shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

Dr. Griffin acknowledges that the Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

11. Dr. Griffin and the Board agree that it is the intent of this Consent Agreement that Dr. Griffin shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Griffin, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Griffin:
 - a. Within thirty days of the date upon which Dr. Griffin is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Griffin, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Griffin shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Griffin's residence or employment location, or to a physician who practices in the same

STATE MEDICAL BOARD
OF OHIO

2013 JAN 28 AM 11:08

locale as Dr. Griffin. Dr. Griffin shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Griffin acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

- b. Dr. Griffin shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.
- c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Griffin must immediately notify the Board in writing. Dr. Griffin shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Griffin shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Griffin.
- d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Griffin's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.
- e. In the event that the Board approved an alternate drug testing facility and/or collection site, or a supervising physician, pursuant to the June 2012 Step I Consent Agreement between Dr. Griffin and the Board, Dr. Griffin and the Board agree that the entity, facility or person previously approved by the Board to so serve pursuant to the June 2012 Step I Consent Agreement is hereby approved to continue as Dr. Griffin's designated alternate drug testing facility

STATE MEDICAL BOARD
OF OHIO
2013 JAN -8 AM 11:09

and collection site or as his supervising physician under this Consent Agreement.

12. All screening reports required under this Consent Agreement from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Griffin's quarterly declaration. It is Dr. Griffin's responsibility to ensure that reports are timely submitted.
13. The Board retains the right to require, and Dr. Griffin agrees to submit, blood, urine, breath, saliva and/or hair specimens for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Griffin, or for any other purpose, at Dr. Griffin's expense upon the Board's request and without prior notice. Dr. Griffin's refusal to submit a specimen upon request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary or Supervising Member of the Board.

Monitoring Physician

14. Before engaging in any medical practice, Dr. Griffin shall submit to the Board in writing the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Griffin and who is engaged in the same or similar practice specialty.

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

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

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Griffin must immediately so notify the Board in writing. In addition, Dr. Griffin shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Griffin shall 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.

2013 JAN - 8 AM 11:09
STATE MEDICAL BOARD
OF OHIO

The Board expressly reserves the right to disapprove any person proposed to serve as Dr. Griffin's designated monitoring physician, or to withdraw approval of any person previously approved to serve as Dr. Griffin's designated 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.

Rehabilitation Program

15. Dr. Griffin shall maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than three times per week. Substitution of any other specific program must receive prior Board approval.

Dr. Griffin shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Griffin's quarterly declarations.

Aftercare

16. Dr. Griffin shall contact an appropriate impaired physicians committee, approved by the Board, to arrange for assistance in recovery or aftercare.
17. Dr. Griffin shall maintain continued compliance with the terms of the aftercare contract entered into with a Board-approved treatment provider, provided that, where terms of the aftercare contract conflict with terms of this Consent Agreement, the terms of this Consent Agreement shall control.

2013 JAN -8 AM 11:09
STATE MEDICAL BOARD
OF OHIO

Releases

18. Dr. Griffin shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Griffin's chemical dependency or related conditions, or for purposes of complying with this Consent Agreement, whether such treatment or evaluation occurred before or after the effective date of this Consent Agreement. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Griffin further agrees to provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Consent Agreement.

Required Reporting by Licensee

19. Within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall provide a copy of this Consent Agreement to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Griffin shall promptly provide a copy of this Consent Agreement to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Griffin provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall provide a copy of this Consent Agreement to the Ohio Department of Public Safety, Division of Emergency Medical Services. Further, Dr. Griffin shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

20. Within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall provide a copy of this Consent Agreement to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. Griffin further agrees to provide a copy of this Consent Agreement at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license. Further, Dr. Griffin shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent

2013 JAN -8 AM 11:09

STATE MEDICAL BOARD
OF OHIO

Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

21. Dr. Griffin shall promptly provide a copy of this Consent Agreement to all persons and entities that provide Dr. Griffin chemical dependency treatment or monitoring. Further, Dr. Griffin shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.
22. Dr. Griffin shall notify the Board in writing of any change of principal practice address or residence address within thirty days of such change.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. Griffin appears to have violated or breached any term or condition of this Consent Agreement, the Board reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including, but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Consent Agreement.

If the Secretary and Supervising Member of the Board determine that there is clear and convincing evidence that Dr. Griffin has violated any term, condition or limitation of this Consent Agreement, Dr. Griffin agrees that the violation, as alleged, also constitutes clear and convincing evidence that his continued practice presents a danger of immediate and serious harm to the public for purposes of initiating a summary suspension pursuant to Section 4731.22(G), Ohio Revised Code.

DURATION/MODIFICATION OF TERMS

Dr. Griffin shall not request termination of this Consent Agreement for a minimum of five years. In addition, Dr. Griffin shall not request modification to the probationary terms, limitations, and conditions contained herein for at least one year, except that Dr. Griffin may make such request with the mutual approval and joint recommendation of the Secretary and Supervising Member. Otherwise, the above-described terms, limitations and conditions may be amended or terminated in writing at any time upon the agreement of both parties.

2013 JAN - 8 AM 11: 09
STATE MEDICAL BOARD
OF OHIO

In the event that the Board initiates future formal proceedings against Dr. Griffin, including but not limited to issuance of a Notice of Opportunity for Hearing, this Consent Agreement shall continue in full force and effect until such time that it is superseded by ratification by the Board of a subsequent Consent Agreement or issuance by the Board of a final Board Order.

In the event that any term, limitation, or condition contained in this Consent Agreement is determined to be invalid by a court of competent jurisdiction, Dr. Griffin and the Board agree that all other terms, limitations, and conditions contained in this Consent Agreement shall be unaffected.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. Griffin acknowledges that he has had an opportunity to ask questions concerning the terms of this Consent Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

Dr. Griffin hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data Griffin and governmental bodies. Dr. Griffin acknowledges that his social security number will be used if this information is so reported and agrees to provide his social security number to the Board for such purposes.

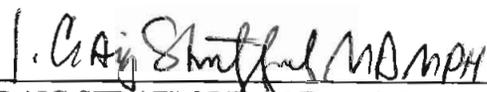
STATE MEDICAL BOARD
OF OHIO
2013 JAN -8 AM 11:09

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.



BRIAN FREDERIC GRIFFIN, M.D.



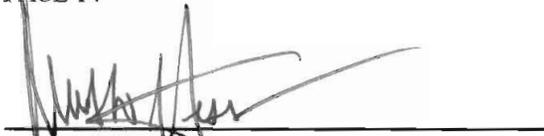
J. CRAIG STRAFFORD, M.D., M.P.H.
Secretary

1/4/2013

DATE

9 JAN, 2013

DATE



THOMAS W. HESS, ESQ.
Attorney for Dr. Griffin

1/7/13
DATE



MARK A. BECHTEL, M.D.
Supervising Member

1/9/2013
DATE



DANIEL S. ZINSMASTER, ESQ.
Enforcement Attorney

1/8/2013
DATE

STATE MEDICAL BOARD
OF OHIO
2013 JAN -8 AM 11:09

STEP I
CONSENT AGREEMENT
BETWEEN
BRIAN FREDERIC GRIFFIN, M.D.,
AND
THE STATE MEDICAL BOARD OF OHIO

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Dr. Griffin enters into this Consent Agreement being fully informed of his rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

BASIS FOR ACTION

This Consent Agreement is entered into on the basis of the following stipulations, admissions and understandings:

- A. The Board is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for violation of Section 4731.22(B)(26), Ohio Revised Code, for “[i]mpairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice;” and/or Section 4731.22(B)(15), Ohio Revised Code, based upon a “[v]iolation of the conditions of limitation placed by the board upon a certificate to practice.”
- B. The Board enters into this Consent Agreement in lieu of formal proceedings based upon the violation of Sections 4731.22(B)(15) and (B)(26), Ohio Revised Code, as set forth in Paragraphs E through H below, and expressly reserves the right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Agreement. Such express reservation includes, but is not limited to, violations based on any methods used by Dr. Griffin to obtain controlled substances or drugs for self-use other than as particularly described in Paragraphs E through H below, acts involving or related to patient care or otherwise involving others, and/or any future plea of guilty to, a judicial finding of guilt of, or a judicial finding of eligibility for intervention in lieu of conviction for, any criminal offense(s), regardless of whether the acts underlying such additional violations are related to the violations of Sections 4731.22(B)(15) and (26), Ohio Revised Code, as set forth below and described herein.

- C. Dr. Griffin is licensed to practice medicine and surgery in the State of Ohio, License Number 35.044328, subject to the terms, conditions and limitations set forth in the Entry or Order issued by the Board on or about August 13, 2008, as modified by the Board.
- D. Dr. Griffin states that he is not licensed to practice in any other state or jurisdiction.
- E. Dr. Griffin admits that on or about July 14, 1993, the Board immediately suspended his certificate to practice medicine and surgery [certificate] in Ohio based on his pleas of guilty in the Hamilton County Court of Common Pleas, Cincinnati, Ohio, and in the Franklin County Court of Common Pleas, Columbus, Ohio, to felony drug abuse offenses, namely Deception to Obtain a Dangerous Drug, for which he was granted treatment in lieu of conviction.

Dr. Griffin admits that on or about July 16, 1993, he entered into a Consent Agreement with the Board, staying the immediate suspension and imposing probationary terms, conditions and limitations on his certificate, based in part on his admissions that due to opiate dependence, as well as prior instances of inpatient treatment in or about 1992, he was impaired in his ability to practice in violation of Section 4731.22(B)(26), Ohio Revised Code.

Dr. Griffin further admits that on or about August 12, 1993, he entered into another Consent Agreement with the Board, terminating the stayed immediate suspension and imposing probationary terms, conditions and limitations on his certificate. Dr. Griffin states that on or about August 15, 1996, the Board released him from the terms of the August 12, 1993 Consent Agreement.

- F. Dr. Griffin admits that on or about August 13, 2008, the Board issued an Entry of Order [August 2008 Board Order], whereby he was found to have violated Section 4731.22(B)(6), Ohio Revised Code, based on the Board's determination that he failed to conform to minimal standards of care in rendering medical treatment, including the use of EDX studies and interventions in the practice of pain medicine. Dr. Griffin further admits that pursuant to the August 2008 Board Order, his certificate was permanently revoked, with said permanent revocation stayed, and he was placed on probation for a period of at least three years. Dr. Griffin acknowledges that he currently remains subject to the terms, conditions and limitations of the August 2008 Board Order, as modified by the Board, including Paragraph 1.a., which requires that him to obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
- G. Dr. Griffin admits that on or about May 14, 2012, as ordered by the Board, he entered Shepherd Hill Hospital [Shepherd Hill], a Board-approved treatment provider in Newark, Ohio, for the purpose of undergoing a 72-hour evaluation to determine whether he is in violation of Section 4731.22(B)(26), Ohio Revised Code. Dr. Griffin states that said order was based on, *inter alia*, his recent acknowledgment to Board staff that he had

consumed oxycodone in response to pain from a dental procedure in or about late January 2012. Dr. Griffin further acknowledged to Board staff that the controlled substances were not prescribed by his dentist or other health care professional in response to the dental procedure, but in fact, had been originally prescribed to him by a physician over a year prior for the treatment of back pain. Moreover, Dr. Griffin further admits that he has consumed additional controlled substances in recent weeks and months, which he had retained from previous prescriptions issued by his treatment providers from in or about May 2011 and before.

Dr. Griffin admits that as a result of his 72-hour evaluation, Richard N. Whitney, M.D., Medical Director at Shepherd Hill, opined that Dr. Griffin has suffered a relapse from the use of self-administered opiates and benzodiazepines, which Dr. Griffin acknowledges constitutes a violation of his August 2008 Board Order, as modified by the Board, *to wit*: Paragraph 1.a. Dr. Griffin further admits that he was diagnosed by Dr. Whitney with opiate and benzodiazepine dependence in active relapse, that he is currently impaired in his ability to practice medicine and surgery according to acceptable and prevailing standards of care, and that he was recommended to complete at least the minimum twenty-eight days of inpatient or residential treatment at a Board-approved provider.

Dr. Griffin states that on or about May 24, 2012, he entered Glenbeigh Hospital, a Board-approved treatment provider in Rock Creek, Ohio, for further treatment, to include a minimum of twenty-eight days of residential treatment.

- H. Dr. Griffin expressly asserts that he did not obtain any drugs or controlled substances for self-use related to his relapse by any method other than through the consumption of medications retained from previous prescriptions as described above. Further, Dr. Griffin specifically denies that he involved any patients or other individuals in obtaining drugs or controlled substances for Dr. Griffin's self-use. Further, Dr. Griffin states and acknowledges he understands that the Board has the authority to pursue by separate action any violations beyond Sections 4731.22(B)(15) and (26), Ohio Revised Code, including but not limited to, Sections 4731.22(B)(9) and/or 4731.22(B)(10), Ohio Revised Code, even if such violations arise from the same common nucleus of operative fact as outlined within this Consent Agreement addressing the issue of Dr. Griffin's impairment and relapse in violation of his current August 2008 Board Order. Dr. Griffin further states and acknowledges that he understands that subsequent Board Orders may supersede this Step I Consent Agreement and may result in further discipline, up to and including permanent revocation of his license to practice medicine in the State of Ohio.

AGREED CONDITIONS

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, Dr. Griffin knowingly and voluntarily agrees with the Board to the following terms, conditions and limitations:

SUSPENSION OF CERTIFICATE

1. The certificate of Dr. Griffin to practice medicine and surgery in the State of Ohio shall be SUSPENDED for an indefinite period of time, but not less than 90 days. The previous probationary terms, conditions and limitations stemming from the August 2008 Board Order, are hereby terminated upon the effective date of the instant Step I Consent Agreement.

Obey all Laws

2. Dr. Griffin shall obey all federal, state, and local laws.

Sobriety

3. Dr. Griffin shall abstain completely from the personal use or personal possession of drugs, except those prescribed, dispensed or administered to him after the effective date of this Consent Agreement by another so authorized by law who has full knowledge of Dr. Griffin's history of chemical dependency and relapse, and any portion of such drugs that remains unused upon resolution of the specific medical condition for which they were provided must be immediately discarded by Dr. Griffin. In the event that Dr. Griffin is so prescribed, dispensed or administered any controlled substance, carisoprodol, or tramadol, Dr. Griffin shall notify the Board in writing within seven days, providing the Board with the identity of the prescriber; the name of the drug Dr. Griffin received; the medical purpose for which he received said drug; the date such drug was initially received; and the dosage, amount, number of refills, and directions for use. Further, within thirty days of the date said drug is so prescribed, dispensed, or administered to him, Dr. Griffin shall provide the Board with either a copy of the written prescription or other written verification from the prescriber, including the dosage, amount, number of refills, and directions for use.
4. Dr. Griffin shall abstain completely from the use of alcohol.

Absences from Ohio

5. Dr. Griffin shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed. Further, the Secretary and Supervising Member of the Board shall have the discretion to grant a waiver of part or all of the monitoring terms set forth in this Consent Agreement for occasional periods of absence of fourteen days or less. In the event that Dr. Griffin resides and/or is employed at a location that is within fifty

miles of the geographic border of Ohio and any of its contiguous states, Dr. Griffin may travel between Ohio and that contiguous state without seeking prior approval of the Secretary or Supervising Member provided that Dr. Griffin is able to otherwise maintain full compliance with all other terms, conditions and limitations set forth in this Consent Agreement.

Releases; Quarterly Declarations and Appearances

6. Dr. Griffin shall provide authorization, through appropriate written consent forms, for disclosure of evaluative reports, summaries, and records, of whatever nature, by any and all parties that provide treatment or evaluation for Dr. Griffin's chemical dependency or related conditions, or for purposes of complying with this Consent Agreement, whether such treatment or evaluation occurred before or after the effective date of this Consent Agreement. To the extent permitted by law, the above-mentioned evaluative reports, summaries, and records are considered medical records for purposes of Section 149.43 of the Ohio Revised Code and are confidential pursuant to statute. Dr. Griffin further agrees to provide the Board written consent permitting any treatment provider from whom he obtains treatment to notify the Board in the event he fails to agree to or comply with any treatment contract or aftercare contract. Failure to provide such consent, or revocation of such consent, shall constitute a violation of this Consent Agreement.
7. Dr. Griffin shall submit quarterly declarations under penalty of Board disciplinary action and/or criminal prosecution, stating whether there has been compliance with all the conditions of this Consent Agreement. The first quarterly declaration must be received in the Board's offices on the date his quarterly declaration would have been due pursuant to his August 2008 Board Order, or as otherwise requested by the Board. Subsequent quarterly declarations must be received in the Board's offices on or before the first day of every third month.
8. Dr. Griffin shall appear in person for an interview before the full Board or its designated representative. The first such appearance shall take place on the date his appearance would have been scheduled pursuant to his August 2008 Board Order. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested 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.

Drug & Alcohol Screens; Drug Testing Facility and Collection Site

9. Dr. Griffin shall submit to random urine screenings for drugs and alcohol at least four times per month, or as otherwise directed by the Board. Dr. Griffin shall ensure that all screening reports are forwarded directly to the Board on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board, and shall include Dr. Griffin's drug(s) of choice.

Dr. Griffin shall abstain from the use of any substance and the consumption of poppy seeds or any other food or liquid that may produce a low level positive result in a toxicology screen. Dr. Griffin acknowledges that he understands that the consumption or use of such substances, including but not limited to substances such as mouthwash or hand cleaning gel, may cause a positive drug screen that may not be able to be differentiated from intentional ingestion, and therefore such consumption or use is prohibited under this Consent Agreement.

All such urine screenings for drugs and alcohol shall be conducted through a Board-approved drug testing facility and collection site pursuant to the global contract between said facility and the Board, that provides for the Board to maintain ultimate control over the urine screening process and to preserve the confidentiality of all positive screening results in accordance with Section 4731.22(F)(5), Ohio Revised Code, and the screening process shall require a daily call-in procedure. Further, in the event that the Board exercises its discretion, as provided in Paragraph 10 below, to approve urine screenings to be conducted at an alternative drug testing facility and/or collection site or a supervising physician, such approval shall be expressly contingent upon the Board retaining ultimate control over the urine screening process in a manner that preserves the aforementioned confidentiality of all positive screening results.

Dr. Griffin shall submit, at his expense and on the day selected, urine specimens for drug and/or alcohol analysis. All specimens submitted by Dr. Griffin shall be negative, except for those substances prescribed, administered, or dispensed to him in conformance with the terms, conditions and limitations set forth in this Consent Agreement. Refusal to submit such specimen, or failure to submit such specimen on the day he is selected or in such manner as the Board may request, shall constitute a violation of this Consent Agreement.

Further, within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall enter into the necessary financial and/or contractual arrangements with the Board-approved drug testing facility and/or collection site in order to facilitate the urine screening process in the manner required by this Consent Agreement. Further, Dr. Griffin shall promptly provide to the Board written documentation of completion of such arrangements, including a copy of any contract entered into between Dr. Griffin and the Board-approved drug testing facility and/or collection site. Dr. Griffin's failure to timely complete such arrangements, or failure to timely provide written documentation to the Board of completion of such arrangements, shall constitute a violation of this Consent Agreement.

Dr. Griffin shall ensure that the urine screening process performed through the Board-approved drug testing facility and/or collection site requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable person. In addition, Dr. Griffin and the Board-

approved drug testing facility and collection site shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.

Dr. Griffin shall ensure that the Board-approved drug testing facility and/or collection site provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.

In the event that the Board-approved drug testing facility and/or collection site becomes unable or unwilling to serve as required by this Consent Agreement, Dr. Griffin must immediately notify the Board in writing, and make arrangements acceptable to the Board, pursuant to Paragraph 10 below, as soon as practicable. Dr. Griffin shall further ensure that the Board-approved drug testing facility and/or collection site also notifies the Board directly of its inability to continue to serve and the reasons therefore.

Dr. Griffin acknowledges that the Board expressly reserves the right to withdraw its approval of any drug testing facility and/or collection site in the event that the Secretary and Supervising Member of the Board determine that the drug testing facility and/or collection site has demonstrated a lack of cooperation in providing information to the Board or for any other reason.

10. Dr. Griffin and the Board agree that it is the intent of this Consent Agreement that Dr. Griffin shall submit his urine specimens to the Board-approved drug testing facility and collection site chosen by the Board. However, in the event that utilizing said Board-approved drug testing facility and/or collection site creates an extraordinary hardship upon Dr. Griffin, as determined in the sole discretion of the Board, then subject to the following requirements, the Board may approve an alternate drug testing facility and/or collection site, or a supervising physician, to facilitate the urine screening process for Dr. Griffin:
 - a. Within thirty days of the date upon which Dr. Griffin is notified of the Board's determination that utilizing the Board-approved drug testing facility and/or collection site constitutes an extraordinary hardship upon Dr. Griffin, he shall submit to the Board in writing for its prior approval the identity of either an alternate drug testing facility and collection site, or the name of a proposed supervising physician, to whom Dr. Griffin shall submit the required urine specimens. In approving a facility, entity, or an individual to serve in this capacity, the Board will give preference to a facility located near Dr. Griffin's residence or employment location, or to a physician who practices in the same locale as Dr. Griffin. Dr. Griffin shall ensure that the urine screening process performed through the alternate drug testing facility and/or collection site, or through the supervising physician, requires a daily call-in procedure; that the urine specimens are obtained on a random basis; and that the giving of the specimen is witnessed by a reliable

- person. In addition, Dr. Griffin acknowledges that the alternate drug testing facility and collection site, or the supervising physician, shall assure that appropriate control over the specimen is maintained and shall immediately inform the Board of any positive screening results.
- b. Dr. Griffin shall ensure that the alternate drug testing facility and/or collection site, or the supervising physician, provides quarterly reports to the Board, in a format acceptable to the Board, verifying whether all urine screens have been conducted in compliance with this Consent Agreement, and whether all urine screens have been negative.
 - c. In the event that the designated alternate drug testing facility and/or collection site, or the supervising physician, becomes unable or unwilling to so serve, Dr. Griffin must immediately notify the Board in writing. Dr. Griffin shall further ensure that the previously designated alternate drug testing facility and collection site, or the supervising physician, also notifies the Board directly of the inability to continue to serve and the reasons therefore. Further, in order to ensure that there will be no interruption in his urine screening process, upon the previously approved alternate drug testing facility, collection site, or supervising physician becoming unable to serve, Dr. Griffin shall immediately commence urine screening at the Board-approved drug testing facility and collection site chosen by the Board, until such time, if any, that the Board approves a subsequent alternate drug testing facility, collection site, or supervising physician, if requested by Dr. Griffin.
 - d. The Board expressly reserves the right to disapprove any entity or facility proposed to serve as Dr. Griffin's designated alternate drug testing facility and/or collection site, or any person proposed to serve as his supervising physician, or to withdraw approval of any entity, facility or person previously approved to so serve in the event that the Secretary and Supervising Member of the Board determine that any such entity, facility or person has demonstrated a lack of cooperation in providing information to the Board or for any other reason.
11. All screening reports required under this Consent Agreement from the Board-approved drug testing facility and/or collection site, or from the alternate drug testing facility and/or collection site or supervising physician, must be received in the Board's offices no later than the due date for Dr. Griffin's quarterly declaration. It is Dr. Griffin's responsibility to ensure that reports are timely submitted.
 12. The Board retains the right to require, and Dr. Griffin agrees to submit, blood, urine, breath, saliva and/or hair specimens for screening for drugs and alcohol, for analysis of therapeutic levels of medications that may be prescribed for Dr. Griffin, or for any other purpose, at Dr. Griffin's expense upon the Board's request and without prior notice. Dr. Griffin's refusal to submit a specimen upon request of the Board shall result in a minimum of one year of actual license suspension. Further, the collection of such

specimens shall be witnessed by a representative of the Board, or another person acceptable to the Secretary or Supervising Member of the Board.

Rehabilitation Program

13. Within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall undertake and maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., C.A., or Caduceus, no less than three times per week. Substitution of any other specific program must receive prior Board approval.

Dr. Griffin shall submit acceptable documentary evidence of continuing compliance with this program, including submission to the Board of meeting attendance logs, which must be received in the Board's offices no later than the due date for Dr. Griffin's quarterly declarations.

14. Immediately upon completion of any required treatment for chemical dependency, Dr. Griffin shall enter into an aftercare contract with a Board-approved treatment provider and shall maintain continued compliance with the terms of said aftercare contract, provided that, where the terms of the aftercare contract conflict with the terms of this Consent Agreement, the terms of this Consent Agreement shall control.

CONDITIONS FOR REINSTATEMENT

15. The Board shall not consider reinstatement or restoration of Dr. Griffin's certificate to practice medicine and surgery until all of the following conditions are met:
 - a. Dr. Griffin shall submit an application for reinstatement or restoration, as appropriate, accompanied by appropriate fees, if any.
 - b. Dr. Griffin shall demonstrate to the satisfaction of the Board that he can resume practice in compliance with acceptable and prevailing standards of care under the provisions of his certificate. Such demonstration shall include but shall not be limited to the following:
 - i. Certification from a treatment provider approved under Section 4731.25 of the Revised Code that Dr. Griffin has successfully completed any required inpatient treatment, including at least twenty-eight days of inpatient or residential treatment for chemical abuse/dependence, as set forth in Rules 4731-16-02 and 4731-16-08, Ohio Administrative Code, completed consecutively.
 - ii. Evidence of continuing full compliance with, or successful completion of, a post-discharge aftercare contract with a treatment provider approved under Section 4731.25 of the Revised Code. Such evidence shall include, but not

be limited to, a copy of the signed aftercare contract. The aftercare contract must comply with rule 4731-16-10 of the Administrative Code.

- iii. Evidence of continuing full compliance with this Consent Agreement.
- iv. Two written reports indicating that Dr. Griffin's ability to practice has been assessed and that he has been found capable of practicing according to acceptable and prevailing standards of care. The reports shall be made by physicians knowledgeable in the area of addictionology and who are either affiliated with a current Board-approved treatment provider or otherwise have been approved in advance by the Board to provide an assessment of Dr. Griffin. Further, the two aforementioned physicians shall not be affiliated with the same treatment provider or medical group practice. Prior to the assessments, Dr. Griffin shall provide the evaluators with copies of patient records from any evaluations and/or treatment that he has received, and a copy of this Consent Agreement. The reports from the evaluators shall include any recommendations for treatment, monitoring, or supervision of Dr. Griffin, and any conditions, restrictions, or limitations that should be imposed on Dr. Griffin's practice. The reports shall also describe the basis for the evaluator's determinations.

All reports required pursuant to this paragraph shall be based upon examinations occurring within the three months immediately preceding any application for reinstatement. Further, at the discretion of the Secretary and Supervising Member of the Board, the Board may request an updated assessment and report if the Secretary and Supervising Member determine that such updated assessment and report is warranted for any reason.

- v. In the event that the Board initiates future formal proceedings against Dr. Griffin, including but not limited to issuance of a Notice of Opportunity for Hearing, Dr. Griffin shall be ineligible for reinstatement until such proceedings are fully resolved by ratification by the Board of a subsequent Consent Agreement or issuance by the Board of a final Board Order.
 - vi. In the event that any criminal charges are filed against Dr. Griffin, Dr. Griffin shall be ineligible for reinstatement until the criminal matter has been fully, finally and completely resolved, including all appeals, if any.
- c. Dr. Griffin shall enter into a written consent agreement including probationary terms, conditions and limitations as determined by the Board within 180 days of the date upon which all the above-specified conditions for reinstatement or restoration have been completed or, if the Board and Dr. Griffin are unable to agree on the terms of a written Consent Agreement, then Dr. Griffin further agrees to abide by any terms, conditions and limitations imposed by Board Order after a

hearing conducted pursuant to Chapter 119. of the Ohio Revised Code. The Board shall provide notice to Dr. Griffin that said hearing has been scheduled, advising Dr. Griffin of his hearing rights, and stating the date, time, and location of the hearing at which the Board will present its evidence, after which the Board will make a determination of the matter by Board Order.

Further, upon reinstatement of Dr. Griffin's certificate to practice medicine and surgery in this state, the Board shall require continued monitoring which shall include, but not be limited to, compliance with the written consent agreement entered into before reinstatement or with conditions imposed by Board Order after a hearing conducted pursuant to Chapter 119. of the Revised Code. Moreover, upon termination of the consent agreement or Board Order, Dr. Griffin shall submit to the Board for at least two years annual progress reports made under penalty of Board disciplinary action or criminal prosecution stating whether Dr. Griffin has maintained sobriety.

16. In the event that Dr. Griffin 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, the Board may exercise its discretion under Section 4731.222, Ohio Revised Code, to require additional evidence of Dr. Griffin's fitness to resume practice.

REQUIRED REPORTING BY LICENSEE

17. Within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall provide a copy of this Consent Agreement to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training; and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Griffin shall promptly provide a copy of this Consent Agreement to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Griffin provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall provide a copy of this Consent Agreement to the Ohio Department of Public Safety, Division of Emergency Medical Services. Further, Dr. Griffin shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the

Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.

18. Within thirty days of the effective date of this Consent Agreement, Dr. Griffin shall provide a copy of this Consent Agreement to the proper licensing authority of any state or jurisdiction in which he currently holds any professional license, as well as any federal agency or entity, including but not limited to the Drug Enforcement Agency, through which he currently holds any license or certificate. Dr. Griffin further agrees to provide a copy of this Consent Agreement at time of application to the proper licensing authority of any state in which he applies for any professional license or reinstatement of any professional license. Further, Dr. Griffin shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.
19. Dr. Griffin shall promptly provide a copy of this Consent Agreement to all persons and entities that provide Dr. Griffin chemical dependency treatment or monitoring. Further, Dr. Griffin shall provide the Board with one of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Consent Agreement was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Consent Agreement to the person or entity to whom a copy of the Consent Agreement was emailed.
20. Dr. Griffin shall notify the Board in writing of any change of principal practice address or residence address within thirty days of such change.

DURATION/MODIFICATION OF TERMS

The above-described terms, conditions and limitations may be amended or terminated in writing at any time upon the agreement of both parties. In the event that the Board initiates future formal proceedings against Dr. Griffin, including but not limited to issuance of a Notice of Opportunity for Hearing, this Consent Agreement shall continue in full force and effect until such time that it is

superseded by ratification by the Board of a subsequent Consent Agreement or issuance by the Board of a final Board Order.

In the event that any term, limitation, or condition contained in this Consent Agreement is determined to be invalid by a court of competent jurisdiction, Dr. Griffin and the Board agree that all other terms, limitations, and conditions contained in this Consent Agreement shall be unaffected.

FAILURE TO COMPLY

If, in the discretion of the Secretary and Supervising Member of the Board, Dr. Griffin appears to have violated or breached any term or condition of this Consent Agreement, the Board reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Consent Agreement.

ACKNOWLEDGMENTS/LIABILITY RELEASE

Dr. Griffin acknowledges that he has had an opportunity to ask questions concerning the terms of this Consent Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the Board based on alleged violations of this Consent Agreement shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

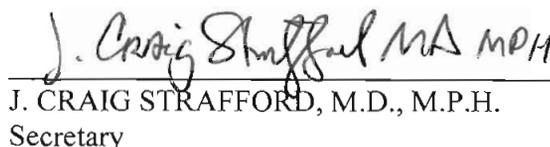
Dr. Griffin hereby releases the Board, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This Consent Agreement shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. Further, this information may be reported to appropriate organizations, data banks and governmental bodies. Dr. Griffin acknowledges that his social security number will be used if this information is so reported and agrees to provide his social security number to the Board for such purposes.

EFFECTIVE DATE

It is expressly understood that this Consent Agreement is subject to ratification by the Board prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.


BRIAN FREDERIC GRIFFIN, M.D.

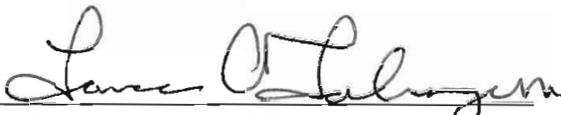

J. CRAIG STRAFFORD, M.D., M.P.H.
Secretary

6-7-12
DATE


THOMAS W. HESS, ESQ.
Attorney for Dr. Griffin

6-8-12
DATE

13 June 2012
DATE


LANCE A. TALMAGE, M.D.
Acting Supervising Member

6-13-12
DATE


DANIEL S. ZINSMaster, ESQ.
Enforcement Attorney

6/8/2012
DATE

The Supreme Court of Ohio

FILED

DEC 30 2009

CLERK OF COURT
SUPREME COURT OF OHIO

Brian Frederic Griffin, M.D.

Case No. 2009-1824

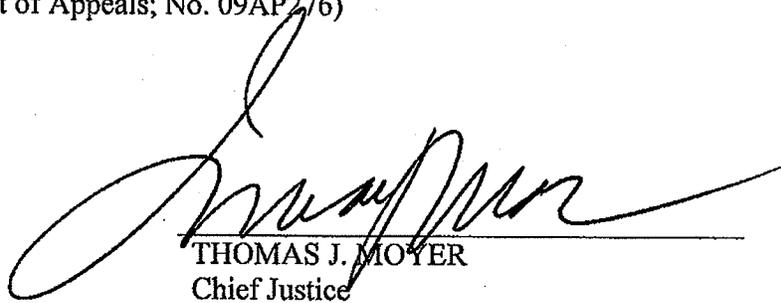
v.

ENTRY

State Medical Board of Ohio

Upon consideration of the jurisdictional memoranda filed in this case, the Court declines jurisdiction to hear the case and dismisses the appeal as not involving any substantial constitutional question.

(Franklin County Court of Appeals; No. 09AP276)



THOMAS J. MOYER
Chief Justice

FILED

NOV 18 2009

CLERK OF COURT
SUPREME COURT OF OHIO

The Supreme Court of Ohio

Brian Frederic Griffin, M.D.

Case No. 2009-1824

v.

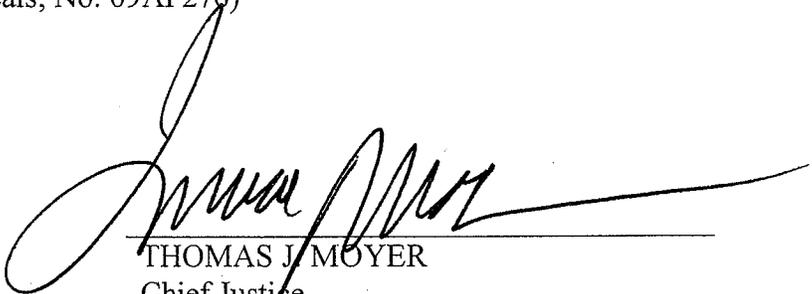
ENTRY

State Medical Board of Ohio

This cause is pending before the Court as a discretionary appeal and claimed appeal of right. Upon consideration of appellant's motion for stay of the court of appeals' judgment,

It is ordered by the Court that the motion is granted.

(Franklin County Court of Appeals; No. 09AP276)



THOMAS J. MOYER
Chief Justice

HEALTH & HUMAN

NOV 20 2009

SERVICES SECTION

ORIGINAL

IN THE SUPREME COURT OF OHIO

Brian Frederic Griffin, M.D. :
: Appellant, :
: v. :
: State Medical Board of Ohio, :
: Appellee. :

09-1824

CASE NO. _____

ON APPEAL FROM THE
FRANKLIN COUNTY COURT OF APPEALS
10TH APPELLATE DISTRICT
CASE NO. 09AP-276

NOTICE OF APPEAL OF BRIAN FREDERIC GRIFFIN, M.D.

Thomas W. Hess (#0025149)
Gregory B. Mathews (#0039632)
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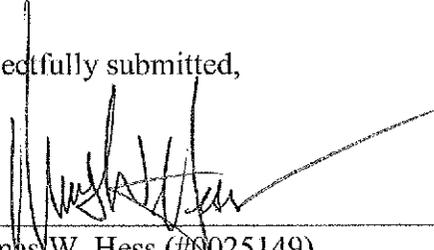
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CLERK OF COURT
SUPREME COURT OF OHIO

NOTICE OF APPEAL

Appellant, Brian Frederic Griffin, M.D., hereby gives notice of appeal to the Supreme Court of Ohio from the Judgment of the Franklin County Court of Common Pleas, 10th Appellate District, entered in the Court of Appeals No. 09-AP-276 on September 15, 2009. This case raises a substantial constitutional question and is a case of public or great general interest.

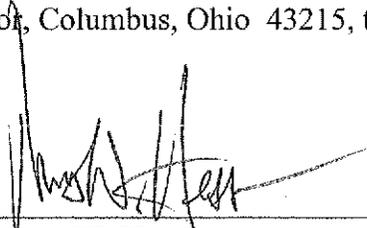
Respectfully submitted,



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CERTIFICATE OF SERVICE

I certify that the original of the foregoing Notice of Appeal has been sent via regular U.S. mail, postage prepaid, to Kyle C. Wilcox, Assistant Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215, this 9th of October, 2009.



Thomas W. Hess

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CLERK OF COURTS

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

Brian Frederic Griffin, M.D., :

Appellant-Appellant, :

v. :

State Medical Board of Ohio, :

Appellee-Appellee. :

No. 09AP-276
(C.P.C. No. 08CVF-13539)

(REGULAR CALENDAR)

JUDGMENT ENTRY

For the reasons stated in the decision of this court rendered herein on September 15, 2009, appellant's assignments of error are overruled. Therefore, it is the judgment and order of this court that the judgment of the Franklin County Court of Common Pleas is affirmed. Costs shall be assessed against appellant.

TYACK, BRYANT & CONNOR, JJ.

By 
Judge G. Gary Tyack

[Cite as *Griffin v. State Med. Bd. of Ohio*, 2009-Ohio-4849.]

IN THE COURT OF APPEALS OF OHIO
TENTH APPELLATE DISTRICT

Brian Frederic Griffin, M.D.,	:	
Appellant-Appellant,	:	
v.	:	No. 09AP-276
State Medical Board of Ohio,	:	(C.P.C. No. 08CVF-13539)
Appellee-Appellee.	:	(REGULAR CALENDAR)

D E C I S I O N

Rendered on September 15, 2009

Dinsmore & Shohl, LLP, Thomas W. Hess and Gregory P. Mathews, for appellant.

Richard Cordray, Attorney General, and *Kyle C. Wilcox*, for appellee.

APPEAL from the Franklin County Court of Common Pleas.

TYACK, J.

{¶1} This is an administrative appeal from the Ohio State Medical Board ("Board"). On August 13, 2008, the Board permanently revoked Dr. Brian F. Griffin's medical license, staying the revocation in lieu of three years probation. The conduct at issue allegedly occurred between 1999 and 2001 when Dr. Griffin was a student in a fellowship, at a Columbus, Ohio pain management clinic. In addition to his argument that the Board's decision was not supported by reliable, probative, or substantial evidence, Dr. Griffin also argues that the Board violated his due process rights by waiting roughly five

years after learning about the complained-of conduct to bring a formal disciplinary proceeding against him. The trial court affirmed the Board's order, and this appeal ensued.

{¶2} Dr. Griffin assigns three errors for our review:

[I.] THE COURT OF COMMON PLEAS ABUSED ITS DISCRETION BY APPLYING THE INCORRECT LEGAL STANDARD TO DR. GRIFFIN'S DUE-PROCESS ASSIGNMENT OF ERROR.

[II.] THE COURT OF COMMON PLEAS ABUSED ITS DISCRETION BY FINDING THAT THE BOARD DID NOT VIOLATE DR. GRIFFIN'S DUE PROCESS RIGHTS BY WAITING FIVE YEARS TO INSTITUTE THE ADMINISTRATIVE ACTION AGAINST HIM.

[III.] THE COURT OF COMMON PLEAS ABUSED ITS DISCRETION BY FINDING THAT THE ORDER WAS SUPPORTED BY RELIABLE, PROBATIVE, AND SUBSTANTIAL EVIDENCE WHERE THE EXPERTS RELIED UPON BY THE BOARD WERE INHERENTLY UNRELIABLE.

{¶3} The Ohio Revised Code vests the Board with broad authority to regulate the medical profession in this state, and to discipline any physician whose care constitutes "[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." R.C. 4731.22(B)(6).

{¶4} The common pleas court is the reviewing tribunal for appeals from administrative agencies, such as the Board, and the standard of review is provided by R.C. 119.12. This statute provides that the trial court may affirm the agency's order complained of in the appeal if, after considering the entire record, the court finds that the order is supported by reliable, probative, and substantial evidence, and is in accordance

with law. R.C. 119.12; *Pons v. Ohio State Med. Bd.*, 66 Ohio St.3d 619, 621, 1993-Ohio-122. On appeal, courts must defer to the Board's interpretation of the technical and ethical requirements of that profession. *Id.* at syllabus.

{¶5} Our review is even more limited than that of the trial court because it is the trial court's function to examine the evidence. *Id.* The court of appeals' function is solely to determine whether the trial court abused its discretion—"not merely an error of judgment, but perversity of will, passion, prejudice, partiality, or moral delinquency." *Id.* Furthermore, neither we, nor the trial court may substitute our judgment for that of the Board. See *id.* (citing *Lorain City Sch. Dist. Bd. of Ed. v. State Emp. Relations Bd.* (1988), 40 Ohio St.3d 257, 260–61).

DUE PROCESS

{¶6} The first two assignments of error are procedural, in that they claim that the Board violated Dr. Griffin's due-process rights by waiting so long after the alleged violations to bring formal accusations against him. We will therefore address these assigned errors together.

{¶7} One of the fundamental principles of due process is that it is considered procedurally unfair to allow the state to bring charges against an individual long after the individual committed the alleged wrongful acts. See generally *U.S. v. McDonald* (1982), 456 U.S. 1, 7, 102 S.Ct. 1497 (noting that delays before indictment may give rise to a general due process violation, but do not violate the speedy trial clause of the Sixth Amendment). This is why most crimes have statutes of limitations. In Ohio, excluding murder, the state must prosecute most crimes (felonies) within six years. See R.C. 2901.13; see also *State v. Selvage*, 80 Ohio St.3d 465, 467, 1997-Ohio-287.

{¶8} This case is, of course, *not* a criminal prosecution, but rather a professional disciplinary proceeding by an administrative agency. The Board derives its authority to conduct its disciplinary proceeding from R.C. 4731.22(B)(6), which provides:

The board, by an affirmative vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend an individual's certificate to practice * * * for one or more of the following reasons:

* * *

(6) 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[.]

{¶9} There is no per se statute of limitations in R.C. 4731.22. We have held that administrative agencies must give licensees a fair hearing and determination as expeditiously as possible under the circumstances, but we have never imposed a per se time limitation upon an agency. See, e.g., *Gourmet Beverage Center, Inc. v. Ohio Liquor Control Comm.*, 10th Dist. No. 01AP-1217, 2002-Ohio-3338, ¶25 ("[I]t is the duty of an administrative agency to hear matters pending before it without unreasonable delay and with due regard to the rights and interests of the litigants."). Agencies are free to set their own parameters regarding time limitations, but this is purely voluntary. One court of appeals opined that when an administrative agency *does not* have a self-imposed time limitation for prosecution, the agency might leave itself vulnerable to due process challenges such as this one. See *Mowery v. Ohio St. Bd. of Pharmacy* (Sept. 30, 1997), 11th Dist. No. 96-G-2005, 1997 WL 663505, at *4, n.1. Thus, when evaluating a due-process argument within the context of an agency's delay in bringing formal accusations against a professional license holder, there is no precise standard. In the absence of a

specified time limit, we focus our analysis on whether the licensee suffered any material prejudice as a result of the agency's delay. See, e.g., *Smith v. State Med. Bd. of Ohio* (July 19, 2001), 10th Dist. No. 00AP-1301, 2001 WL 811839, at *5 ("[W]e find that appellant failed to demonstrate how he has been materially prejudiced by the Board's delay, and that the trial court did not abuse its discretion by rejecting the affirmative defense of laches.").

{¶10} The crux of Dr. Griffin's due-process argument centers not on any prejudice that he may have suffered, but on the Board's "unjustified delay." (Appellant's brief, at 7.) Further, he argues that the common pleas court applied the wrong standard to his due-process argument—that the court instead considered the doctrines of laches and estoppel, which he argues are separate and distinct from due process: "Laches is an equitable doctrine that discourages parties from sitting on their rights. * * * 'The purpose of equitable estoppel is to prevent actual or constructive fraud[,] and to promote the ends of justice.' " (Appellant's brief, at 10, citing *Ohio State Bd. of Pharmacy v. Frantz*, 51 Ohio St.3d 143, 145.) Regardless of the origins of these two principles, they exist to protect the fundamental fairness of our judicial system, much like due process. Moreover, regardless of which standard the common pleas court applied, Dr. Griffin has still failed to demonstrate any material prejudice.

{¶11} Absent demonstrating some material prejudice as a result of the Board's delay in bringing formal accusations against Dr. Griffin, we cannot hold that the Board violated his due process rights, or that the trial court abused its discretion by applying the wrong legal standard to the claimed due-process violation. We, therefore, overrule the first and second assignments of error.

RELIABILITY OF EXPERT TESTIMONY

{¶12} The third assignment of error is substantive, and concerns the merits of whether there was reliable, probative, and substantial evidence supporting the Board's disciplinary order against Dr. Griffin. Dr. Griffin argues that the evidence the Board relied upon was insufficient because the state's expert testimony was inherently unreliable, based on the experts' lack of familiarity with the relevant standard of care in the field of pain management. (See Appellant's brief, at 16.) We will examine the 3100-page transcript of the 17-day hearing before the Board (hereafter "Tr."), and specifically focus on the 136-page report and recommendation issued by Board hearing officer, R. Gregory Porter, filed on July 7, 2008 (hereafter "Report").

{¶13} Although the Board is not required to present expert testimony to support a charge against an accused physician, the charge must somehow be supported by reliable, probative, and substantial evidence. *In re Williams* (1991), 60 Ohio St.3d 85, syllabus. When the Board does present expert testimony, however, the expert must be capable of expressing an opinion in terms of the particular standard of care that applies to the physician whose license is at issue. *Lawrence v. State Med. Bd. of Ohio* (Mar. 11, 1993), 10th Dist. No. 92AP-1018, 1993 WL 69476, at *3. In civil litigation, the legislature has enacted a statutory provision that a person is not competent to testify unless they practice in the "same or a substantially similar specialty as the defendant." R.C. 2743.43(A)(3). "The court shall not permit an expert in one medical specialty to testify against a health care provider in another medical specialty unless the expert shows both that the standards of care and practice in the two specialties are similar and that the expert has substantial familiarity between the[m]." *Id.* The rationale behind this rule is

that just because a medical expert is well-educated and well-credentialed does not necessarily mean that the expert should be qualified as an expert in every medical field. See, e.g., *Valentine v. Conrad*, 110 Ohio St.3d 42, 2006-Ohio-3561, ¶17 ("[E]ven a qualified expert is capable of rendering scientifically unreliable testimony.").

{¶14} The experts at issue in this case are Thomas Chelimsky, M.D., and Bashar Katirji, M.D., who are purportedly world-renowned in the field of neurology. (See Appellee's brief, at 6.) According to the hearing examiner's report, the pain management field has two differing philosophical foundations, one rooted in neurology, the other rooted in anesthesia. This is supported in part by the fact that three separate certifying boards "offer subspecialty certification in pain medicine: the American Board of Anesthesiology, the American Board of Psychiatry and Neurology [ABPN], and the American Board of Physical Medicine and Rehabilitation." (Report, at 23.) Dr. Chelimsky testified that all three boards use the same certifying exam. *Id.*

{¶15} Prior to his training in pain management, Dr. Griffin was board certified in emergency medicine in 1988. He was later certified by the American Academy of Pain Management in 2001, and certified with a subspecialty in pain medicine by the American Board of Anesthesiology in 2004. Since 2003, Dr. Griffin has been the president and owner of Interventional Pain Solutions, in Columbus, Ohio. His practice is solely devoted to interventional pain management. (Report, at 14.)

{¶16} Dr. Chelimsky was board certified in internal medicine in 1986 by the American Board of Electrodiagnostic Medicine in 1992, in neurology and neurophysiology by the ABPN in 1992 and 1994 respectively, and in pain management by the ABPN in 2000. (Report, at 17.)

{¶17} Dr. Katirji was board certified in neurology and neurophysiology by the ABPN in 1985 and 1992 respectively, by the American Board of Electroencephalography in 1985, by the American Association of Electrodiagnosis and Electromyography in 1986, and by the American Board of Electrodiagnostic Medicine in 1990. (Report, at 16.) Dr. Katirji is not certified in any area of pain management, or physical medicine and rehabilitation, and he testified that he does not practice in the field of interventional pain management. (Report, at 17.)

{¶18} Dr. Katirji opined that he is an expert in somatosensory evoked potentials (SSEPs), which are studies that involve stimulating nerves in the limbs and recording nerve activity from the spine to the brain. (Tr. 1016.) SSEPs are performed by placing electrodes on nerves at the base of the neck and on the fingers. (Tr. 1017–18.) Then, the practitioner sends an electric current through the nerves and documents the nerve response. Dr. Katirji stated that although SSEPs may indicate an abnormality along the nerve route, there is no way for the doctor to pinpoint the problem. His conclusion, thus, was that SSEPs have no ability to identify the source of pain, and that there is no medical reason for a physician to conduct these tests.

{¶19} Dr. Katirji specifically reviewed the records of those of Dr. Griffin's patients referenced in the Board's allegations, and his general conclusion was that neither Dr. Griffin nor W. David Leak, M.D., the fellowship's program director, specifically indicated why they performed SSEPs and other similar tests on each patient. (Report, at 27.) Dr. Katirji's belief was that for each new patient presenting radiating pain, Drs. Griffin and Leak simply ordered a standard battery of tests that included SSEPs. See *id.* "In summary, I find that Drs. [Leak and Griffin] practiced below minimal standards of care by

performing unnecessary electrodiagnostic testing for no apparent clinical reason in most of their patients." (Report, at 28.) Despite this generalized conclusion, Dr. Katirji stated that the original test data for the patients was not available, and that he was only able to review tabulated charts of the data. See *id.* at 27–28. The report does not state whether the reason the original test data was unavailable was in any way attributable to the length of time that had passed since the tests were administered.

{¶20} In response to the Board's expert testimony, Dr. Griffin argues that although well qualified in neurology, Drs. Chelimsky and Katirji were not qualified to render reliable expert opinions regarding the diagnosis, management, and treatment of the interventional pain patients at issue. (Appellant's brief, at 17.)

The opinions of Dr. Chelimsky and Dr. Katirji reflected the general consensus of neurologists on the use of * * * pain medications, and various injections to diagnose and treat pain. Using their neurology approach, [they] testified that a needle EMG is always necessary in conjunction with nerve conduction studies in the diagnosis of rad[iating pain], that STCs are not reproducible, reliable, or valid, and that SSEPs are not effective in the diagnosis of radi[ating pain], and have no ability to identify pain.

Id. at 18 (quoting Tr. 1024–25, 1142–43, 1154, 1584–94).

{¶21} Another of the Board's witnesses, Mark V. Boswell, M.D., Ph.D., explained, however, how the viewpoints and philosophies of neurologists and anesthesiologists differ in the field of pain medicine:

The neurology approach is more medication and less intervention. Anesthesiology has always been more interventional in the sense of doing nerve blocks and stimulators and pumps, things like that.

Dr. Boswell went on to explain that he worked with Dr. Chelimsky for 15 years, and would have interdisciplinary meetings so they could discuss patients and work together because they had different approaches. They did not always agree on approaches, but they always had a good plan for the patients that they co-managed. (Tr. 43–45.)

{¶22} Dr. Boswell was also board certified in pain medicine by the American Board of Anesthesiology in 1993, and by the American Board of Pain Medicine in 1995, and 2004. (Report, at 22.) At the time of the hearing, Dr. Boswell was Professor and Chair of the Department of Anesthesiology, and Director of the Messer Racz Pain Center at the Texas Tech University Health Sciences Center in Lubbock, Texas. The pain medicine program at Texas Tech is one of the top ten programs of its kind in the country. Id.

{¶23} Dr. Boswell further stated that regardless of the different approaches taken by him in comparison with Dr. Chelimsky, both physicians' treatments were within the standard of care. Id. Perhaps if Dr. Chelimsky had been practicing alongside Dr. Griffin, they would have co-managed their patients in a similar manner.

{¶24} Dr. Griffin also proffered expert testimony at the Board's hearing. James P. Bressi, D.O., was board certified in anesthesiology by the American Osteopathic Board of Anesthesiology in 1993, with a qualification in pain management in 1996, and was also certified by the American Academy of Pain Management. (Report, at 19.) David R. Longmire, M.D., was certified by the American Academy of Pain Management in 1982, and by the American Board of Electroencephalography and Neurophysiology in 1989, and Gary W. Jay, M.D., who graduated from Northwestern University Medical Center in

1976, and has 25 years experience in the private practice of pain medicine. At the time of the hearing, Dr. Jay was the medical director for pain at Schwarz Biosciences.

{¶25} The trial court found that there was "no dispute as to any of [the] experts' qualifications." (February 4, 2009 Decision, at 12.) The trial court also found that "[a]ll of the experts appeared highly qualified and well-versed in the arena of pain management." *Id.* Although the trial court recognized the two contrasting philosophies in pain medicine, the court did not attempt to explain or reconcile the differences in testimony proffered by the experts from a neurological background versus the experts from an anesthesiology background. Indeed, the trial court did not have to reconcile the two because the trial court's analysis centered on two issues: (1) was the Board's decision in accordance with law?; and (2) was the Board's decision based upon reliable, substantial, and probative evidence? The decision as to which medical philosophy is more appropriate for pain management is best left to the medical professionals, not appellate judges or trial court judges sitting in an appellate role on an administrative appeal. This is the clear indication of *Pons*, *supra*.

{¶26} As noted above, the trial court was supposed to review the record in this case, and determine whether there was reliable, probative, and substantial evidence to support the Board's action. The trial court having found that there was such evidence in the record, our review is limited to whether the trial court abused its discretion in so finding. This is a difficult standard to overcome, and was not overcome here.

{¶27} The evidence clearly demonstrates that there were two types of expert witnesses in this case: Some of the experts were highly trained in neurology. The other

experts were experienced and highly-credentialed pain medicine doctors, with backgrounds in anesthesiology. *Lawrence*, at *3; *Valentine*, at ¶17.

{¶28} The trial court considered the disparity in qualifications among the experts in this case. The trial court then found:

Based upon the evidence presented[,] the Hearing Officer came to the conclusion that the [sic] Dr. Griffin's treatment of 23 patients violated the minimum standard of care * * * includ[ing] subjecting patients to unnecessary tests[,] and in some cases an extraordinary number of tests. The Hearing Officer found that Dr. Griffin had done so without documenting the necessity for those tests and without heed to abnormal results when abnormal results were obtained. * * *

(Decision, at 9.) These findings were clearly supported by the witnesses called by the Board. It is not our place to substitute our judgment for that of the Board (or the trial court).

{¶29} After reviewing the evidence in this case, we conclude that the trial court did not abuse its discretion in finding that there was reliable, probative, and substantial evidence supporting the Board's order. Accordingly, we overrule the third assignment of error.

{¶30} Having overruled all three assignments of error, we affirm the judgment of the Franklin County Court of Common Pleas.

Judgment affirmed.

BRYANT and CONNOR, JJ., concur.

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

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Brian Frederic Griffin, M.D.,

Appellant,

vs.

State Medical Board of Ohio,

Appellee.

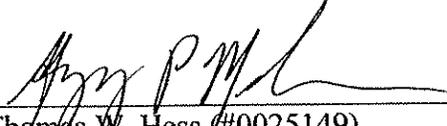
Case No. 08 CV 013539

Judge Schneider

NOTICE OF APPEAL OF APPELLANT BRIAN FREDERIC GRIFFIN, M.D.

Appellant Brian Frederic Griffin, M.D., by and through the undersigned counsel, hereby gives this Notice of Appeal of this matter to the Tenth District Court of Appeals from the decision and final judgment of the Court of Common Pleas, Franklin County, Ohio, filed on February 20, 2009, which affirmed the State Medical Board of Ohio's Order. The judgment entry was issued as a final and appealable order on February 20, 2009.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing has been sent via regular U.S. mail to Kyle C. Wilcox, Assistant Attorney General, Health and Human Services Section, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215, this 19th of March, 2009.



Thomas W. Hess
Gregory P. Mathews

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

TERMINATION NO. 10
BY: KT

BRIAN FREDERIC GRIFFIN, M.D. :

Appellant, :

v. :

STATE MEDICAL BOARD OF OHIO :

Appellee. :

Case No. 08CV-13539

JUDGE SCHNEIDER

FINAL APPEALABLE ORDER

**JUDGMENT ENTRY AFFIRMING THE STATE MEDICAL BOARD'S
AUGUST 13, 2008, ORDER PERMANENTLY REVOKING DR. GRIFFIN'S MEDICAL
LICENSE AND STAYING THE REVOCATION WITH THREE YEARS PROBATION**

This case is before the Court upon the appeal, pursuant to R.C. 119.12, of the August 13, 2008, Order of the State Medical Board of Ohio which permanently revoked the Medical License of Brian Frederic Griffin, stayed the revocation, and placed him on probation for 3 years. For the reasons stated in the decision of this Court rendered and filed on February 4, 2009, which decision is incorporated by reference as if fully rewritten herein, it is hereby:

ORDERED, ADJUDGED AND DECREED that judgment is entered in favor of Appellee, State Medical Board of Ohio, and the August 13, 2008, Order of the State Medical Board in the matter of Brian Frederic Griffin, M.D., is hereby AFFIRMED. Costs to Appellant.

IT IS SO ORDERED.

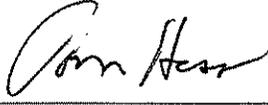
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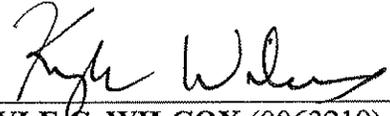
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Attorney for Appellee,
State Medical Board of Ohio

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

BRIAN FREDERIC GRIFFIN, M.D.,

CASE NO. 08CV-13539

APPELLANT,

JUDGE SCHNEIDER

VS.

STATE MEDICAL BOARD OF OHIO,

APPELLEE.

DECISION ON MERITS OF APPEAL

Entered this 3 day of February, 2009.

The Court has for consideration this appeal by Brian Frederic Griffin, M.D. from an Order of Revocation by the Ohio State Medical Board (Board). That Order, issued August 13, 2008, permanently revoked Appellant's certificate to practice medicine and surgery, but stayed the permanent revocation with probationary terms for a period of at least three years. Appellant has sought this Court's review under Revised Code Chapter 119. The record of proceedings and legal arguments by counsel have been filed.

PROCEDURAL AND FACTUAL BACKGROUND

Appellant, until 1999, was employed as an emergency room physician at Columbus Community Hospital. Appellant is a Board certified physician in emergency medicine. Appellant was offered a fellowship position with Pain Control Consultants, Inc. (PCC). W. David Leak, M.D. was the medical director for PCC. Appellant worked in that fellowship at PCC from 1999 to 2001.

On August 9, 2006 the Board issued to Appellant a Notice of Opportunity for Hearing alleging misconduct committed at PCC during the fellowship. The notice alleged that Appellant had:

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“(1) from in or about 1999 to in or about 2001, and in the routine course of your practice, you undertook the treatment of patients 1-23 as identified on the attached patient C.

(confidential to be withheld from public disclosure). In treating patients 1-23, you failed to form and/or document the formation of an overall clinical impression, and/or prescribed controlled substances and/or other dangerous drugs in an inappropriate manner and otherwise failed to provide treatment in accordance with the minimal standards of care. Examples of such conduct include, but are not limited to, the following:

- (a) you failed to refer or timely refer and or document the referral or timely referral of patients 1-4, 8-20, 22 and 23 for psychological consultation.
- (b) you failed to refer patients 19 and 22 to an addiction medicine specialist and/or obtain toxicology screens despite signs of drug abuse and/or diversion.
- (c) you performed unnecessary testing including somatosensory evoked potentials, nerve conduction studies and/or "selective tissue conductance" studies [collectively, EDX studies] on patients 1-5, 9, 14-17, and 22. Further, you performed unnecessary testing including somatosensory evoked potentials and/or "selective tissue conductance" studies on patients 6-8, 10-13 and 18-20.
- (d) you failed to identify and/or document and appropriate indication for the use of the EDX studies on patients 1-10, 13-18, and 20-22.
- (e) assuming, arguendo, that the EDX studies on patients 1-10, 13-18, and 20-22 were necessary, you failed to perform or recommend and/or document the performance or recommendation of a needle EMG examination.
- (f) you failed to properly document and appropriate comment on purported abnormal EDX study results for patients 1, 3, 5-8, 10-13, 16-18, 20 and 21.

(g) you failed to change and/or document a change in treatment for management of patients 1, 3, 5-8, 10-13, 16-18, 20 and 21 based on the abnormal results of EDX studies.

(h) you failed to follow-up and/or document follow-up on a large mean corpuscular volume finding for patient 19.

(i) you failed to form and/or document the formation of an overall clinical impression for patients 1-9 and 11-23.

(j) you inappropriately used and/or supervised a podiatrist to engage in the use of, destructive modalities of treatment such as chemolytic agents indiscriminately on nerves and muscles one patients 1-6, 10, 13, 16 and 20.

(k) you engaged in and/or supervised the excessive use of invasive techniques and blocks, including: chemoneurolytic and other injections into the splenius capitis, levator scapulae, trapezius, superior trapezius, cervical erector spinae, thorascic erector spinae, lumbar erector spinae, latissimus dorse, paraspinal, and/or rhomboid muscles, and/or the intraspinous ligament, and/or greater trochanter in Patients 1-8, 10, 11, 13, 14, 16, 17, 19, 20, and 21.

(l) you excessively prescribed morphine to patient three and failed to consider and/or document the consideration of the interaction of the combination of daily use of Topamax and opiates despite evidence of development of cognitive dysfunction in the patient.

(m) you excessively prescribed OxyContin to patient 10.

(2) during the period in or about August 2000 through in or opt out November 2001, you aided and abetted Kyle Elliott Hoogendoorn, DPM, in the unlawful practice of medicine and surgery by permitting and/or supervising doctor Hoogendoorn in :

(a) administering chemoneurolytic and other injections into the splenius capitis, levator scapulae, trapezius, superior trapezius, cervical erector spinae, thoracic erector spinae, lumbar erector spinae, latissimus dorse, paraspinal, and/or rhomboid muscles, and/or the interspinous ligament, and/or greater trochanter and/or gluteal area, and/or zygapophyseal joint of patients 1-8, 10, 13, 16, 19, 20 and 21;

(b) prescribing controlled and noncontrolled medications, including, but not limited to, Nicotrol, Wellbutrin, Neurontin, Propranolol, Vioxx, Zyprexa, Ultram, Oxycontin, Clnazepam, Duragesic, Depakote, Senokot, Trazadone, hydrocone, methadone, Transderm Scop, Celebrex, Zanaflex, Catapres, Zithromax, proppoxyphene, oxazepam, and/or methylphenidate to patients 2, 6, 10-13, 17, 19, 22 and 23 for the treatment of non-podiatric conditions.

Your acts, conduct, and/or omissions as alleged in paragraph (1) 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.

Your acts, conduct, and/or omissions as alleged in paragraph (two) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in the state, regardless of the jurisdiction in which the act was committed," as that clause is used in section 4731.22(B)(10), Ohio Revised Code , to wit: Section 2923.03, Ohio Revised Code, complicity, to wit: section 473 1.41, Ohio Revised Code, practice of medicine or surgery without certificate. Pursuant to section 473 1.99 (8), Ohio Revised Code, violation of section 4731.41, Ohio Revised Code, constitutes a felony offense."

Dr. Leak and Dr. Hoogendoorn were also notified of alleged charges. An administrative hearing was conducted by a Hearing Officer for the Board in which there was a consolidation of all of the charges against the three doctors. The Hearing Officer issued a Report and Recommendation concluding that Appellant did not engage in criminal conduct constituting a commission of a felony but did depart from or fail to conform to minimum standards of care. The Board adopted the Hearing Officer's report and recommendation but modified the penalty and limited Appellant's practice as referenced in the Board order.

STANDARD OF REVIEW

Several opinions have considered the standard of review in appeals brought under R.C. 119.12 from decisions of administrative agencies, including those from the Medical Board. Chapter 119 provides that there must be reliable, probative and substantial evidence to support the agency's decision. *University of Cincinnati v. Conrad* (1980), 63 Ohio St.2d 108, 407 N.E.2d 1265 still stands as the illustrative holding for review in a Chapter 119 appeal. While the review is a type of hybrid, the Court cannot simply substitute its judgment on the evidence. In *Rossiter v. State Med. Bd.*,¹ it was reaffirmed that when reviewing such an order, the Court must accord due deference to the Board's interpretation of the technical and ethical requirements of its profession.² Under the applicable standard, the Court must affirm the order if it is supported by reliable, probative and substantial evidence and is in accordance with law.

In *Our Place, Inc. v. Ohio Liquor Control Comm.*³, the Ohio Supreme Court defined such evidence to be: "(1) "Reliable" evidence is dependable; that is, it can be

¹ 155 Ohio App. 3d 689; 2004-Ohio-128; 802 N.E.2d 1149

² Citing *Pons v. Ohio State Med. Bd.* (1993), 66 Ohio St. 3d 619, 614 N.E.2d 748

³ (1992) 63 Ohio St. 3d 570, 571, 589 N.E.2d 1303

confidently trusted. In order to be reliable, there must be a reasonable probability that the evidence is true. (2) "Probative" evidence is evidence that tends to prove the issue in question; it must be relevant in determining the issue. (3) "Substantial" evidence is evidence with some weight; it must have importance and value." If the evidence meets the requisite standard, a reviewing Court may not modify a sanction if such sanction is authorized by statute.⁴ If the sanction is within the range of permissible alternatives, then the Court must affirm.

The reviewing Courts have determined that from a due process standpoint, a proper evidentiary basis must be provided before levying a sanction. While a full adversarial and evidentiary proceeding may not be required, there must be some sort of reliable evidentiary review, including sworn testimony, as well as a full consideration of the circumstances of the case.⁵ With the above standard of review in mind, the Court will consider the assigned errors offered by Appellant.

ASSIGNED ERRORS

Appellant has offered three assigned errors. Appellant first states that the order was not in accordance with law because the Board violated Dr. Griffin's due process rights by waiting five years to institute the administrative action against him. The second assigned error is that the order was not in accordance with law because the Board violated R.C. 119.07 by failing to provide sufficient notice of the charges. The final assigned error is that the Board was not supported by reliable, probative, and substantial evidence because the experts relied upon by the Board were inherently unreliable.

⁴ *Henry's Cafe, Inc. v. Board of Liquor Control* (1959), 170 Ohio St. 233, 163 N.E.2d 678. Citing also to *Hale v. Ohio State Veterinary Med. Bd.* (1988), 47 Ohio App.3d 167, 548 N.E.2d 247

⁵ *Goldman v. State Medical Bd.* (1996), 110 Ohio App. 3d 124, 673 N.E.2d 677, Dismissed by *Goldman v. State Medical Bd.*(1996), 77 Ohio St. 3d 1411, 670 N.E.2d 1001

DISCUSSION

Appellant's hearing began May 14, 2007 and continued on various days in May and into June. The report and recommendation was issued in July 2008 and consists of 136 pages. The Hearing Officer offered in the report and recommendation 286 excerpts of the evidence along with transcript reference notations. The Hearing Officer relied upon that evidence and issued findings of fact and conclusions of law which determined that while the evidence was insufficient to support a finding that Appellant had engaged in conduct constituting commission of a felony, there was sufficient evidence that Appellant had failed to conform to minimal standards of care of similar practitioners under the same or similar circumstances. The issue of commission of a felony related to aiding and abetting Dr. Hoogendoorn in the unlawful practice of medicine and surgery. Since this charge was found not supported, it will not be addressed by the Court.

R.C. § 4731.22 provides the grounds for discipline by the Board. It provides in relevant part of section (B) that “The Board, by an affirmative vote of not fewer than six members, shall, to the extent permitted by law, limit, revoke, or suspend an individual's certificate to practice, refuse to register an individual, refuse to reinstate a certificate, or reprimand or place on probation the holder of a certificate for one or more of the following reasons:

(6) 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;”

The hearing in this appeal encompassed both the testimony of Appellant, Dr. Leak and Dr. Hoogendoorn as well as their experts James P. Bressi, D.O. and David R.

Longmire, M.D. and Dr. Gary W. Jay, M.D. Dr. Bressi is the director of the Falls Pain Management Center in Cuyahoga Falls Ohio. He is a certified anesthesiologist by the American Osteopathic Board of Anesthesiology. Dr. Longmire is a clinical associate professor and in private practice and is affiliated with the Department of Internal Medicine at the University of Alabama at Birmingham-Huntsville Regional Hospital. He is a neurologist and certified in pain management by the American Academy of Pain Management and the American Board of Electroencephalography and Neurophysiology. Dr. Jay is the medical director for pain at Schwarz Biosciences. Dr. Jay obtained his medical degree from Northwestern University and has 25 years in pain medicine.

The state presented the testimony of Bashar Katirji, Md. He is trained in internal medicine and certified in neurology by the American Board of Psychiatry and Neurology and in clinical neurophysiology. He is also certified by the American Board of Electroencephalography and by the American Association of Electrodiagnosis as well as the American Board of Electrodiagnostic medicine. The state's other expert was Thomas C. Chelimsky, M.D.. Dr. Chelimsky is certified by the American Board of Internal Medicine and by the American Board of Electrodiagnostic Medicine as well as being certified in neurology by the American Board of Psychiatry and Neurology. He is also certified in clinical neurophysiology and pain management from the American Board of Psychiatry and Neurology. Dr. Chelimsky is currently Professor of Neurology at Case Western Reserve University and was director of Pain Center of the Pain Center at University Hospitals of Cleveland. Dr. Katirji is currently a Professor of Neurology at Case Western Reserve University of Medicine and a lecturer in the Department of Medicine at the Ohio College of Podiatric Medicine. The final medically trained witness

was a fact witness, Dr. Mark V. Boswell, M.D. PhD. He is certified as a board anesthesiologist and a fellow in pain management. At the time of the hearing, he was a professor and chair of the Department of Anesthesiology and Director of Messer Racz Pain Center at Texas Tech University.

Based upon the evidence presented the Hearing Officer came to the conclusion that the Dr. Griffin's treatment of 23 patients violated the minimum standard of care. The Hearing Officer found that the violations included subjecting patients to unnecessary tests and in some cases an extraordinary number of tests. The Hearing Officer found that Dr. Griffin had done so without documenting the necessity for those tests and without heed to abnormal results when abnormal results were obtained. He further found that Dr. Griffin subjected patients to an extraordinary number of invasive procedures, including chemoneurolytic injections in the muscle tissue. The Hearing Officer stated that such conduct would ordinarily warrant permanently removing Dr. Griffin but because Dr. Griffin was in fact a fellow in Dr. Leach Fellowship program, the Hearing Officer recommended that the Board issue a permanent revocation.

The hearing in this matter generated a 3100 page transcript. Appellant, Dr. Leak, Dr. Hoogendoorn and their experts opined the that the standard of care had been met that and that their conduct did not violate any standards of conduct in practice. The experts for the state concluded that the doctors had failed to meet the minimum standards of care by ordering tests which were not warranted by diagnosis of the patient, tests which were ineffective or of little value, and the experts testified that based upon the numbers of procedures and the types of procedures the doctors fell below the standard of care.

Assigned Error One is that Appellant was denied due process because the Board delayed from 2001 until 2006 to bring charges against him. Appellant cites in support of this contention the case of *Mowery v. Ohio State Bd. of Pharm.*⁶ That Court relied upon several federal cases in reaching the decision that due process had been denied due to the delay in bring charges. In *Barker v. Wingo*⁷, the Court addressed a speedy trial issue and cited a test using these four factors: length of delay, reason for the delay, asserting of the right to speedy trial, and prejudice to the Defendant. The Court in *EEOC v. Bell Helicopter Co.*⁸ offered the following for consideration of the issue of unreasonable delay: "(1) a delay in action on the part of the agency; (2) which is *unreasonable* -- that is, resulting from slothfulness, lethargy, inertia, caprice, etc.; and (3) a showing of *prejudice* to the defendant occasioned by the agency delay." These Courts and others have determined that each case must be considered on its facts. If the facts are sufficiently egregious then a denial of due process has occurred.

In contrast to the *Mowery* and above decisions is the 10th district decision of *McCutcheon v. State Medical Bd.*⁹ That case addressed a three-year delay and concluded that due process had not been denied. Likewise the case of *Sutton v. Ohio State Bd. of Pharm*¹⁰ opined that although two and one-half years had elapsed, between the alleged violation and the notice of charged, prejudice would not be inferred from the mere lapse of time. The Supreme Court in *Ohio State Bd. of Pharm. v. Frantz*¹¹ considered a six-year delay and rejected claims of estoppel and laches. The delay in that matter was

⁶ (September 30, 1997), Geauga App. No. 96-G-2005

⁷ (1972), 407 U.S. 514, 33 L.Ed. 2d 101, 92 S. Ct. 2182

⁸ (N.D.Tex. 1976), 426 F. Supp. 785, 792

⁹ (1988), 65 Ohio App. 3d 49; 582 N.E.2d 103

¹⁰ (April 30, 2002), Trumbull App. No.s 2001-T-0030, 2001-T-0031, and 2001-T-0032

¹¹ (1989), 51 Ohio St. 3d 143; 555 N.E.2d 630

occasioned in part by federal charges, but the thrust of the Court's decision was the Court should not impede the state's pursuit of justice.

In examining the current case, the Board has offered no explanation for the four to five year delay other than to point out that the case was complex and required a multi-day hearing. On the other hand, Appellant has offered no evidence of prejudice other than the passage of time. Since the Court entered a stay of the order Appellant has continued to practice from the date the investigation began until present, Appellant cannot claim that he has been impaired as to his practice of medicine. While not precisely on point, the Court in *Haj-Hamed v. State Med. Bd.*¹² reiterated that there must be some type of identifiable prejudice before reaching the conclusion that due process has been denied.

Appellant has offered the case of *Rickett v. Ohio Real Estate Appraiser Bd.*¹³ in support of his claim that the delay constitutes a denial of due process. A careful reading of that case shows that it was decided on grounds other than a delay and due process.

Without some establishment of prejudice the Court finds the precedential value of the *Mowery* case is not persuasive. The Court will instead use for guidance the *Frantz* and *McCutcheon* decisions. Neither of those decisions support Appellant's first argument and Appellant's first assigned error is rejected.

Appellant's second assigned error is that he was not provided sufficient notice of charges. Belying that contention is the sheer volume of testimony and exhibits contained in the record. As to the claim of substandard care, all patients were identified and Appellant had ample opportunity to rebut the state's case. Unlike *Sohi v. State Dental*

¹² 2007-Ohio-2521 Franklin App. No. 06AP-351

¹³ Franklin App. No. 07AP-667, 2008-Ohio-3169

*Bd.*¹⁴ where the doctor was accused of substandard care and not given the names of any patients until the hearing, Appellant was given the ability to prepare and present evidence and did in fact present a substantive defense. After review of the evidence the second assigned error is found not supported.

The third and final assigned error is that the Board lacked reliable, probative, and substantial evidence to support its decision because the experts relied upon by the Board were inherently unreliable. The instant appeal contains testimony from a number of experts. There was no dispute as to any of those experts' qualifications. All of the experts appeared highly qualified and well-versed in the arena of pain management. Appellant frames the issue as one in which the testimony was unreliable because the experts did not express an opinion in terms of care that should have been applicable to Dr. Griffin in his role as a fellow. Appellant also maintains that information was withheld from the Board's experts. Appellant offers that there are two fields of opinion, one based in anesthesiology and the other in neurology. Appellant also offers that the fellowship program was legitimate and that he was bound to follow the directions and standing orders of Dr. Leak.

The standards of care that were found to have been breached in this matter are not esoteric nature. Failure to obtain psychological consultations or addiction specialists, performing tests with limited or no value and excessive prescription of narcotics are matters that cannot be countenanced in any physician review whether viewed under the point of view of anesthesiology or neurology.

While the record does indicate that Dr. Chelimsky and Dr. Katirji were not specifically told that Dr. Griffin was in a fellowship program at the time of their review,

¹⁴ 130 Ohio App. 3d 414; 720 N.E.2d 187

the position taken by Appellant of simply following orders was clearly rejected by the Board as is reflected by the statements of Board member Dr. Egner in the minutes of the Board's meeting of August 13, 2008.

Appellant contends that because he was acting as a fellow, the penalty imposed was improper. The Court suggests that it may have been the fellowship status that kept the Board from imposing permit revocation rather than providing stay conditions.

The substandard care charges might not be applicable to a resident in training. Appellant is a Board certified emergency room physician and the errors and omissions found in the record support the Board's actions. Appellant's third assigned error is not well taken.

CONCLUSION

Upon careful review of the record and arguments of counsel the Court finds the Board's Order to be supported by reliable, probative, and substantial evidence and the Court further finds that it is in accordance with law. Counsel for the Board shall prepare a Judgment Entry pursuant to Local Rule 25.01.



Judge Charles Schneider

Appearances:

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Attorneys for Appellant

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Assistant Attorney General
30 East Broad Street, 26th Floor
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Attorney for Appellee

IN THE COURT OF COMMON PLEAS
FRANKLIN COUNTY, OHIO

Brian Frederic Griffin, M.D.,

Appellant,

vs.

State Medical Board of Ohio,

Appellee.

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Case No. 08 CV 013539

Judge Schneider

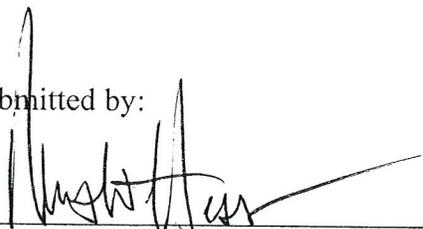
ENTRY GRANTING APPELLANT'S MOTION FOR STAY PENDING APPEAL

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

IT IS SO ORDERED.

Charles Schneider, Judge

Submitted by:



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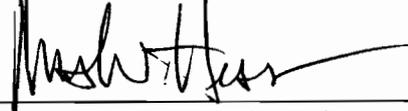
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COMMON PLEAS COURT
FRANKLIN CO. OHIO
2008 OCT -3 AM 11:36
CLERK OF COURTS

The Board is requested to certify the administrative record to the Clerk of Courts, Court
of Common Pleas of Franklin County, Ohio.

2008 SEP 29 P 1:13

A copy of the Notice of Appeal filed with the State Medical Board of Ohio is attached.

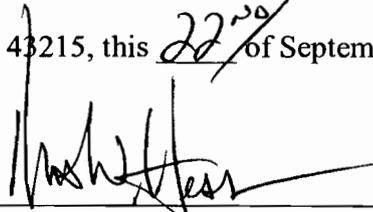
Respectfully submitted,



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Attorneys for Brian Frederic Griffin, M.D.

CERTIFICATE OF SERVICE

I certify that the original of the foregoing Notice of Appeal has been sent via regular U.S.
mail to Kyle C. Wilcox, Assistant Attorney General, Health and Human Services Section, 30
East Broad Street, 26th Floor, Columbus, Ohio 43215, this 22nd of September, 2008.



Thomas W. Hess

State Medical Board of Ohio

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

Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

August 13, 2008

Brian Fredric Griffin, M.D.
3655 Ridge Mill Drive
Hilliard, OH 43026

Dear Doctor Griffin:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of R. Gregory Porter, Attorney Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 13, 2008, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order.

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

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

THE STATE MEDICAL BOARD OF OHIO



Lance A. Talmage, M.D.
Secretary

LAT:jam
Enclosures

CERTIFIED MAIL NO. 91 7108 2133 3934 3690 5913
RETURN RECEIPT REQUESTED

Cc: Thomas W. Hess and Priya J. Bathija, Esqs.
CERTIFIED MAIL NO. 91 7108 2133 3934 3690 5920
RETURN RECEIPT REQUESTED

Mailed 9-10-08

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of R. Gregory Porter, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on August 13, 2008, including motions approving and confirming the Findings of Fact and Conclusions of the Hearing Examiner, and adopting an amended Order; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Brian Frederic Griffin, M.D., as it appears in the Journal of the State Medical Board of Ohio.

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



Lance A. Talmage, M.D.
Secretary

(SEAL)

August 13, 2008
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF *
*
BRIAN FREDERIC GRIFFIN, M.D. *

ENTRY OF ORDER

This matter came on for consideration before the State Medical Board of Ohio on August 13, 2008.

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

It is hereby ORDERED that:

1. **PERMANENT REVOCATION, STAYED; PROBATION:** The certificate of Brian Frederic Griffin, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such permanent revocation is STAYED, subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years.

a. **Obey the Law:** Dr. Griffin shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.

b. **Limitation/Restriction:** The certificate of Dr. Griffin to practice medicine and surgery in the State of Ohio shall be LIMITED and RESTRICTED as follows:

Clinical Education Program: Dr. Griffin's certificate shall be LIMITED and RESTRICTED to participation in a clinical education program, to be approved in advance by the Board or its designee, related to or concerning the use of EDX studies and interventions in the practice of pain medicine. The exact number of hours and the specific content of the program shall be determined by the Board or its designee, but shall total not less than 40 nor more than 80 hours. The Board may require Dr. Griffin to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

Prior to the termination of the limitation, Dr. Griffin shall submit to the Board documentation of successful completion of the clinical education program and a written report describing the program, setting forth what he learned from the program, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future. Upon acceptance of the documentation of successful completion of the clinical education program and the written report, the Board shall provide Dr. Griffin with written notification that this condition has been fulfilled and that the LIMITATION and RESTRICTION has been terminated.

- c. **Declarations of Compliance:** Dr. Griffin shall submit quarterly declarations under penalty of Board disciplinary action 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.
- d. **Personal Appearances:** Dr. Griffin shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested 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.
- e. **Monitoring Physician:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Griffin shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Griffin and who is engaged in the same or similar practice specialty.

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

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

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

addition, Dr. Griffin shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Griffin shall 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.

- f. **Absence from Ohio**: Dr. Griffin shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed.
- g. **Noncompliance Will Not Reduce Probationary Period**: In the event Dr. Griffin is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.

2. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS**: Within thirty days of the effective date of this Board Order, Dr. Griffin shall provide a copy of this Board Order to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Griffin shall promptly provide a copy of this Board Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Griffin provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Board Order Dr. Griffin shall provide a copy of this Board Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. Further, Dr. Griffin shall provide the Board with **one** of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was emailed.

3. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES**: Within thirty days of the effective date of this Board Order, Dr. Griffin shall provide a copy of this Board 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, though which he currently holds any license or certificate. Dr. Griffin further agrees to provide a copy of this Board Order at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license. Further, Dr. Griffin shall provide the Board with **one** of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was emailed.

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

EFFECTIVE DATE OF ORDER: This Order shall become effective thirty days from the date of mailing of notification of approval by the Board.

(SEAL)



Lance A. Talmage, M.D.
Secretary

August 13, 2008
Date

2008 JUL -7 A 8: 32

**REPORT AND RECOMMENDATION
IN THE MATTER OF BRIAN FREDERIC GRIFFIN, M.D.**

The Matter of Brian Frederic Griffin, M.D., was heard by R. Gregory Porter, Hearing Examiner for the State Medical Board of Ohio, on May 14 through 18, 21, 23 through 25, and June 11, 12, 14, 15, and 18 through 21, 2007.¹

INTRODUCTION

Basis for Hearing

By letter dated August 9, 2006, the State Medical Board of Ohio [Board] notified Brian Frederic Griffin, M.D., that it had proposed to take disciplinary action against his certificate to practice medicine and surgery in Ohio. The Board based its proposed action on allegations pertaining to Dr. Griffin's treatment of 23 patients identified on a confidential Patient Key, and/or his alleged aiding and abetting a podiatrist to unlawfully practice medicine and surgery. The Board alleged that Dr. Griffin's conduct constitutes:

- “[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”; and/or
- “[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,” as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate. Pursuant to Section 4731.99(A), Ohio Revised Code, violation of Section 4731.41, Ohio Revised Code, constitutes a felony offense.”

The Board advised Dr. Griffin of his right to request a hearing, and received his written request for hearing on August 31, 2006. (State Exhibits 54A, 54E)

Appearances

Nancy Hardin Rogers, Attorney General, by Damion M. Clifford and Kyle C. Wilcox, Assistant Attorneys General, for the State.

Thomas W. Hess and Priya J. Bathija, Esqs., for Dr. Griffin.

¹ The hearing in this matter was presented in conjunction with the matters of W. David Leak, M.D., and Kyle Elliott Hoogendoorn, D.P.M. Nevertheless, a separate Report and Recommendation was prepared for each individual.

TABLE OF CONTENTS

INTRODUCTION	1
table of contents	2
EVIDENCE EXAMINED	6
PROFFERED EXHIBITS.....	11
Procedural Matters	11
SUMMARY OF THE EVIDENCE	13
Background Information – Respondents	13
Brian F. Griffin, M.D.....	13
W. David Leak, M.D.....	15
Kyle E. Hoogendoorn, D.P.M.....	16
Background Information – Expert Witnesses.....	16
Bashar Katirji, M.D.....	16
Thomas C. Chelimsky, M.D.	17
Dr. Chelimsky’s Pain Medicine Practice	18
James P. Bressi, D.O.....	19
Dr. Bressi’s Pain Medicine Practice	19
David R. Longmire, M.D.....	20
Gary W. Jay, M.D.....	21
Background Information – Fact Witness – Mark V. Boswell, M.D., Ph.D.....	21
Subspecialty Certification in Pain Medicine.....	23
Dr. Leak’s Medical Practice: PCC and Pain Net.....	23
Pain Control Consultants	23
Testimony of Dr. Leak Regarding the PCC Fellowship Program	23
Testimony of Dr. Boswell Concerning Dr. Leak’s Fellowship Program	25
Dr. Griffin’s Participation in the PCC Fellowship.....	25
Dr. Hoogendoorn’s Participation in the PCC Fellowship.....	25
Allegations (1), (1)(c):	26
Electrodiagnostic [EDX] Studies – Background	26
Testimony of Dr. Chelimsky.....	29
EDX Studies – Somatosensory Evoked Potentials [SSEP]	29
Testimony of Dr. Katirji	29
Testimony of Dr. Chelimsky.....	30
Testimony of Dr. Bressi.....	30
Testimony of Dr. Leak.....	31
Testimony of Dr. Griffin.....	32
Testimony of Dr. Boswell.....	33
EDX – Nerve Conduction Studies	33
Testimony of Dr. Katirji	33
Testimony of Dr. Chelimsky.....	33
Testimony of Dr. Leak.....	33
Selective Tissue Conductance [STC]Studies – Autonomic Nervous System	34
Testimony of Dr. Longmire	34

Testimony and Written Reports of Dr. Chelimsky	36
Testimony of Dr. Jay.....	40
Testimony of Dr. Bressi.....	41
Testimony of Dr. Boswell.....	41
Testimony of Dr. Leak.....	42
Testimony of Dr. Griffin.....	42
Table of EDX Studies Performed or Ordered by Dr. Leak and/or Dr. Griffin	43
Allegation (1)(e).....	49
Use of Needle EMG.....	49
Testimony of Dr. Katirji	49
Testimony of Dr. Chelimsky.....	51
Testimony of Dr. Bressi.....	52
Testimony of Dr. Leak.....	52
Testimony of Dr. Griffin.....	53
Testimony of Dr. Boswell.....	53
Allegation (1)(d)	54
Indications for the Use of EDX Studies.....	54
Testimony of Dr. Katirji	54
Testimony of Dr. Bressi.....	55
Testimony of Dr. Griffin.....	55
Standing Orders for EDX Studies.....	56
Testimony of Dr. Griffin.....	56
Testimony of Dr. Chelimsky.....	56
Allegations (1)(g), (1)(h)	56
Comments on Abnormal EDX Study Results.....	57
Dr. Katirji’s Testimony and Report	57
Testimony of Dr. Griffin.....	58
Change in Management Based on the Abnormal Results of EDX Studies	58
Dr. Katirji’s Testimony.....	58
Lack of Overall Clinical Impression.....	59
Testimony and Written Report of Dr. Chelimsky.....	59
Testimony of Dr. Bressi.....	60
Testimony of Dr. Leak.....	60
Testimony of Dr. Griffin.....	61
Medical Records	61
Allegation (1)(a).....	61
Referral for Psychological Consultation.....	62
Testimony and Report of Dr. Chelimsky	62
Testimony of Dr. Bressi.....	62
Testimony of Dr. Leak.....	62
Testimony of Dr. Griffin.....	63
Patient-Specific Evidence re: Psychological Referrals.....	63
Allegation (1)(b):	67
Evidence Specific to Patient 20	68
Drug-Seeking Behavior	68
Testimony of Dr. Chelimsky.....	69

Testimony of Dr. Leak.....	69
Evidence Specific to Patient 23	69
Drug-Seeking Behavior	69
Testimony of Dr. Chelimsky.....	71
Testimony of Dr. Bressi.....	72
Testimony of Dr. Leak.....	73
Further Testimony of Dr. Chelimsky.....	74
Further Testimony of Dr. Bressi.....	74
Testimony of Dr. Griffin.....	74
Allegation (1)(l):.....	75
Patient 3 Medical Records	75
Excessive Morphine.....	76
Testimony of Dr. Chelimsky.....	76
Testimony of Dr. Bressi.....	76
Evidence of Development of Cognitive Dysfunction.....	76
Patient 3 Medical Records	76
Dr. Chelimsky’s January 31, 2005, Report.....	77
Testimony of Dr. Bressi.....	77
Testimony of Dr. Griffin.....	77
Allegation (1)(m):.....	78
Patient 11 Medical Records	78
Allegation (1)(h):.....	79
Patient 20 Medical Records	79
Testimony of Dr. Chelimsky.....	80
Testimony of Dr. Bressi.....	80
Testimony of Dr. Griffin.....	80
Allegation (1)(k):.....	80
Testimony and Written Report of Dr. Chelimsky.....	81
Procedures – Trigger Point Injections.....	81
Testimony of Dr. Bressi.....	82
Testimony of Dr. Leak.....	83
Testimony of Dr. Griffin.....	83
Procedures – Excessive Number of Trigger Point Injections – Respondent’s Defense – “Fanning the Needle”.....	83
Testimony of Dr. Leak.....	83
Testimony of Dr. Bressi.....	84
Procedures – Chemoneurolytic Injections	84
Testimony of Dr. Chelimsky.....	84
Testimony of Dr. Leak.....	84
Testimony of Dr. Griffin.....	84
Procedures – Radiofrequency Lesioning	85
Testimony of Dr. Chelimsky.....	85
Testimony of Dr. Leak.....	85
Additional Procedures Listed in the Table Below that were Performed by Dr. Leak Only .	85
Allegation (1)(j):.....	93
Supervising a Podiatrist to Engage in the Use of Destructive Modalities of Treatment	93

Testimony of Dr. Chelimsky.....	96
Testimony of Dr. Leak.....	96
Testimony of Dr. Griffin.....	96
Allegation (2)(a):	97
Testimony and January 31, 2005, Report of Dr. Chelimsky	101
Testimony of Dr. Bressi.....	101
Testimony of Dr. Griffin.....	102
Testimony of Dr. Hoogendoorn.....	102
Level of Supervision of Dr. Hoogendoorn during Procedures	103
Testimony of Dr. Leak.....	103
Testimony of Dr. Griffin.....	103
Testimony of Dr. Hoogendoorn.....	104
Allegation (2)(b):	104
Dr. Hoogendoorn’s Prescribing of Medications for Non-Podiatric Patients	105
Testimony of Investigator McCafferty	106
Testimony of Dr. Chelimsky Concerning Medications Prescribed by Dr. Hoogendoorn	106
Testimony of Dr. Hoogendoorn.....	107
Further Testimony of Dr. Chelimsky.....	108
Testimony of Dr. Bressi.....	108
Testimony of Dr. Leak.....	109
Testimony of Dr. Griffin.....	109
Further Testimony of Dr. Hoogendoorn	109
Dr. Griffin’s Participation in the PCC Fellowship.....	110
Testimony of Dr. Griffin.....	110
Testimony of Dr. Hoogendoorn.....	111
Testimony of Dr. Katirji	111
Dr. Hoogendoorn’s Participation in the PCC Fellowship.....	111
Testimony of Dr. Hoogendoorn Concerning Podiatric Residency Training	111
Testimony of Dr. Weiner Concerning Podiatric Residency Training.....	111
Testimony of Dr. Loftus Concerning Podiatric Residency Training.....	112
Testimony of Dr. Bastawros Concerning Podiatric Fellowship Training.....	113
The PCC Fellowship.....	114
Testimony of Dr. Hoogendoorn.....	114
Testimony of Dr. Leak.....	116
Testimony of Dr. Griffin.....	117
Testimony of Dr. Chelimsky.....	117
Testimony of Dr. Bressi.....	119
Signed Discharge Summaries for Procedures.....	119
Additional Information	122
Testimony of Dr. Boswell Concerning Dr. Leak.....	122
Testimony of Dr. Boswell Concerning Approaches to Pain Medicine: Neurology vs. Anesthesiology.....	122
Testimony of Dr. Boswell Concerning the Use of EDX Studies in Interventional Pain Management.....	123
Testimony of Dr. Griffin.....	123

Dr. Hoogendoorn’s use of knowledge gained in fellowship..... 124
 FINDINGS OF FACT..... 125
 CONCLUSIONS OF LAW 132
 PROPOSED ORDER 133

EVIDENCE EXAMINED

Testimony Heard

A. Presented by the State

- Mark V. Boswell, M.D.
- Kyle E. Hoogendoorn, D.P.M., as upon cross-examination
- David Shawn McCafferty
- Murray Kopelow, M.D.
- W. David Leak, M.D., as upon cross-examination
- Brian F. Griffin, M.D., as upon cross-examination
- Bashar Katirji, M.D.
- Thomas C. Chelimsky, M.D.

B. Presented by the Respondents

- David R. Longmire, M.D.
- Richard Weiner, D.P.M.
- Kyle E. Hoogendoorn, D.P.M.
- James P. Bressi, D.O.
- Todd C. Loftus, D.P.M.
- Andrew Thomas, M.D.
- David S. Bastawros, D.P.M.
- W. David Leak, M.D.
- Gary W. Jay, M.D.
- Brian F. Griffin, M.D.

Exhibits Examined

(Exhibits marked with an asterisk [*] have been sealed to protect confidentiality.)

A. Presented by the State

- * State’s Exhibits 1 through 24: Copies of medical records for Patients 1 through 24.
- * State’s Exhibit 26: Patient Key.
- State’s Exhibits 27 and 27A: Curriculum vitae of Thomas C. Chelimsky, M.D.

- * State's Exhibits 28 and 29: Copies of written reports prepared by Dr. Chelimsky dated January 31, 2005, and May 2, 2006, respectively.

State's Exhibit 30: Curriculum vitae of Bashar Katirji, M.D.

- * State's Exhibit 31: Copy of August 8, 2006, report prepared by Dr. Katirji.

State's Exhibit 32: Copy of August 31, 2001, letter to Board enforcement staff from Murray Kopelow, M.D., Chief Executive, Accreditation Council for Continuing Medical Education [ACCME], Chicago, Illinois.

State's Exhibit 33: Copy of document published on the Internet by the Accreditation Council for Graduate Medical Education [ACGME] entitled Section II: Essentials of Accredited Residencies in Graduate Medical Education, printed October 18, 2001, <<http://www.acgme.org/GmeDir/Sect2.asp>>.

State's Exhibit 36: Excerpt from transcript of August 17, 2001, Board investigative deposition of Dr. Leak.

State's Exhibit 41: Copy of Dr. Leak's responses to the Board's Second Set of Interrogatories.

State's Exhibit 42: Copy of Dr. Leak's responses to the Board's Third Set of Interrogatories.

State's Exhibits 44 and 44A: Copies of current and previous versions of Section 4731.51, Ohio Revised Code, Defining Practice of Podiatric Medicine and Surgery.

State's Exhibit 45: Copy of April 7, 2001, letter to Dr. Hoogendoorn from Dr. Leak, and attached materials concerning the fellowship offered by Pain Control Consultants, Inc.

State's Exhibit 46: Curriculum vitae of Mark V. Boswell, M.D., Ph.D.

State's Exhibit 47: Section 4731.41, Ohio Revised Code, Practicing Medicine without Certificate

State's Exhibits 48A and 48B: Previous versions of Section 4731.143, Ohio Revised Code, Notice of Lack of Coverage of Medical Malpractice Insurance, as effective April 10, 2001, and December 30, 2004, respectively.

State's Exhibit 49: Section 2923.03, Ohio Revised Code, Complicity.

State's Exhibit 53: Copy of April 27, 2007, letter to Damion M. Clifford, Assistant Attorney General, from Dr. Chelimsky, with portions redacted.

State's Exhibits 54A through 54WWW: Procedural exhibits. [State's Exhibits 54JJ and 54KK have been sealed to protect patient confidentiality.]

State's Exhibit 55: Printed copy of April 2, 2007, email from Mr. Clifford to counsel for Drs. Leak, Griffin, and Hoogendoorn.

State's Exhibit 57: Copy of document published on the Internet by the American Board of Medical Specialties [ABMS] concerning Dr. Griffin's board certification, indicating that he has been certified in Emergency Medicine by the American Board of Emergency Medicine, and that he holds subspecialty certification in Pain Medicine from the American Board of Physical Medicine and Rehabilitation, printed June 4, 2007, <<http://www.abms.org/searchdetail.asp?key=323675>>.

State's Exhibit 58: Copy of document published on the Internet by the ABMS concerning the American Board of Anesthesiology and the specialty and subspecialty certifications it offers, printed June 4, 2007, <http://www.abms.org/Who_We_Help/Consumers/About_Physician_Specialties/anesthesiolo... [remainder of citation not included in original]>.

State's Exhibit 59: Copy of document published on the Internet by the ABMS concerning Dr. Leak's board certification, indicating that he has been certified in Anesthesiology by the American Board of Anesthesiology, printed June 4, 2007, <<http://www.abms.org/searchdetail.asp?key=57133>>.

State's Exhibit 60: State's Closing Argument. [This exhibit was marked by the Hearing Examiner and admitted post-hearing.]

State's Exhibit 61: State's Rebuttal Argument. [This exhibit was marked by the Hearing Examiner and admitted post-hearing.]

B. Presented by the Respondent

Respondents' Exhibit 103H: Curriculum vitae of Kyle E. Hoogendoorn, D.P.M.

Respondents' Exhibit 104H: Curriculum vitae of W. David Leak, M.D.

Respondents' Exhibit 105A-G: Curriculum vitae of Brian F. Griffin, M.D.

Respondents' Exhibit 106G: Curriculum vitae of James Patrick Bressi, D.O.

Respondents' Exhibit 109H: Curriculum vitae of David S. Bastawros, D.P.M.

Respondents' Exhibit 110H: Course Curriculum published by the Ohio College of Podiatric Medicine concerning the four-year curriculum and the five-year extended curriculum, <http://www.ocpm.edu/students/course_curriculum/> (March 19, 2007).

Respondents' Exhibit 111H: Copy of January 1999 *CPME 320: Standards, Requirements, and Guidelines for Approval of Residencies in Podiatric Medicine*, approved by the Council on Podiatric Medical Education [CPME], October 1998.

Respondents' Exhibits 112H and 112aH: Copy and original of October 1999 *CPME 330: Procedures for Approval of Residencies in Podiatric Medicine*, approved by the Council on Podiatric Medical Education [CPME], October 1999.

Respondents' Exhibit 114H: Copy of an April 7, 2001, letter to Dr. Hoogendoorn from Dr. Leak.

Respondents' Exhibit 115H: Copy of Pain Net Inc.'s Fellowship Guidelines for Pain Control Consultants.

Respondents' Exhibits 117H and 118H: Copies of letters to Dr. Hoogendoorn from Vincent J. Hetherington, D.P.M., Vice President and Dean of Academic Affairs, OCPM.

Respondents' Exhibit 119H: Copy of September 19, 2001, Memorandum of Affiliation between The Ohio College of Podiatric Medicine and Pain Control Consultants, Inc.

Respondents' Exhibit 121H: Copy of January 8, 2002, letter to Dr. Leak from Alan Tinkleman, Director, CPME.

Respondents' Exhibit 122H: Copies of various certificates of Dr. Hoogendoorn.

Respondents' Exhibit 156: Copy of March 21, 2007, written report of Gary W. Jay, M.D.

Respondent's Exhibit 157: Copy of the written report of David R. Longmire, M.D.

Respondents' Exhibit 165: Curriculum vitae of Dr. Jay.

Respondents' Exhibit 201: Copies of documents from a seminar entitled "Prescription Paradigm Shift: Kroger Pharmacy and Pain Net," offered by Pain Net, Inc., Pain Control Consultants, Inc., and Kroger Pharmacies on February 13, 2002.

Respondents' Exhibit 202: Copy of document entitled "Building Blocks of Evidence Based Medicine," from Pain Net Technology, LLC.

Respondents' Exhibit 203: Copy of JRRC Application for New Fellowship Program.

Respondents' Exhibit 213L: Longmire D.R.: "An Electrophysiological Approach to the Evaluation of Regional Sympathetic Dysfunction: A Proposed Classification," *Pain Physician* 2006;9:69-82, 2006.

Respondents' Exhibit 214: Ochoa, J.L.: "Chronic Pains Associated with Positive and Negative Sensory, Motor, and Vasomotor Manifestations: CPSMV (RSD;CRPS?), Heterogeneous Somatic Versus Psychopathologic Origins." <<http://mitpress.mit.edu/e-journals/JCN/articles/002/Ochoa.html>> (August 14, 1997).

Respondent's Exhibit 214L: Curriculum Vitae of Dr. Longmire.

Respondents' Exhibits 215 and 215A: Copies of documents from a seminar entitled "Clinical Development for Chronic Pain Therapeutics," offered by Marcus Evans Conferences on March 29 and 30, 2007.

Respondents' Exhibit 216: Luis Garcia-Larrea, *Handbook of Clinical Neurology, Volume 81, 3rd Series, Neurophysiological Examinations in Neuropathic Pain, Chapter 30, Evoked Potentials in the Assessment of Pain*. (Elsevier B.V., 2006)

Respondents' Exhibit 217: Burneo, J.G., Barkley, G.L.: "Somatosensory Evoked Potentials: Clinical Applications." <<http://www.emedicine.com/neuro/topic344.htm>> (May 23, 2007).

Respondents' Exhibit 218: Copies of various certification documents for Dr. Leak.

Respondents' Exhibits 219 through 221: Closing arguments of Drs. Griffin, Hoogendoorn, and Leak, respectively. [Note: These exhibits were marked and admitted by the Hearing Examiner post-hearing.]

C. Presented by the Hearing Examiner

Board Exhibit A: June 27, 2007, Entry establishing schedule for filing written closing arguments.

Board Exhibit B: Copy of the Respondents' joint motion to extend time for filing written closing arguments.

Board Exhibit C: Copy of September 13, 2007, Entry granting the Respondents' motion to extend time for filing written closing arguments.

Board Exhibit D: Copy of the Respondents' second joint motion to extend time for filing written closing arguments.

Board Exhibit E: Copy of September 28, 2007, Entry granting the Respondents' second joint motion to extend time for filing written closing arguments.

Board Exhibit F: Transcript of April 24, 2007, pre-hearing conference.

Board Exhibit G: Copy of the State's October 9, 2007, emailed request to extend time for filing rebuttal closing argument, and responses.

Board Exhibit G1: Copy of October 10, 2007, Entry granting the State's request for an extension of time.

Board Exhibit H: Patient Key conversion chart for the Master Patient Key (Board Exhibit I) and Dr. Katirji's written report.

Board Exhibit I: Master Patient Key which cross references the patient numbers used in Dr. Leak's notice letter (which is identical to the Master Patient Key), Dr. Griffin's notice letter (which differs from the patient numbers used in the Master Patient Key and Dr. Leak's notice letter), and Dr. Hoogendoorn's notice letter (which differs from the patient numbers used in the Master Patient Key, Dr. Leak's notice letter, and Dr. Griffin's notice letter).

PROFFERED EXHIBITS

The following documents were neither admitted to the record nor considered as evidence. However, they have been sealed from public disclosure and will be held as proffered material:

State's Exhibit 25: Copies of Dr. Leak's billing records. (See Hearing Transcript [Tr.] at 2019-2022)

State's Exhibit 43: Copy of the Board's May 13, 1998, Position Paper concerning the Delegation of Medical Tasks. (See Tr. at 2044-2045)

State's Exhibits 50 through 52: Excerpts from the Ohio Administrative Code. (See Tr. at 2051-2055)

State's Exhibit 53: Unredacted April 27, 2007, letter to Mr. Clifford from Dr. Chelimsky. (See Tr. at 2055-2062)

Respondents' Exhibit 113H: Copy of a March 22, 2001, letter to Dr. Hoogendoorn from Dr. Leak. (See Procedural Matters 3.d, below.)

Respondents' Exhibit 120H: Copy of October 29, 2001, letter to the Joint Residency Review Committee [JRRC] from Dr. Leak. (See Procedural Matters 3.e, below.)

PROCEDURAL MATTERS

1. On August 9, 2006, the Board issued notices of opportunity for hearing to Dr. Leak, Dr. Griffin, and Dr. Hoogendoorn. Each requested a hearing. Subsequently, by Entry dated October 12, 2006, and with the agreement of all parties, the matters of Dr. Leak,

Dr. Griffin, and Dr. Hoogendoorn were consolidated for purposes of the administrative hearing. (State's Exhibits 54A, 54B, 54C, 54E, 54G, 54L, and 54BB)

2. The record in this matter was held open until October 15, 2007, to give the parties an opportunity to file written closing arguments. These documents were timely filed and admitted to the record as State's Exhibits 60 and 61, and Respondents' Exhibits 219 through 221.
3. At hearing, the final determination regarding the admissibility of the following exhibits was deferred:
 - a. St. Ex. 32: This exhibit was to be admitted on the condition that it had been identified at hearing by Murray Kopelow, M.D. (Hearing Transcript [Tr.] at 2032-2035) The hearing record indicates that Dr. Kopelow identified the document. (Tr. at 359) Accordingly, the document is admitted to the hearing record.
 - b. St. Ex. 33: This document was to be removed from the record if all witnesses agreed that there was no ACGME²-approved fellowship available in pain management until 2002. If any witness testified to the contrary, the document was to be admitted to the hearing record. (Tr. at 2032-2035) The hearing record indicates that Mark V. Boswell, M.D., testified that the pain medicine fellowship at Case Western Reserve University School of Medicine had obtained ACGME accreditation in 1996 through the American Board of Anesthesiology. (Tr. at 18) Accordingly, this document is admitted to the hearing record.
 - c. St. Ex. 36: This exhibit was to be admitted on the condition that it was used by the State for the purpose of impeaching Dr. Leak's testimony. (Tr. at 2035-2041) The hearing record indicates that pages 93 through 106 of this document had been used by the State for that purpose. (Tr. at 416-423, 471-473) Accordingly, pages 1, 2, and 93-106 of this document are admitted to the hearing record. (This ruling concerns the admissibility of the document only and does not reflect the Hearing Examiner's opinion concerning the success or lack of success of the State's effort to impeach.)
 - d. Respondent's Exhibit 113H: This document was to be admitted on the condition that it had been referenced during hearing. (Tr. at 3120-3121) The Hearing Examiner could find no reference to this exhibit in the hearing record. Accordingly, it will be removed from the record and held as proffered material for the Respondents.
 - e. Respondent's Exhibit 120H: This document was to be admitted on the condition that it had been referenced during hearing. (Tr. at 3123-3124) The Hearing Examiner could find no reference to this exhibit in the hearing record. Accordingly, it will be removed from the record and held as proffered material for the Respondents.

² Accreditation Council for Graduate Medical Education.

4. Dr. Leak made an objection at hearing, and the ruling was deferred. (See Tr. at 951-952) The objection is overruled. Mr. Clifford's characterization of Dr. Griffin's previous testimony during his questioning of Dr. Longmire was accurate. (See Tr. at 663-665)
5. Any other objections where rulings were deferred are hereby overruled. Further, any motions to strike where rulings were deferred are hereby denied.

SUMMARY OF THE EVIDENCE

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

Background Information – Respondents

Brian F. Griffin, M.D.

1. Brian F. Griffin, M.D., obtained his medical degree in 1978 from the University of Cincinnati College of Medicine. From 1978 to 1979 he participated in a one-year internship at Good Samaritan Hospital in Cincinnati, Ohio. Dr. Griffin testified that he did not participate in a residency. He was licensed to practice medicine and surgery in Ohio in 1979. (Respondent's Exhibit [Resp. Ex.] 105a-g at 12; Hearing Transcript [Tr.] at 634-635, 2978)

Dr. Griffin testified that, following his internship, he completed a year of training in hospital administration where he "served as a liaison between the medical staff and hospital administration at Providence Hospital in Cincinnati." Dr. Griffin then became the Director of the Emergency Department at Adams County Hospital where he practiced emergency medicine for two years. He then moved to Portsmouth where he practiced emergency medicine at both Scioto Memorial and Mercy Hospitals for two years. Next, Dr. Griffin moved to Columbus where he practiced emergency medicine at Grant Hospital, Riverside Hospital, Doctors North Hospital, and Doctors West Hospital. In 1994, Dr. Griffin took a position in the emergency department at Columbus Community Hospital [CCH]. Dr. Griffin testified that he had worked in the emergency department at CCH for four years. (Tr. at 634-640)

Dr. Griffin testified that, while he was employed at CCH, Dr. Leak had offered to him a position in an unaccredited pain medicine fellowship at Pain Control Consultants, Inc., [PCC], where Dr. Leak was the owner and medical director. Dr. Griffin testified that he had accepted the offer, entered the fellowship in 1999, and completed two years of fellowship. Dr. Griffin testified that, after his fellowship ended in 2001, he had continued as an employee of PCC until 2003. In December 2003, Dr. Griffin left PCC and opened his own practice of pain medicine in Hilliard, Ohio. (Resp. Ex. 105a-g; Tr. at 640-641, 633, 644, 2978-2979)

2. Dr. Griffin testified that, since late 2003, he has been the president and owner of Interventional Pain Solutions in Columbus. Dr. Griffin testified that Interventional Pain Solutions is “a practice solely devoted to patients in pain, and I do both the clinical side of pain management and the surgical side of pain medicine or management, depending on what phrase you like.” Dr. Griffin testified that his practice employs two registered nurses, a licensed practical nurse, a medical assistant, a front desk clerk, and an office manager. Dr. Griffin further testified that he has over 1,200 patient charts on file, although not all of those patients are active. (Tr. at 2988-2990)

Dr. Griffin testified that he draws patients from all over Ohio, but primarily from Franklin County and nearby counties. However, Dr. Griffin testified that he has patients from other states as well, and has one patient from Florida. When asked why a patient would travel from Florida to see him, Dr. Griffin replied that he has more fellowship training than many other pain physicians. Dr. Griffin further testified that he knows some physicians in Florida who are familiar with his practice and refer patients to him. (Tr. at 2990-2991)

3. Dr. Griffin was certified by the American Board of Emergency Medicine in 1988 and recertified in 1998. In 2001, Dr. Griffin was certified by the American Academy of Pain Management. (Resp. Ex. 1051a-g)

Dr. Griffin’s curriculum vitae states that, in 2004, Dr. Griffin was certified by the American Board of Anesthesiology with subspecialty certification in pain medicine. (Resp. Ex. 105a-g at 1) However, a document presented by the State indicates that Dr. Griffin actually holds subspecialty certification in pain medicine from the American Board of Physical Medicine and Rehabilitation [ABPMR]. (State’s Exhibit [St. Ex.] 57) Dr. Griffin denied that he holds his subspecialty certification through the ABPMR, and that that had just been the board through whom he had taken the certification examination. Nevertheless, Dr. Griffin acknowledged that he does not hold subspecialty certification through the American Board of Anesthesiology. (Tr. at 3088-3090)

Dr. Griffin testified that all of his certifications are current. (Tr. at 2980-2981)

4. Dr. Griffin testified that he writes and publishes extensively. (Resp. Ex. 105a-g; Tr. at 2994-2995)
5. Dr. Griffin testified that, since 2001, he has been the executive director for the medical team at the annual Arnold Schwarzenegger Classic. (Resp. Ex. 105a-g at 2; Tr. at 2985-2986)
6. Dr. Griffin testified that, aside from his medical practice, from 1981 to 2002 he had worked about 20 hours per week as a volunteer deputy for the Adams County Sheriff’s Department. Dr. Griffin further testified that, for three of those years, he had worked as a squad leader for the S.W.A.T. team of the Delaware County Sheriff’s Office. (Resp. Ex. 105a-g at 10; Tr. at 2979-2980, 2983-2984)

W. David Leak, M.D.

7. W. David Leak, M.D., obtained his medical degree in 1979 from the Wake Forest University, Bowman-Gray School of Medicine, in Winston-Salem, North Carolina. From 1979 through 1980, Dr. Leak participated in a rotating internship in the Department of Anesthesia at the Ohio State University Hospitals in Columbus, Ohio. From 1981 through 1983, Dr. Leak participated in a residency in anesthesiology at the Hospital of the University of Pennsylvania in Philadelphia, Pennsylvania. From 1983 through 1984, Dr. Leak participated in a clinical and research fellowship in cardiovascular and regional anesthesia and pain management at that same institution. Finally, from April through June 1984, Dr. Leak completed his fellowship at the Pain Control Center at the University of Cincinnati in Cincinnati, Ohio. (Resp. Ex. 104H at 1; Tr. at 380-381, 2680-2683)

Dr. Leak's curriculum vitae states that, in 1984, he was certified in anesthesiology by the American Board of Anesthesiology. In 1992, Dr. Leak became a diplomate of the American Board of Pain Medicine. In 1993, Dr. Leak was awarded a certificate of added qualifications in pain medicine from the American Board of Anesthesiology.³ In 1995, Dr. Leak became a fellow of the American Academy of Pain Management. (Resp. Ex. 104H; Tr. at 2683-2685)

Dr. Leak testified that he has published articles and book chapters on the subject of pain management, and has made numerous presentations and lectures on that subject throughout his career. (Resp. Ex. 104H; Tr. at 2691)

8. From 1984 through the time of the hearing, Dr. Leak has been the Medical Director of Pain Control Consultants, Inc., [PCC], in Columbus, Ohio, where he practices interventional pain medicine. (Resp. Ex. 104H; Tr. at 2687) From approximately 1998, through Pain Control Consultants, Inc., Dr. Leak ran a fellowship in pain management. Dr. Leak testified that the PCC fellowship is currently inactive and has "not taken a fellow for quite a few years." (Tr. at 408; Tr. at 2689)

Dr. Leak testified that he currently holds privileges at Morrow County Hospital. Dr. Leak further testified that Morrow County Hospital is located about 30 minutes north of the "Polaris" development in southern Delaware County, north of Columbus, Ohio. Dr. Leak indicated that he does not have privileges at any hospital in Columbus, stating:

Hospitals [in Columbus] usually require physicians who are anesthesiologists to be part of the anesthesia department. They don't have what's known as open staff. And most of the anesthesiologists that do pain end up working either out of their offices or at hospitals where they have open staff. Morrow County has open staff.

(Tr. at 2897-2898)

³ Dr. Leak testified that he has not recertified his added qualifications in pain medicine, and that it expired in 2003. (Tr. at 2684, 3145-3146)

Kyle E. Hoogendoorn, D.P.M.

9. Kyle Elliott Hoogendoorn, D.P.M., obtained his podiatric medical degree in 1997 from the Ohio College of Podiatric Medicine in Cleveland, Ohio. From 1997 through 1998, Dr. Hoogendoorn participated in a primary podiatric medical residency at Richmond Heights Hospital⁴ in Richmond Heights, Ohio. Subsequently, from August 2000 to February 2003, Dr. Hoogendoorn participated in a pain management fellowship through PCC. (Resp. Ex. 103H; Tr. at 81-84, 411, 2181-2182)

Since 1997, Dr. Hoogendoorn has been licensed by the Board to practice podiatric medicine and surgery in Ohio. (Resp. Ex. 103H)

10. Dr. Hoogendoorn has been certified by the American Board of Orthopedic and Primary Podiatric Medicine and the American Academy of Wound Management. (Resp. Ex. 103H)

In addition, Dr. Hoogendoorn testified that he has been certified by the American Academy of Pain Management, and that he sits on the academy's committee for continuing education. Dr. Hoogendoorn noted that M.D.s, D.O.s, D.P.M.s, and dentists who practice pain management are eligible for membership in that organization, and that they all take the same certifying examination. (Tr. at 2215-2216)

11. Dr. Hoogendoorn currently practices at Pro-Active Wound Care Clinics, Inc., in Hilliard, Ohio, and the Foot and Ankle Health Center, Inc., in Grove City, Ohio. (Resp. Ex. 103H)

Background Information – Expert Witnesses*Bashar Katirji, M.D.*

12. Bashar Katirji, M.D., testified as an expert on behalf of the State. Dr. Katirji obtained his medical degree in 1977 from the University of Aleppo in Aleppo, Syria. From 1977 through 1980, Dr. Katirji trained in internal medicine in the Middle East. From 1980 through 1983, Dr. Katirji participated in a neurology residency at the University Health Center of Pittsburgh in Pittsburgh, Pennsylvania. Finally, from 1983 through 1984, Dr. Katirji participated in a fellowship in electromyography at The Cleveland Clinic Foundation in Cleveland, Ohio. (St. Ex. 30 at 1-3; Tr. at 987)

In 1985, Dr. Katirji was certified in neurology by the American Board of Psychiatry and Neurology and, in 1992, he obtained added qualifications in clinical neurophysiology from the same board. In addition, Dr. Katirji was certified by the American Board of Electroencephalography in 1985, by the American Association of Electrodiagnosis and Electromyography in 1986, and by the American Board of Electrodiagnostic Medicine in 1990. (St. Ex. 30 at 3; Tr. at 989-991)

⁴ Dr. Hoogendoorn testified that Richmond Heights Hospital is now known as PHC-Mt. Sinai East Hospital. (Tr. at 82-83)

Dr. Katirji has held several academic appointments in the United States beginning in 1984. He is currently Professor of Neurology at the Case Western Reserve University School of Medicine [CWRU] in Cleveland, Ohio, and a Lecturer in the Department of Medicine at the Ohio College of Podiatric Medicine, also located in Cleveland. In addition to his academic appointments, Dr. Katirji currently holds several hospital appointments at University Hospitals of Cleveland: Director of the Electromyography Laboratory, Chief of the Neuromuscular Division, Program Director of Clinical Neurophysiology, and Director of the Muscle Disease Center. In addition, he is a member of the attending staff in the Department of Neurology. (St. Ex. 30 at 1-2; Tr. at 988-989)

13. Dr. Katirji holds medical licenses in Ohio and Pennsylvania. (Tr. at 991)
14. Dr. Katirji testified that his work is about 80 percent clinical in nature. (Tr. at 991-992)
15. Dr. Katirji testified that he does not administer trigger point injections, joint injections, or nerve block injections. Dr. Katirji further testified that he does not prescribe opioid medication to patients. Moreover, Dr. Katirji testified that he does not practice in the field of interventional pain management. (Tr. at 1002-1004)

Thomas C. Chelimsky, M.D.

16. Thomas C. Chelimsky, M.D., testified as an expert on behalf of the State. Dr. Chelimsky obtained his medical degree in 1983 from Washington University in St. Louis, Missouri. From 1983 through 1986, Dr. Chelimsky participated in a residency in internal medicine at the Mayo Clinic in Rochester, Minnesota and, from 1986 through 1989, he participated in a residency in neurology at the same institution. In addition, from 1986 through 1987, Dr. Chelimsky participated in a fellowship in autonomic research at the Mayo Clinic. Finally, from 1989 through 1990, Dr. Chelimsky participated in a six-month fellowship in electromyography at the same institution. (St. Ex. 27A; Tr. at 1487-1491)

Dr. Chelimsky was certified by the American Board of Internal Medicine in 1986 and by the American Board of Electrodiagnostic Medicine in 1992. He was also certified in neurology by the American Board of Psychiatry and Neurology [ABPN] in 1992. Subsequently, in 1994, Dr. Chelimsky obtained an added qualification in clinical neurophysiology from the ABPN and, in 2000, he obtained an added qualification in pain management from the ABPN. (St. Ex. 27A; Tr. at 1491-1493)

Since 1990, Dr. Chelimsky has served in academic capacities at CWRU and is currently a Professor of Neurology. In addition, since 1990, Dr. Chelimsky has been a member of the attending staff, a member of the staff at the EMG laboratory, and Director of the Division of Autonomic Disorders at University Hospitals of Cleveland. In addition, from 1994 through 2000 and from 2001 through 2004, Dr. Chelimsky was Director of the Pain Center at University Hospitals of Cleveland. (St. Ex. 27A; Tr. at 1499)

17. Dr. Chelimsky testified that, as director of the pain center, he had supervised an active fellowship program in pain medicine. The fellows were usually neurologists, and they were trained in both interventional and non-interventional techniques.⁵ (Tr. at 1508)
18. Dr. Chelimsky has participated in many presentations and lectures throughout the United States and has authored numerous articles and book chapters. (St. Ex. 27A)
19. Dr. Chelimsky has been licensed to practice medicine in Ohio since 1990. (Tr. at 1491)
20. Dr. Chelimsky testified that about 50 percent of his current medical practice consists of pain management and the other 50 percent consists of evaluating patients in the autonomic laboratory and doing research in that area. Dr. Chelimsky noted that he performs all his work as a member of the faculty at CWRU and that he has no private practice. (Tr. at 1493-1494, 1498)
21. Dr. Chelimsky testified that he has taught podiatric students; however he has not worked with podiatric students or residents in a clinical setting. (Tr. at 1557-1560)

Dr. Chelimsky's Pain Medicine Practice

22. Dr. Chelimsky testified that, from 1994 through 2004, with the exception of one year between 2000 and 2001, he had directed the Pain Center at University Hospitals of Cleveland. Dr. Chelimsky further testified:

The Pain Center is no longer in existence. It was an interdisciplinary center that included anesthesiology, neurology, and psychology, as well as P.T. and O.T. And the amount of money being spent on rehabilitating the patients with this—it was a very intense program, five days a week, eight hours a day, for four weeks. And the insurers were no longer paying for that kind of support, so the hospital administration decided to, to use a polite term, axe it.

(Tr. at 1499) Dr. Chelimsky testified that Mark V. Boswell, M.D., an anesthesiology-trained pain management physician who also testified during the hearing, had done most of the anesthesiology work for the Pain Center. (Tr. at 1500)

23. Dr. Chelimsky testified that he currently has a grant that allows him “to teach primary care physicians the management of chronic pain and to support them with ancillary services.” Dr. Chelimsky testified that he goes to the physicians’ offices, asks the physicians to choose two of their most difficult chronic pain patients, and teaches them how to manage the chosen patients. Dr. Chelimsky further testified that he has a team that consists of physical therapists, an occupational therapist, and a psychologist that works closely with the physicians. (Tr. at 1496-1497)

⁵ Dr. Chelimsky testified that interventional pain medicine techniques include any kind of injection, such as nerve blocks, as well as radiofrequency lesioning and surgical procedures. (Tr. at 1506)

Dr. Chelimsky testified that he teaches all aspects of pain management, including interventional pain management. Dr. Chelimsky further testified that the interventional techniques that he performs are trigger point injections, injections into the bursa, and local nerve injections. (Tr. at 1506-1507)

Dr. Chelimsky testified that, in conjunction with his education program, he currently performs approximately two nerve blocks, three trigger point injections, and one joint injection per month. (Tr. at 1548)

24. Dr. Chelimsky testified that, in addition to his education program, he also runs a clinic that includes an anesthesiologist and a psychologist to treat patients who suffer from complex regional pain syndrome (formerly called reflex sympathetic dystrophy). (Tr. at 1498)

James P. Bressi, D.O.

25. James P. Bressi, D.O., testified as an expert on behalf of the Respondents. Dr. Bressi obtained his osteopathic medical degree in 1987 from the Ohio University College of Osteopathic Medicine. From 1987 to 1988, he participated in a rotating internship at Warren General Hospital (St. Joseph Health Center) [Warren General] in Warren, Ohio. From 1988 to 1989, Dr. Bressi worked as an emergency department staff physician at Warren General. From 1989 to 1992, Dr. Bressi participated in an anesthesiology residency at Warren General. In 1992, Dr. Bressi participated in a six month pain medicine fellowship at the University of Rochester Medical Center, Strong Memorial Hospital, in Rochester, New York. Dr. Bressi is currently the Director of the Falls Pain Management Center at Cuyahoga Falls General Hospital in Cuyahoga Falls, Ohio, and has served in that capacity since 1998. (Resp. Ex. 106G)

Dr. Bressi was certified in Anesthesiology by the American Osteopathic Board of Anesthesiology in 1993, and obtained added qualifications in pain management from that board in 1996. Dr. Bressi was also certified by the American Academy of Pain Management. (Resp. Ex. 106G)

26. Dr. Bressi testified that he has lectured, and continues to lecture, on the subject of interventional pain management. Dr. Bressi further testified that he has written on the subject as well. (Resp. Ex. 106G; Tr. at 2259-2260)

Dr. Bressi's Pain Medicine Practice

27. Dr. Bressi testified that his current practice as the director of Falls Pain Management Center is devoted entirely to the treatment of chronic pain, "both interventional and pain medicine." He explained that "[i]nterventional pain medicine requires a specialist trained for more invasive-type procedures" such as placement of spinal cord stimulators or intrathecal or spinal pumps, spinal blocks, and injections such as trigger point injections and peripheral nerve blocks. (Resp. Ex. 106G at 2; Tr. at 2250-2253)

Dr. Bressi testified that, besides himself, his practice consists of a partner who is also an interventionalist, a family doctor, two physician assistants, a nurse practitioner, many nurses and medical assistants, and clerical staff. He further testified that his practice is “blended into the hospital pain clinic[.]” Dr. Bressi testified that a large physical therapy/occupational therapy facility is across the hall from the pain clinic. (Tr. at 2255-2257)

28. Dr. Bressi testified that the pain center currently serves 6,000 patients, and draws patients from the Akron area and from three counties around Summit County. Dr. Bressi testified that he treats patients ranging from 18 years old to 102, and that all suffer from chronic pain that impacts their lives in a negative way. Dr. Bressi stated that most of his patients are employed and need treatment to allow them to continue working and being productive. (Tr. at 2250, 2255-2256)
29. Dr. Bressi testified that residents and medical students from the area hospitals rotate through his pain center. In addition, Dr. Bressi testified that nurses and pharmacists come to the pain center for lectures and to observe. (Tr. at 2260-2261)
30. Dr. Bressi testified that about 90 percent of his time involves the clinical care of patients. (Tr. at 2262-2264)

David R. Longmire, M.D.

31. David R. Longmire, M.D., testified as an expert on behalf of the Respondents. Dr. Longmire obtained his medical degree in 1980 from the McMaster University School of Medicine and Health Sciences in Hamilton, Ontario. From 1980 through 1981, he participated in an internship at McMaster University Health Sciences Centre; from 1981 through 1982, he participated at the PGY-2 level in a Pediatric/Adult Neurology residency at the University of Toronto/Hospital for Sick Children and Toronto Western Hospital; from 1982 through 1983, he participated at the PGY-3 level in a Pediatric Neurology residency at the University of Toronto/Hospital for Sick Children; and from 1983 through 1984, he participated at the PGY-4 level as an Adult Neurology Clinical Research Fellow at the Clinical Institute of the Addiction Research Foundation, Department of Medicine, University of Toronto. (Resp. Ex. 214L)

Dr. Longmire is a Clinical Associate Professor in the Department of Internal Medicine at the University of Alabama at Birmingham-Huntsville Regional Medical Campus. He is also a Consulting Neurologist at Helen Keller Hospital in Sheffield, Alabama; an Attending Neurologist at Russellville Hospital in Russellville, Alabama; and is engaged in the private practice of neurology, clinical neurophysiology, and pain management. (Resp. Ex. 214L)

Dr. Longmire was certified by the American Academy of Pain Management in 1982, and by the American Board of Electroencephalography and Neurophysiology in 1989. (Resp. Ex. 214L)

32. Dr. Longmire noted that he has published widely, including in peer-reviewed publications, and that he has authored textbook chapters on the subject of selective tissue conductance

[STC]. Dr. Longmire noted that his most recent article concerns methods for classifying abnormalities of sympathetic sudomotor dysfunction. The article was published in 2006 in *Pain Physician*. (Resp. Exs. 213L, 214L; Tr. at 859-860)

Dr. Longmire further testified that he had co-authored chapters in Weiner's Textbook of Pain Management, along with Dr. Mark V. Boswell and Dr. Gary W. Jay. (Tr. at 861)

33. Dr. Longmire testified that neither the American Academy of Pain Management or the American Board of Electroencephalography and Neurophysiology is recognized by the American Board of Medical Specialties [ABMS]. (Tr. at 923)

Dr. Longmire testified that he is not board certified in neurology. (Tr. at 923)

Gary W. Jay, M.D.

34. Gary W. Jay, M.D., testified as an expert on behalf of the Respondents. Dr. Jay testified that he had obtained his medical degree in 1976 from Northwestern University Medical Center. Dr. Jay participated in an internship and residency in neurology at that same institution in 1980, and spent the next 25 years in the private practice of pain medicine. (Tr. at 2808)

Dr. Jay testified that he is currently the medical director for pain at Schwarz Biosciences and has been so employed for two and one-half years. Dr. Jay noted that he is no longer engaged in the clinical care of patients. However, Dr. Jay stated that he supervises clinical research. (Tr. at 2807-2809)

Dr. Jay testified that he is currently licensed to practice medicine in Florida, Ohio, Nebraska, and Colorado. (Tr. at 2808)

35. Dr. Jay is a member of several certifying boards, although he testified that none are ABMS-approved. Among these, Dr. Jay became a diplomate of the American Academy of Pain Management in 1992, and became a fellow of the American Academy of Pain Medicine in 1996. (Resp. Ex. 165 at 9; Tr. at 2809-2810)
36. Dr. Jay has published extensively, including authoring three medical textbooks, a large number of book chapters, and articles. Dr. Jay has also spoken at numerous presentations and medical meetings. (Resp. Ex. 165; Tr. at 2810-2812)

Background Information – Fact Witness – Mark V. Boswell, M.D., Ph.D.

37. Mark V. Boswell, M.D., Ph.D., testified as a fact witness on behalf of the State. In 1982, Dr. Boswell obtained a Doctor of Philosophy degree in experimental pathology from CWRU in Cleveland, Ohio. In 1984, he obtained a medical degree from CWRU. From 1984 through 1985, he participated in a general surgery categorical internship at the Oregon Health Sciences University in Portland, Oregon. From 1985 through 1987, he

participated in an anesthesiology residency at CWRU. Finally, from 1987 through 1988, Dr. Boswell participated in a fellowship in anesthesiology in “Clinical Scientist Track (Neuroscience)” at CWRU. (St. Ex. 46; Tr. at 12)

Dr. Boswell was certified by the American Board of Anesthesiology in 1988, and he obtained subspecialty certification in pain medicine from the same board in 1993. Further, in 1995, Dr. Boswell was certified by the American Board of Pain Medicine, for which he recertified in 2004. Finally, in 2005, Dr. Boswell became a Fellow in Interventional Pain Practice. (St. Ex. 46)

Dr. Boswell testified that he is licensed to practice medicine in Ohio, Texas, Oregon, and Arizona. (Tr. at 17)

38. Since 1988, Dr. Boswell has held academic appointments. These include academic appointments at CWRU and University Hospitals of Cleveland from 1990 through 2005. In 1990, Dr. Boswell joined the faculty as an Assistant Professor and Chief of the Pain Medicine Service in the Department of Anesthesiology. Further, in 1996, he obtained appointments as Associate Professor in the Department of Anesthesiology and Director of the Pain Medicine Fellowship. In 2005, Dr. Boswell left CWRU and University Hospitals of Cleveland for Texas Tech University Health Sciences Center in Lubbock, Texas. At the time of the hearing, Dr. Boswell was Professor and Chair of the Department of Anesthesiology and Director of the Messer Racz Pain Center at that institution. (St. Ex. 46)
39. Dr. Boswell testified concerning the interventional pain management program at Texas Tech University. Dr. Boswell testified that the founding chairman of the Department of Anesthesiology at Texas Tech had been Gabor Racz, M.D. Dr. Boswell testified that Dr. Racz “was the founding chairman, I believe, in about 1977, and he was a pioneer in pain medicine and anesthesiology.” Dr. Boswell further testified:

[Dr. Racz] was involved in, as far as I could tell, in the same pain medicine community that ultimately founded the American Board of Pain Medicine, was involved with that group and with Dr. Leak as well. * * * [Dr.] Racz developed a well recognized pain medicine program at Texas Tech, lectured widely * * * and developed an international following with the program.

(Tr. at 37)

40. Dr. Boswell testified that the pain medicine program at Texas Tech is one of the top ten pain medicine programs in the country. (Tr. at 38)
41. With regard to the weight that should be accorded Dr. Boswell’s testimony, counsel for both the State and Dr. Leak each spoke very highly of Dr. Boswell. During the course of arguing in favor of an objection, Mr. Clifford stated:

Are we using Dr. Boswell's medical knowledge, which is vast and I don't dispute that? * * * [Dr. Boswell was brought to discuss other matters], not his knowledge, which I don't dispute as being vast, in pain medicine.

(Tr. at 50)

To which Mr. Graff, Dr. Leak's counsel, responded:

We have available to us, thankfully from the State, one of the very top pain interventionists in the country, from one of the number one programs in the world. * * * (Tr. at 50-51)

Subspecialty Certification in Pain Medicine

42. Three ABMS-member certifying boards offer subspecialty certification in pain medicine: the American Board of Anesthesiology, the American Board of Psychiatry and Neurology, and the American Board of Physical Medicine and Rehabilitation. However, Dr. Chelimsky testified that the same certifying examination is used by each board. (Tr. at 1536-1537)

Dr. Leak's Medical Practice: PCC and Pain Net

Pain Control Consultants

43. From 1984 through the time of the hearing, Dr. Leak was the Medical Director of Pain Control Consultants, Inc. [PCC] (Resp. Ex. 104H at 5)
44. Dr. Leak testified that his practice is limited to "pain medicine and pain management[]." Dr. Leak further testified, "given my background and training, the emphasis is on interventional methodologies, but we do offer a balanced service for our patients." (Tr. at 2688)
45. Dr. Griffin testified that "interventional pain management" refers to the treatment of pain with invasive modalities such as epidural injections, nerve blocks, and partial nerve destruction. (Tr. at 2986-2987)

Testimony of Dr. Leak Regarding the PCC Fellowship Program

46. Dr. Leak testified that during his career he had gained a reputation for his ability to diagnose and treat patients with "otherwise intractable painful conditions." He stated that physicians from all over the country had come to Columbus to observe his work. Dr. Leak further testified that, in the early 1990s, he along with others formed organizations called Pain Net and Pain Net Education, which he described as "a network to communicate with physicians." (Tr. at 2694-2695)

Dr. Leak testified that "[t]he dearth of knowledge about [pain] medicine needed to be filled, so we wanted to have some didactic information. So we first embarked on looking

at procedure-based training. We would teach people how to do a procedure and how to do that procedure right * * *.” However, Dr. Leak testified that it had been ineffective. Dr. Leak stated that they had had physicians come in, do a “weekend warrior course,” and then return to their practices and perform procedures “on people that they had no business operating on* * *.” Accordingly, Dr. Leak testified that, around 1991 or 1992, he and Dr. Longmire developed an outline for fellowship training in pain medicine. That eventually became the 75-page Pain Net Fellowship Guidelines for Pain Control Consultants [Fellowship Guidelines]. Finally, Dr. Leak testified that the PCC began a fellowship program in around 1998. (Resp. Ex. 115H; Tr. at 2695-2698)

47. Dr. Leak testified that fellows in the PCC program worked from 10 to 14 hours per day seeing patients, doing paperwork, and doing clinical research. Their duties also included reading a number of relevant journals and writing for publication. Further, their duties included making presentations during grand rounds. (Tr. at 2720, 2729-2730, 2733-2734)

Dr. Leak testified that his fellows worked very hard. Dr. Leak further testified:

It was not uncommon to hear statements such as, to work around there, you needed to be a cyborg. It was demanding and we had a lot of information to cover. The service demands were high. The academic and the didactic demands were high. And we had to make up for everything that had been missed [concerning the treatment of pain] in medical school, residency, and postgraduate experience.

(Tr. at 2721-2722)

48. Dr. Leak testified that the PCC fellowship program took approximately 14 months for a full-time fellow to complete because of the volume of material covered. Dr. Leak further testified that the curriculum was also designed for part-time fellows to complete in 36 months. (Tr. at 2699)
49. Dr. Leak testified that, during the time he offered the fellowship, which lasted through at least 2003, a total of about 12 fellows completed the program, including Dr. Griffin and Dr. Hoogendoorn. Dr. Leak testified that all but two of the fellows who completed the PCC fellowship obtained subspecialty certification in pain medicine from ABMS-approved boards. Dr. Leak noted that one fellow who did not, Dr. Hoogendoorn, did not meet ABMS requirements because he was a podiatrist; however, Dr. Hoogendoorn obtained certification from the American Academy of Pain Management. (Tr. at 2698, 2701-2703)
50. Dr. Leak testified that the PCC fellowship had not been accredited by the Accreditation Council for Graduate Medical Education [ACGME], and that he had not contacted the ACGME prior to establishing the PCC fellowship. However, Dr. Leak further testified that he had applied for and received accreditation from the Accreditation Council for Continuing Medical Education [ACCME] so that his fellows could get CME credit for grand rounds. (Tr. at 413-414, 2702, 2734-2735)

Testimony of Dr. Boswell Concerning Dr. Leak's Fellowship Program

51. Dr. Boswell testified that Pain Net had been a program created by Dr. Leak that included the leaders in pain medicine. Dr. Boswell further testified that he had first spoken at a Pain Net program in Dallas in 1995, and that he had been "honored to be in that program" because he had been just an assistant professor at the time. Dr. Boswell testified that he has worked with Pain Net almost every year since that time. (Tr. at 41-42)
52. Dr. Boswell further testified that Dr. Leak had had a faculty appointment at CWRU which permitted CWRU's fellows to spend some time at Dr. Leak's facility. Dr. Boswell noted that Dr. Leak had sought to formally affiliate his program with CWRU; however, that never came to fruition. (Tr. at 25-28)

Dr. Boswell testified that he had thought that Dr. Leak had a good program. Moreover, Dr. Boswell testified that Dr. Leak "was doing some of the invasive techniques that are now fairly commonplace, actually. But he was doing them back in '96, so it was a very attractive opportunity for the residents." (Tr. at 29-30)

53. Dr. Boswell testified that Dr. Leak's program was not accredited. Dr. Boswell stated that both accredited and non-accredited pain medicine fellowship programs offer the same clinical training opportunities and level of education, but an accredited program allows the fellow to sit for the pain medicine subspecialty examination. Nevertheless, Dr. Boswell testified that there are "some potential advantages to a non-accredited program." He stated that more emphasis can be placed on interventional techniques and other areas of interest to someone focusing on interventional pain management. Dr. Boswell testified that, by contrast, "[w]e have to teach a lot of things in the accredited program that might be of, say, tangential interest to some residents." (Tr. at 50-52, 75)

Dr. Boswell testified that, other than obtaining board certification, the general purpose for taking a fellowship is to acquire additional knowledge and skills. Dr. Boswell stated that that can happen in both accredited and non-accredited programs. (Tr. at 78-79)

Dr. Griffin's Participation in the PCC Fellowship

54. According to Dr. Griffin, he had entered the PCC fellowship program in August 1999 and completed it two years later in 2001. (Tr. at 800, 3004) Dr. Griffin's participation in the fellowship will be described in greater detail later in this report.
55. Dr. Griffin testified that he did not have any ownership interest in PCC. (Tr. at 642)

Dr. Hoogendoorn's Participation in the PCC Fellowship

56. Dr. Hoogendoorn testified that he had entered the PCC fellowship in August 2000. He remained in the program until around November 2003. (Tr. at 2498, 2528) Dr. Hoogendoorn's participation in the fellowship will be described in greater detail later in this report.

Allegations (1), (1)(c):

57. In its August 9, 2006, notice of opportunity for hearing, the Board alleged, in part, as follows:

Allegation (1):

From in or about 1999 to in or about 2001, in the routine course of his practice, [Dr. Griffin] undertook the treatment of 23 patients as identified on a confidential Patient Key. In treating those patients, [Dr. Griffin] failed to form and/or document the formation of an overall clinical impression, and/or prescribed controlled substances and/or other dangerous drugs in an inappropriate manner and otherwise failed to provide treatment in accordance with the minimal standards of care. [Specific allegations of such treatment were numbered (1)(a) through (1)(m).]

Allegation (1)(c):

[Dr. Griffin] performed unnecessary testing including somatosensory evoked potentials, nerve conduction studies and/or “selective tissue conductance” studies [collectively, EDX studies] on Patients 1-5, 10, 15-18, and 23.⁶ Further, [Dr. Griffin] performed unnecessary testing including somatosensory evoked potentials and/or “selective tissue conductance” studies on Patients 7-8, 11-14 and 19-21.

(St. Ex. 54A)

Electrodiagnostic [EDX] Studies – Background

58. Several of the allegations against Dr. Leak and Dr. Griffin concern the use of electrodiagnostic [EDX] studies; specifically: somatosensory evoked potentials [SSEP], nerve conduction studies [sometimes abbreviated as NCS], and selective tissue conductance [STC] studies. Moreover, Dr. Leak and Dr. Griffin are accused of failing to order, perform, or recommend needle electromyography [EMG] studies in conjunction with the nerve conduction studies performed. (St. Ex. 54C; St. Ex. 54A)

⁶ The notice letters issued to Dr. Leak, Dr. Griffin, and Dr. Hoogendoorn were based upon different patient keys. Dr. Leak’s patient key named 24 patients, numbered 1 through 24; Dr. Griffin’s named 23 patients, numbered 1 through 23, and Dr. Hoogendoorn’s named 19 patients, numbered 1 through 19. Dr. Griffin’s patient key was a subset of Dr. Leak’s, and Dr. Hoogendoorn’s patient key was a subset of Dr. Leak’s and Dr. Griffin’s. Prior to the hearing, the Hearing Examiner ordered that Dr. Leak’s patient key be used as a master patient key, and that all patients in the consolidated hearing be referenced using the patient number from the master patient key. In this report, all patient references in the Summary of the Evidence refer to the master patient key. (See State’s Exhibit 26 and Board Exhibit I)

59. In his August 8, 2006, written report, Dr. Katirji stated that he had reviewed the records of 26 patients, which included two patients not referenced in the Board's allegations against Drs. Leak and Griffin. Dr. Katirji's review concerned the use by Dr. Leak and Dr. Griffin of SSEP and nerve conduction studies, and the lack of use of needle EMG, in the diagnosis and management of patients. Dr. Katirji stated, in part:

Most patients suffered from a chronic pain, mostly of spine origin, but others had joint pain, mostly knees and ankles. Only in about 1/3 of cases [Patients 7-9, 11-14, 18-20, and 22]⁷ [do] the charts show that the patients suffered from radicular pain or signs of lumbar canal stenosis. * * * All had NCSs and dermatomal SSEPs on the upper extremities, lower extremities, and/or thoracic dermatomes.⁸ None had (or were referred for) a needle electromyography (EMG). * * *

After reviewing these charts, it was clear to me that the SSEP and NCS were done on all of these patients as part of a routine diagnostic testing. A common statement encountered in these charts is "We will plug him (her) into our very extensive diagnostic process." Though spinal pain was [a] common complaint[] in many of these patients, only few had symptoms of cervical, thoracic or lumbar radiculopathy. In many patients, EDX tests were performed to evaluate two or three segments of spine (cervical, thoracic or lumbar) despite that the major complaint was to only one of these segments. These EDX tests were clearly performed with a "cookbook" approach as evidenced by identical[] SSEPs and NCSs done on all patients regardless of symptoms. * * * Dr. Leak, who interpreted the EDX tests, did not perform or recommend a needle EMG examination, the most essential EDX testing for the diagnosis of radiculopathy * * *.

* * * [N]one of the physician notes, in all the charts I reviewed, ever discussed the indication for these tests. More importantly, the physicians never commented on the results of these tests in their notes, nor did they act upon these results, even when they were reported to be significantly abnormal. In all the charts I reviewed, I found no indication of any change in the treatment or management of these patients based on the results of these EDX tests. It was clearly below minimal standards of care for these physicians to not reflect any need or indication for the EDX tests.

In a significant number of patients, the physician interpreting the EDX testing (mainly Dr. Leak) found abnormalities on SSEPs (and rarely on NCS, based on H-reflex studies) suggesting one or multiple radiculopathies. [As the raw test data was not available,] I only was able to review the tabulated charts of

⁷ Dr. Katirji's patient numbers as used in his report differ from the Patient Key used during this hearing. For purposes of this Report and Recommendation, the patient numbers in Dr. Katirji's report have been replaced by the appropriate patient number as set forth in the Master Patient Key. (St. Ex. 31; Board Exhibit H)

⁸ Dr. Leak testified to the effect that a dermatome is a distribution of peripheral nerves that originate from a single nerve root. (Tr. at 522-526)

the results of these EDX tests, and I cannot comment on their accuracy. However, I was amazed to find that many of these patients [Patients 1, 3, 5-9, 11-14, 17-19, 21, and 22] had significantly abnormal dermatomal SSEPs, including those that evaluated the thoracic roots (Thoracic radiculopathies and thoracic disc herniations are extremely rare). This contradicts clinical experience or published studies that points to the fact that dermatomal SSEPs are insensitive for the diagnosis of radiculopathies. Despite these EDX abnormalities that were reported the treating physician failed to comment on these findings in his notes, or act upon the results such as requesting needle EMG or changing his treatment plan.

In summary, I find that Drs. William David Leak and Brian F. Griffin practiced below minimal standards of care by performing unnecessary electrodiagnostic testing for no apparent clinical reason in most of their patients. In addition, they omitted the most sensitive electrodiagnostic testing (needle electromyography) in patients with clinical symptoms of radiculopathy. Most importantly, these physicians did not acknowledge or act upon the results of these tests, even when they were abnormal. It is clear to me from this review that they did not intend to use nor [did they utilize] the results of the studies to influence the management of their patients.

(St. Ex. 31)

60. Dr. Leak and Dr. Griffin testified that that they had used EDX studies not for diagnostic purposes, but to obtain objective evidence to support their patients' subjective complaints of pain. (Tr. at 563-569, 614-615, 660-661, 683-684, 696, 2794-2795, 2862-2864) For example, Dr. Leak testified why an EDX study that was performed on Patient 1 on July 23, 2001, had been necessary. Dr. Leak explained, "The patient complained subjectively of having pain, and we wished to determine whether there was an objective measure or evidence outside his verbal attestation that there was pathology that would be consistent with his complaint of pain." Dr. Leak added that the tests yielded some abnormal results. (Tr. at 563-565) Dr. Leak further testified:

If clinically we have determined we need to treat a person for pain and we live in a culture where treatment of pain is challenged frequently, the more objective data you have, the more comfortable one is with saying I have this objective information, I've got a positive MRI, I've got positive nerve studies, and I've got a positive physical exam, they all lead me to the same conclusion and I should treat this person.

(Tr. at 568) For another example, with regard to another EDX study performed on Patient 1, Dr. Griffin testified that the test had been performed because "there is no objective test for pain other than the electrophysiologic studies, with SSEP being the best." (Tr. at 659)

Testimony of Dr. Chelimsky

61. Dr. Chelimsky was asked at hearing to comment on testimony that Dr. Leak and Dr. Griffin had ordered or performed EDX studies for the purpose of obtaining objective evidence of pathology to support their patient's subjective pain complaints. Dr. Chelimsky replied that medical evidence shows that there are only two objective and valid measurements for pain: the visual analog scale and the McGill Pain Questionnaire. Dr. Chelimsky testified that both instruments "have been validated and shown to be excellent, reproducible measures of how much pain a person is having." Moreover, Dr. Chelimsky testified that both had been used by Dr. Leak and Dr. Griffin, and should have been used in the treatment of these patients. (Tr. at 1608-1609)

Dr. Chelimsky testified that pain "is intrinsically a subjective experience. There is no test of any kind, even conceptually. How could one imagine a test that would tell us how much pain a person is having? It's impossible." Dr. Chelimsky testified that there are documented cases of patients who suffered from pain where no abnormal condition could be found until MRI came into existence. On the other hand, there are patients who have physical findings of many abnormalities but do not suffer from pain. Dr. Chelimsky testified that "the presence of physical findings doesn't mean the patient is in physical pain and the absence of physical findings doesn't mean the absence of pain." (Tr. at 1609-1610)

*EDX Studies – Somatosensory Evoked Potentials [SSEP]*Testimony of Dr. Katirji

62. Dr. Katirji testified that SSEPs are performed by applying electrical stimulation to a patient's limb and recording the electrical stimulation conducted to the spine and brain. For example, the SSEP electrode would be placed over the patient's wrist or fingers, and sensors would be placed over three locations: above the clavicle, spine, and brain. If the electrical signal is delayed in reaching the sensors, the physician tries to locate the area of the abnormality. Dr. Katirji testified: "You hope to localize it, but you're not localizing it very accurately. You're localizing it to a long segment of the pathway." (Tr. at 1016-1018)
63. Dr. Katirji testified that SSEP had become available in the 1980s. Studies published in the late 1980s indicated that SSEP tests could be used to diagnose radiculopathy. In addition, prior to MRI becoming widely available, SSEP had been used to diagnose multiple sclerosis. However, by the mid 1990s, newer studies indicated that SSEP is not an effective tool for diagnosing radiculopathy. Dr. Katirji testified that SSEP was shown not to be effective in the diagnosing of radiculopathy due to false negative results. (Tr. at 1016-1019)

Dr. Katirji further testified that "there are several problems" with SSEP as a diagnostic tool. He stated that, for one thing, SSEP "only looks at latencies * * * and doesn't look at the actual potential size." Dr. Katirji explained that, even if 50 percent of the nerve

bundle is damaged, the remaining 50 percent of the nerve that is still intact allows the electrical signal to travel at a normal speed, yielding a normal SSEP result. (Tr. at 1019)

Moreover, Dr. Katirji testified that, today, SSEP is “not used at all in most centers” to diagnose radiculopathy. He stated that, currently, SSEP is most often “used in the intraoperative monitoring of patients who are undergoing [cervical or thoracic] spinal cord surgery[.]” (Tr. at 1017, 1020)

Furthermore Dr. Katirji testified that SSEP is “never used” today to diagnose radiculopathy in the thoracic region. Dr. Katirji testified that thoracic radiculopathy and/or disc herniation is very rare, occurring in about one out of 50 cases in the general population of spine patients. This is true because the thoracic spine is rigid and not as prone to those maladies as the cervical or lumbar spine, which are flexible. Finally, Dr. Katirji testified that thoracic disk herniations can be diagnosed only by using MRI. (Tr. at 1020, 1141, 1269-1270)

64. Dr. Katirji disagreed with Dr. Griffin’s testimony that SSEP is the best objective test for pain. Dr. Katirji testified that SSEP studies “have no relevance to pain,” and that there is “no correlation between the somatosensory and pain levels.” Dr. Katirji likened it to comparing apples and oranges. (Tr. at 1025; See also Tr. at 659)
65. On cross-examination, Dr. Katirji acknowledged that some physicians continue to use SSEPs based upon earlier literature. (Tr. at 1181-1184)

Testimony of Dr. Chelimsky

66. Dr. Chelimsky testified that Dr. Leak’s and Dr. Griffin’s use of SSEPs on nerve roots for which no normal range is established had violated the standard of care. Dr. Chelimsky testified: “Any test without norms is below the standard of care. It’s an experimental test by definition.” (Tr. at 1921-1922)
67. Based upon the SSEP test forms used by Dr. Leak and Dr. Griffin, which were used for nearly all of the SSEP and nerve conduction studies performed on Patients 1 through 24, no normal ranges have been established for SSEP studies of the following:
 - C4 and C5;
 - T8, T10, and T12; and
 - L2 and L3.

(St. Exs. 1-24)

Testimony of Dr. Bressi

68. Dr. Bressi testified that he is familiar with SSEP testing. Dr. Bressi further testified that the tests can be used to find underlying pathology in the nerves and muscles that could underlie the patient’s pain complaint. Dr. Bressi testified that he has not utilized SSEPs very often

because, until recently, there was no one in his area who could perform them.
(Tr. at 2332-2333, 2373-2375)

69. Dr. Bressi testified that there is literature for and against the use of SSEP testing. Dr. Bressi testified that the literature against it states that the test is not reliable “[b]ecause it’s a skin-based diagnostic testing, and they feel that the skin electrodes may not be representative of what’s going on in the deeper tissues that you’re trying to analyze.”
(Tr. at 2934-2935)

Testimony of Dr. Leak

70. Dr. Leak testified that, for some nerve distributions for which no normal ranges of values have been established, the data obtained from one side is compared to the data obtained from the contralateral side. If the difference between those values exceeds a certain amount, then the result is considered abnormal. (Tr. at 531-532)
71. Dr. Leak testified that SSEPs are still being utilized in pain management practice. Dr. Leak presented articles in support of his position. First, Dr. Leak presented an excerpt from the Handbook of Clinical Neurology, Vol. 81 (3rd Series) entitled *Neurophysiological Examinations in Neuropathic Pain, Chapter 30, Evoked Potentials in the Assessment of Pain*, authored by Luis Garcia-Larrea, M.D., Ph.D., and published by Elsevier B.V. in 2006. Dr. Leak testified that that article discusses the use of SSEPs in the practice of pain management. (Resp. Ex. 216; Tr. at 2883-2884)

Dr. Leak also presented an article entitled, *Somatosensory Evoked Potentials: Clinical Applications*, authored by Jorge G. Burneo, M.D., Ph.D., and Gregory L. Barkley, M.D., and published online at <<http://www.emedicine.com/neuro/topic344.htm>> (May 23, 2007). The printed article indicates that it had last been updated on September 28, 2006. Dr. Leak testified that that report indicates that SSEPs were being used in the practice of pain management in 2006. (Resp. Ex. 217; Tr. at 2885-2886)

Although the article does support the use of SSEPs to test the peripheral nervous system, it does not necessarily support Dr. Leak’s use of SSEPs on the spinal cord and brain. With regard to the use of SSEPs to test the peripheral nervous system, the article states:

Peripheral nervous system

SEPs may be used in evaluation of the peripheral nervous system when traditional nerve conduction studies (NCSs) are not possible (for any reason) or are not reliable (eg, technical problems, or artifacts).

Peripheral neuropathy: SEPs rarely are used to assess peripheral neuropathy since standard NCSs are the test of choice. The stimulation is applied at 2 or more sites and the responses are recorded over the scalp. In the presence of polyneuropathies and mononeuropathies, SEP waveforms recorded over the scalp may be absent or show delayed latencies with normal central conduction velocities. In this way, SEPs can be used to measure the afferent fiber

conduction velocities of proximal segments. Higher stimulation currents typically are required in patients with peripheral neuropathies. Use of SEPs has been reported for the following peripheral nerve disorders:

- Hereditary neuropathies (eg, Charcot-Marie-Tooth disease, Friedreich ataxia)
- Diabetic neuropathy
- Inflammatory polyradiculopathies, such as Guillain-Barré syndrome, particularly early in the course of the disease, when distal conduction and F-wave studies may be normal
- Infectious causes (eg, HIV)
- Toxic neuropathies

Focal neuropathy: The test of choice in focal neuropathy is standard NCSs. Entrapment neuropathies, such as carpal tunnel syndrome, may be found incidentally when SEPs are recorded. The use of SEP for detection of saphenous neuropathy, intercostal neuropathy, and trigeminal neuropathy has been reported. However, standard NCSs are the preferred diagnostic test for these conditions.

Plexopathy: SEPs are useful for evaluation of brachial plexopathy and traumatic plexopathies. In thoracic outlet syndrome, SEPs are of limited value with regard to the neurogenic variety of plexopathy and have no established value in diagnosis of the nonneurogenic (ie, vascular) variety. The value of SEPs in preventing or minimizing intraoperative damage of the peripheral nervous system is unproven.

Ventral rootlets and roots: Recent studies suggest that SEPs may have some utility in the evaluation of rootlet and root dysfunction. However, needle electromyography (EMG) provides superior information in these disorders and remains the test of choice.

Lumbosacral root disease: SEPs may have some utility in the evaluation of acute lumbosacral root disease or in lumbosacral spinal stenosis.

Thoracic root disease: No data are available.

Cervical root disease: EMG is the best neurophysiological tool for evaluation of this condition. SEPs may or may not have a limited role in these conditions.

(Resp. Ex. 217 at 2-3)

Testimony of Dr. Griffin

72. Dr. Griffin testified that, in his current practice, he had not ordered any SSEPs for about six months because the practitioner who had performed those tests for him passed away.

When asked if he has since found anyone else to perform the tests for him, Dr. Griffin replied:

We have, but they have their way of doing it and it's not—it would help, but it's just not what I want out of the tests, and I don't—I think it would be a waste of patients' money to do a test that I don't want or I don't need.

(Tr. at 3084-3085)

Testimony of Dr. Boswell

73. Dr. Boswell testified that some clinicians use SSEP to determine if the patient has “a neurologic problem that doesn't involve motor fibers.” (Tr. at 57-58)

EDX – Nerve Conduction Studies

Testimony of Dr. Katirji

74. Dr. Katirji testified that nerve conduction studies involve stimulating a nerve in a limb and recording from another location on the same limb. Dr. Katirji further testified:

For example, you could stimulate the wrist and record from the fingers. You can stimulate the ankle and record from the foot. You can stimulate from the knee and record from the foot, and so on. So there are several stimulation points and you can make a calculation of speed of nerve and also of the potential size, telling us whether there is any loss of nerve.

(Tr. at 1020)

Testimony of Dr. Chelimsky

75. Dr. Chelimsky further defined nerve conduction studies thusly:

[Nerve conduction studies] are examinations of the nerves performed by providing a shock to the nerve and then recording along the nerve, either away from the center of the body or towards the center of the body that shock wave as it propagates. And then you can tell how much of the nerve is working and how fast it's working by looking to see how long it takes for the time between the shock and the recording and the size of the response.

(Tr. at 1570-1571)

Testimony of Dr. Leak

76. Dr. Leak testified that, whereas SSEP testing focuses more on the spinal cord and brain, nerve conduction studies focus on the peripheral nerves. Dr. Leak testified that high

frequency stimulation is used in sensory nerve conduction studies and low frequency stimulation is used for motor nerve conduction studies. (Tr. at 547-548)

*Selective Tissue Conductance [STC] Studies – Autonomic Nervous System*⁹

Testimony of Dr. Longmire

77. Dr. Longmire testified that he is one of the co-developers of STC testing and a device that is used to perform such testing, called the Epi-Scan. Dr. Longmire further testified that he had begun working on the principles of selective tissue conductance in the 1960s. The other co-designer is William Woodley, a physiologist with a Master's degree in biomedical engineering. (Tr. at 853)

Dr. Longmire testified that, at one time, he and Mr. Woodley had owned the patent to STC technology. However, Dr. Longmire stated that the patent is now held by the EDX Epi-Scan Company in Huntsville, Alabama. Dr. Longmire testified that he is not employed by EDX Epi-Scan and that he receives no remuneration from the company. However, he testified that the company contacts him from time to time with questions concerning the use and development of STC. (Tr. at 854)

78. Dr. Longmire testified that the Epi-Scan employs a target-shaped sensor that consists of a flat, smooth center core and a circular, washer-shaped outer rim. The conductivity of the skin is tested by placing the sensor on the skin and passing a small electrical current through the device and onto the skin. The device measures the electrical current that passes from the center contact to the outer rim. The results are then expressed in nanosiemens per square centimeter. (Tr. at 878-884)
79. Dr. Longmire testified that STC testing measures the activity of the sympathetic nervous system by measuring the part of the sympathetic nervous system that controls the body's sweat glands, the sudomotor nerve fibers. (Tr. at 872-873)

Dr. Longmire further testified that the surface of skin conducts electricity. How well it conducts electricity is determined by the amount of moisture on the skin. As the moisture level of the skin increases via increased activity of the sweat glands, the conductivity of the skin increases. Moreover, Dr. Longmire testified that the extent to which the sudomotor nerve fibers cause the sweat glands to increase or decrease activity is affected by the health of the nerve. Dr. Longmire further testified that, if the nerve is cut or damaged, sweat decreases. Alternatively, if the nerve is irritated by a painful disorder, sweat increases. (Tr. at 873-877)

80. Dr. Longmire testified that multiple locations on the body are measured during an STC test. For example, in Dr. Leak's *Pain Medicine* article, with regard to a patient who suffered from facial pain, 36 measurements were taken on her face: nine (in three rows of three)

⁹ The term "autonomic nervous system" and the term describing one of its components, the "sympathetic nervous system," were used interchangeably by witnesses in this matter.

above the right eyebrow, nine (in three rows of three) below the right eye, and a similar number on the left side of the face. (Resp. Ex. 213L at 78; Tr. at 889-890)

Dr. Longmire testified: “The measuring end of the system would go against the surface of the skin in sequence, and the screen on the device tells you where to measure. It tells you what sequence, what measurement you're going to make next.” After finishing one side of the body, the corresponding areas on the other side of the body are measured. The final calculations are then made by the machine. (Tr. at 896-899)

Dr. Longmire testified that, prior to and after testing the area to be measured, measurements are taken from a neutral, unaffected part of the body to measure variability. (Tr. at 897)

Dr. Longmire testified that measurements from the two sides are then compared.
Dr. Longmire further testified:

[W]hat you look for specifically is you must have an asymmetry that is greater—in an unheated person that's greater than 1.5 times the opposite number. And what you try to do is to look for the greatest area of difference, the greatest area of asymmetry. And when you look at that in terms of where it is distributed, it frequently tells you what areas of the nerve roots are more hyperactive in terms of their sympathetic outflow to the skin. And that guides you. That's part of your overall diagnosis.

It's not the only thing. And it certainly does not say—even though there is a high relationship between the number of areas that are high STC regionally and where the patients say their pain is, this device does not measure the intensity of the person's pain. This is not a pain measuring device.

* * *

It only measures abnormalities in the outflow of the nerve fibers * * * from the sympathetic spinal chain along the spinal nerve roots to the surface of the skin.

(Tr. at 899-901)

Dr. Longmire testified that the results of STC testing can be used to locate where further diagnosis studies, such as MRI, should be performed. Moreover, Dr. Longmire noted that STC testing can locate an area of abnormality if the patient has sympathetically referred pain. (Tr. at 901-902)

81. Dr. Longmire testified that humidity does not alter the results of STC testing because the test measures relative values of different areas of the body, and that all areas of the body are exposed to the same humidity level. (Tr. at 887-889)

82. Dr. Longmire testified concerning FDA classification of the STC device:

The device has been classified as regulatory class 2, and it's been classified by the FDA twice. * * *

Initial classification as a selective tissue conductance meter was in 1988. It has subsequently been re-evaluated in the last two years and reclassified under the same category.

(Tr. at 880)

Dr. Longmire further testified that the operational definition as submitted to the United States Food and Drug Administration [FDA] and other governmental authorities is:

Selective tissue conductance, abbreviated as STC, is the relative ability of biological tissue to conduct a weak, direct current, electrical signal, which is applied for a selected period of time to a selected, limited, and restricted surface area of that tissue.

(Tr. at 872)

Testimony and Written Reports of Dr. Chelimsky

83. Dr. Chelimsky testified that the autonomic nervous system controls most involuntary functions. Dr. Chelimsky further testified that, for example, if a person is frightened, the person flushes and the blood pressure and heart rate go up. Dr. Chelimsky testified that all of those reactions are controlled by the autonomic nervous system. (Tr. at 1489-1490)

Dr. Chelimsky testified that, during his fellowship in autonomic research, he had learned how to test the autonomic nervous system, and how the autonomic nervous system interacts with pain in a condition known as reflex sympathetic dystrophy or complex regional pain syndrome, a severely painful condition that is difficult to treat. Dr. Chelimsky further testified that he is considered an expert in that area, and that there are less than 20 neurologists in the country who are so recognized. (Tr. at 1490, 1498)

Dr. Chelimsky testified that there are several available methods to test sudomotor function and that he uses two. The first, called the axon reflex test, involves applying a small capsule to the skin and passing an electric current through a solution in the capsule. The amount of sweat produced is then measured. The other test used by Dr. Chelimsky is called the thermoregulatory sweat test, nicknamed the "shake and bake" test. The test involves putting the patient in a sauna-like structure and applying a dye on the patient's skin. Areas where the patient sweats turn purple; areas where the patient doesn't sweat stay orange. Dr. Chelimsky testified, "[T]hat gives you a map of the nerves through the body, what's sweating, what's not sweating." (Tr. at 1495-1496)

84. Dr. Chelimsky stated in his written report that STC testing “is an entirely unproven diagnostic tool and its performance under any circumstance is intrinsically below [the] minimal standard of care. The results make no scientific sense, as the axes are unlabeled.” (St. Ex. 28 at 2) Dr. Chelimsky further wrote that the results made no clinical sense, either. Referring to Patient 21, Dr. Chelimsky commented on the following examples:

- On July 13, 2001, Patient 21 received chemoneurolytic injections in the cervical region. Chemoneurolytic injections are one of the interventional techniques utilized by PCC, and will be described in greater detail later in this report. They are intended to relieve pain by destroying or impairing the ability of nerve tissue to relay pain information to the brain. Pre- and post-injection STC testing of Patient 21’s cervical region was performed. Dr. Griffin interpreted the results. (St. Ex. 21 at 600-605; Tr. at 1574)

- The results of the pre-injection STC test were as follows:

“The C3 (Third Occipital Nerve) is not clinically significant.
“The C4 has a greater than 51% chance of clinically significant disease.
“The C5 has a greater than 51% chance of clinically significant disease.
“The C6 is not clinically significant.”

(St. Ex. 21 at 602)

The results of the post-injection STC test were as follows:

“The C3 (Third Occipital Nerve) has significant pathology.
“The C4 has a greater than 51% chance of clinically significant disease.
“The C5 has severe pathology.
“The C6 has significant pathology.”

(St. Ex. 21 at 605)

Dr. Chelimsky indicated in his report that the STC tests performed on the same area before and after a chemoneurolytic injection “showed that C3-C6 were normal pre-treatment but post-treatment there was now C5 severe involvement.” (St. Ex. 21 at 600-605; St. Ex. 28 at 2)

- The results of an STC test on Patient 21 on September 27, 2001, yielded the following results, interpreted by Dr. Griffin:

“The C3 (Third Occipital Nerve) has significant pathology.
“The C4 has a greater than 51% chance of clinically significant disease.

“The C5 has a greater than 51% chance of clinically significant disease.

“The C6 has a greater than 51% chance of clinically significant disease.”

(St. Ex. 21 at 598)

The following day, Patient 21 was tested again. The record does not state whether the test occurred before or after the trigger point injection¹⁰ she received that day. The results of the September 28, 2001, STC were:

“The C3 (Third Occipital Nerve) has severe pathology.

“The C4 has severe pathology.

“The C5 has severe pathology.

“The C6 has significant pathology.”

Dr. Chelimsky commented that on September 27, 2001, STC tests “showed that C3-C6 were mildly diseased, but on [September 28, 2001], one day later, it showed a different pattern[.]” (St. Ex. 28 at 594-599; St. Ex. 28 at 2)

- On October 12, 2001, Patient 21 received another trigger point injection in her cervical region. Pre- and post-injection STC testing of Patient 21’s cervical region was performed. Dr. Griffin interpreted the results. (St. Ex. 28 at 587-592)

“The C3 (Third Occipital Nerve) is not clinically significant.

“The C4 is not clinically significant.

“The C5 is not clinically significant.

“The C6 has a greater than 51% chance of clinically significant disease.”

(St. Ex. 21 at 588)

The results of the post-injection STC test were as follows:

“The C3 (Third Occipital Nerve) has a greater than 51% chance of clinically significant disease.

“The C4 has a greater than 51% chance of clinically significant disease.

“The C5 has significant pathology is not clinically significant.

“The C6 is not clinically significant.”

(St. Ex. 21 at 591)

¹⁰ A trigger point injection is another interventional technique utilized by PCC that will be discussed in detail later in this report. A trigger point injection involves the injection of anesthetic, sometimes combined with a steroid, to relieve pain. (Tr. at 1572-1574)

Dr. Chelimsky stated that the October 12, 2001, STC testing indicated that “C6 was diseased pre-block and [post-block] there was new disease at C3-C5 that wasn’t present before the block.” (St. Ex. 21 at 587-592; St. Ex. 28 at 2)

Dr. Chelimsky further wrote that the large numbers of nerves tested by Dr. Leak at any single visit virtually guaranteed that some would be abnormal based on statistical grounds alone. Moreover, Dr. Chelimsky wrote:

These results are meaningless since they do vary so randomly from one session to the next in the same patient at the same level and do not change consistently or reliably after the intervention procedures. The record reflects that even the ordering physicians themselves did not alter their plan of care in any way based on the results.

(St. Ex. 28 at 2)

85. Dr. Chelimsky testified that “for a test to have any reliability, it should be reproducible.” However, Dr. Chelimsky testified that STCs are not reproducible “because skin conductions change from day to day.” (Tr. at 1590-1592)

Even if the test was reproducible, Dr. Chelimsky testified that he has “a hard time understanding what it’s really telling you.” Dr. Chelimsky testified that, “even on theoretical grounds, it would be hard to understand how this would anatomically connect.” (Tr. at 1592) Dr. Chelimsky testified that there is no relationship between sweating and pain because the autonomic nerve fibers do not travel along the same paths as the sensory and motor nerves. Dr. Chelimsky explained that the autonomic nerves run alongside and outside of the spine, and that the autonomic nerves to a particular area may originate at a different level from a sensory pain nerve to that same area. Dr. Chelimsky testified that there is no way to know that damage to the autonomic nervous system at a particular level corresponds to sensory nerve root damage at the same level—that there is no reason to believe that a change in skin conductance at L5 reflects a problem with the sensory nerve root at L5. The problem could be anywhere, or there could be no problem at all; the results may only reflect a change in the patient’s sweating that day. (Tr. at 1590-1592, 1947-1950)

86. In addition to a test being reproducible and anatomically reliable, Dr. Chelimsky testified that a test should be valid. A valid test means that “the test tells you something meaningful about the disease.” However, Dr. Chelimsky testified that, in the case of STCs, “you don’t have reproducibility, you don’t have reliability, and you don’t have validity.” Furthermore, Dr. Chelimsky testified that, in his opinion, STC is an experimental procedure but that Dr. Leak is using it “clinically, not experimentally.” Finally, Dr. Chelimsky reiterated his opinion that STC is an unproven diagnostic tool and that its use is below the minimal standard of care. (Tr. at 1592-1594)

87. When asked if changes in the skin's electrical resistance can be used to locate where pain is radiating from, or damage to a nerve, Dr. Chelimsky replied: "No, not at all. This is totally—this is a fraud. There's absolutely nothing to this." (Tr. at 1950)
88. Dr. Chelimsky testified that Dr. Longmire's 2006 article in *Pain Physician* was a review article, which "is basically an opinion of a physician that has been published in a journal." A review article differs from a peer-reviewed article in that the peer-reviewed article has been subjected to a rigorous review by at least two other physicians "who actually look at the data, determine its validity, and determine the publishability of the information. A review article is simply published at an editor's discretion." (St. Ex. 213L; Tr. at 1795)

Dr. Chelimsky further testified concerning the substance of Dr. Longmire's article: "[M]y impressions are that this is a nice set of theories, but there is really nothing in this article that validates the procedure of selective tissue conductance. So they do have an FDA device approved, but that simply tells you about safety. It doesn't tell you about validity." (Tr. at 1796)

In addition, Dr. Chelimsky testified that he had performed a search using "Pub Med," an Internet search engine that will return any peer-review article published since 1966. Dr. Chelimsky testified:

"[F]rom 1966 until now, there was no peer-reviewed publication if one puts in the words selective tissue conductance or puts in [either Dr. Longmire or Dr. Woolsey as author], except for this article right here.

And the only reason that's in Pub Med is because that journal just got listed with Pub Med in the last year. So prior to that, *Pain Physician* was not listed with Pub Med. But whether it's listed in Pub Med is irrelevant. The issue is whether there's a peer-reviewed scholarly discussion of a technique, and there is none.

(Tr. at 1796-1797)

Testimony of Dr. Jay

89. In his March 21, 2007, written report, Dr. Jay stated, in pertinent part:

My medical opinion regarding the use of Selective Tissue Conductance in Pain Medicine is that it is valuable, reproducible and when used correctly it is useful in the diagnosis of chronic non-cancer pain diatheses. Medically it would certainly be within the standard of care to use this tool in the diagnosis of such patients. I think that the fact that there is a CMS originated CPT code also speaks for its legitimacy.

(Resp. Ex. 156)

During hearing, Dr. Jay could not recall the CPT code used to bill for STC testing, and acknowledged that STC testing might be billed using a code that is not specifically for STC testing.¹¹ (Tr. at 2839)

90. Dr. Jay testified that Medicare has approved the use of STC, as has the State of Colorado. (Tr. at 2831-2832)
91. Dr. Jay testified that he has been using STC testing since 1992 or 1993. Dr. Jay further testified that STC is “a fairly objective way to look at regional sympathetic sudomotor or sweat dysfunction.” Dr. Jay further testified that other tests that study the same thing are more expensive, inconvenient, and uncomfortable for the patient. Moreover, Dr. Jay testified that one would expect to see the same results repeated in testing the same person with the same disease, and that STC is reproducible, reliable, and valid. However, Dr. Jay did not discuss PCC’s medical records and the seemingly inconsistent and unreliable results. Finally, Dr. Jay testified that, in his opinion, the use of STC testing is within the standard of care for pain practitioners. (Tr. at 2815-2818, 2829, 2832-2833, 2836)
92. Dr. Jay noted that STC testing can be used pre- and post-block to see whether it affected the targeted area “[o]nly if it’s an autonomic block.” (Tr. at 2822) (Emphasis added)

Testimony of Dr. Bressi

93. Dr. Bressi testified that the sympathetic nervous system is affected by the sensory nerves. Dr. Bressi further testified: “When you’re hot, the sympathetics dilate your blood vessels in your skin to let heat go. And when you’re cold, they do the opposite; they constrict the blood vessels to keep heat in. So they are part of the nerves that go to the skin and they can be affected by various problems, including pain.” (Tr. at 2939-2940)
94. Dr. Bressi testified that he does not use STC testing in his practice. (Tr. at 2377, 2995)

Testimony of Dr. Boswell

95. Dr. Boswell testified that he is familiar with selective tissue conductance, and that he has employed that modality in his practice using a device that had been provided to him by Dr. Longmire. (Tr. at 40) Dr. Boswell further testified:

I have used a hand-held device on some patients, not routinely. I have trialed the device. I have used the device on patients with radiculopathy in clinic. I was loaned the machine for a few months. I used it while I was doing anesthesia for electroconvulsive therapy and found extreme results after

¹¹ Dr. Chelimsky disagreed that there is a CPT code for STC testing. Dr. Chelimsky testified that the CPT code being discussed covers other types of sudomotor testing but not STC. (Tr. at 1653-1654) Further, in an April 27, 2007, report, Dr. Chelimsky stated that “CPT Code 95923: Evaluation of Sudomotor Function” is not to be used for STC testing but can be used for other sudomotor function tests such as the axon reflex test and the thermoregulatory sweat test. (St. Ex. 53)

electrical induced seizures during therapy for depression. So I'm familiar with the device.

(Tr. at 62)

Testimony of Dr. Leak

96. Dr. Leak testified that a selective tissue conductance test is “part of an electrodiagnostic battery of studies used to provide objective data that there is, in fact, some dysfunction that we would perceive as anomalous. Anomalous, meaning not normal or that’s consistent with the patient’s complaint of pain.” Dr. Leak further testified that “it does not allow the patient to alter the results” because “we average repeated numbers.” (Tr. at 493-494)

Moreover, Dr. Leak testified that using STC “is a very, very reliable method for getting information that will or will not match the patient’s complaint * * *.” Dr. Leak testified that STC testing provides objective results. Dr. Leak stated that the results of some other tests, such as a straight leg test for a patient who complains of back pain, can be intentionally influenced by the patient. (Tr. at 494-496)

97. Dr. Leak testified concerning the STC tests referenced in Dr. Chelimsky’s written report; in particular, the STC tests that were performed on Patient 21 on July 13, 2001, before and after trigger point injections. (St. Ex. 21 at 600-605) Dr. Leak testified:

These are limited selective tissue tests. In other words, we have a person that is complaining of a confined area of discomfort. She has had treatment. We are determining whether or not—if she has active sympathetic manifestation of disease after local anesthetic injection, do we prove that we are able to change the amount of autonomic activity?

On—if you look at [State’s Exhibit 21 at] page 602, the four nerves that were evaluated prior to injection were the C3-C4, C5-C6. The same after injection—that’s what the post means. Postinjection. And we see the contralateral activity, or due to neural blockade, there’s increased sympathetic output, meaning that there has been a successful block. * * *

In addition, Dr. Leak explained that, if a nerve block is administered on one side, there should be an increase in autonomic activity on the contralateral side. Dr. Leak testified that that occurs because the contralateral side is “unimpeded and you have an increased outflow of sympathetic activity, because you’ve blocked the side with local anesthetic.” (Tr. at 2850-2851; see also 2917-2918) [Note, however, that the July 13, 2001, Procedural Note states that the injections were performed bilaterally. (St. Ex. 21 at 324)]

Testimony of Dr. Griffin

98. Dr. Griffin testified that STC is “a great theory. It wasn’t the best test we did. * * * But then again, we didn’t really have much to do, so we did the best we could to try and get

objective evidence.” Dr. Griffin testified that he and Dr. Leak had worked with the test over a period of time to improve the reproducibility of the results, but that it is still not very reliable. Dr. Griffin added that the results of STC testing had influenced what he and Dr. Leak did with patients, “but we wouldn’t hang our hat on the study.” (Tr. at 3067-3068)

99. Dr. Griffin testified that he has not ordered or performed STC studies since leaving PCC in December 2003. (Tr. at 3083)

Table of EDX Studies Performed or Ordered by Dr. Leak and/or Dr. Griffin

100. The medical records indicate that Dr. Leak and/or Dr. Griffin performed or ordered the following tests. All tests were performed bilaterally.

Pt	Date	Physician	Test	SSEP: Nerve Root Level(s) Tested NCS: Nerves Tested STC: Level(s)/Dermatome(s) Tested	Med Rcd Page No.
1	07/18/01	Griffin	STC	C3-C6	229-231
	07/23/01	Leak	SSEP	Cervical, ¹² including C4 and C5	227-228
	07/23/01	Leak	NCS	Median and ulnar, sensory and motor	227-228
	07/24/01	Leak	STC	C3-C6, upper extremities	222-226
	07/25/01	Leak	STC	L1-S5, lower extremities	216-221
	07/26/01	Griffin	SSEP	Lumbar, ¹³ including L2 and L3 ¹⁴	214-215
	07/26/01	Griffin	NCS	Sural sensory, peroneal and tibial motor	214-215
	08/22/01	Griffin	STC	C3-C6, pre-injection	208-213
	08/22/01	Griffin	STC	C3-C6, post-injection	208-213
	08/28/01	Griffin	STC	C3-C6, pre-injection	201-206
	08/28/01	Griffin	STC	C3-C6, post-injection	201-206
	09/18/01	Griffin	STC	C3-C6, pre-injection	194-200
	09/18/01	Griffin	STC	C3-C6, post-injection	194-200
	10/02/01	Griffin	STC	C3-C6, pre-injection	188-193
	10/02/01	Griffin	STC	C3-C6, post-injection	188-193
	10/12/01	Griffin	STC	C3-C6, pre-injection	182-187
	10/30/01	Griffin	STC	C3-C6, pre-injection	176-181
	10/30/01	Griffin	STC	C3-C6, post-injection	176-181
	11/16/01	Griffin	STC	L1-L4, pre-injection	170-175
	11/16/01	Griffin	STC	L1-L4, post-injection	170-175
	11/28/01	Griffin	STC	L1-L4, pre-injection	164-169
	11/28/01	Griffin	STC	L1-L4, post-injection	164-169
	12/12/01	Griffin	STC	T1-T12	161-163
	12/13/01	Griffin	SSEP	Thoracic, ¹⁵ including T8, T10, and T12	159-160

¹² SSEPs of cervical nerve root levels always included C4-C8.

¹³ Except for the cases of Patient 8 and the October 7, 1999, SSEP of Patient 11, SSEPs of lumbar nerve root levels always included L2 – L5 and S1.

¹⁴ Dr. Katirji testified that SSEP studies at L-2 and L-3 do not have normal ranges because they are not ordinarily performed. Dr. Katirji explained that SSEP studies at L-2 and L-3 involve “stimulating the groin and recording [the results] from that.” (1073-1074)

Pt	Date	Physician	Test	SSEP: Nerve Root Level(s) Tested NCS: Nerves Tested STC: Level(s)/Dermatome(s) Tested	Med Rcd Page No.
2	01/02/01	Griffin	STC	T1-T12	357-359
	01/08/01	Leak	SSEP	Lumbar, including L2 and L3	355-356
	01/08/01	Leak	NCS	Sural sensory, peroneal and tibial motor	355-356
	01/11/01	Leak	SSEP	Cervical, including C4 and C5	353-354
	01/11/01	Leak	NCS	Median and ulnar, sensory and motor	353-354
	01/26/01	Griffin	STC	L1-S5, lower extremities	346-349
	07/23/01	Leak	STC	L1-L4	343-345
	10/16/01	Griffin	STC	L3-L5, pre-injection	337-342
	10/16/01	Griffin	STC	L3-L5, post-injection	337-342
	10/30/01	Griffin	STC	L1-L4, pre-injection	331-336
	10/30/01	Griffin	STC	L1-L4, post-injection	331-336
	11/13/01	Griffin	STC	L1-L4, pre-injection	325-330
	11/13/01	Griffin	STC	L1-L4, post-injection	325-330
3	04/24/01	Griffin	STC	L1-L5	334-336
	04/25/01	Griffin	SSEP	Lumbar, including L2 and L3	332-333
	04/25/01	Griffin	NCS	Sural sensory, peroneal and tibial motor	332-333
	07/16/01	Griffin	STC	L3-L5	329-331
	09/14/01	Griffin	STC	T11-L2, pre-injection	322-328
	09/14/01	Griffin	STC	T11-L2, post-injection	322-328
	09/28/01	Griffin	STC	T11-L2, pre-injection	314-327
	09/28/01	Griffin	STC	T11-L2, post-injection	314-327
	10/17/01	Griffin	STC	T11-L2, pre-injection	307-313
	10/17/01	Griffin	STC	T11-L2, post-injection	307-313
	11/13/01	Not documented	STC	T11-L2, pre-injection	300-306
	11/13/01	Not documented	STC	T11-L2, post-injection	300-306
	12/06/01	Leak	STC	T7-T9 and L4-S1, pre-injection	292-299
	12/06/01	Leak	STC	T7-T9 and L4-S1, post-injection	292-299
4	05/26/00	Leak	SSEP	Cervical, including C4 and C5	404-405
	05/26/00	Leak	NCS	Median and ulnar, sensory and motor	404-405
	06/05/00	Not documented	STC	C3-C6, upper extremities	400-403
	06/06/00	Not documented	STC	T1-T12	393-395
	06/08/01	Leak	SSEP	Thoracic, including T8, T10, and T12	391-392
	10/30/01	Griffin	STC	T3-T6, pre-injection	381-387
	10/30/01	Griffin	STC	T3-T6, post-injection	381-387
	11/06/01	Griffin	STC	T3-T6, pre-injection	374-379
	11/06/01	Griffin	STC	T3-T6, post-injection	374-379
	11/20/01	Griffin	STC	T3-T6, pre-injection	368-373
	11/20/01	Griffin	STC	T3-T6, post-injection	368-373
5	08/10/99	Not documented	STC	L1-S5, lower extremities	326-331
	08/11/99	Leak	SSEP	Lumbar, including L2 and L3	324-325
	08/11/99	Leak	NCS	Sural sensory, peroneal and tibial motor	324-325

¹⁵ Except for the October 8, 1999, SSEP of Patient 11, SSEPs of thoracic nerve root levels always included T2, T4, T6, T8, T10, and T12.

Pt	Date	Physician	Test	SSEP: Nerve Root Level(s) Tested NCS: Nerves Tested STC: Level(s)/Dermatome(s) Tested	Med Rcd Page No.
	04/05/00	Not documented	STC	C3-C6, upper extremities	318-323
	04/06/00	Leak	SSEP	Cervical, including C4 and C5	316-317
	04/06/00	Leak	NCS	Median and ulnar, sensory and motor	316-317
	04/07/00	Leak	SSEP	Thoracic, including T8, T10, and T12	314-315
	04/10/00	Not documented	STC	T1-T12	309-313
	06/22/01	Griffin	STC	T6-T10, pre-injection	303-308
	06/22/01	Griffin	STC	T6-T10, post-injection	303-308
	06/29/01	Griffin	STC	L1-L3, pre-injection	297-302
	06/29/01	Griffin	STC	L1-L3, post-injection	297-302
	07/13/01	Griffin	STC	T6-T10, pre-injection	292-296
	07/13/01	Griffin	STC	T6-T10, post-injection	292-296
	07/20/01	Griffin	STC	L1-L4, pre-injection	286-291
	07/20/01	Griffin	STC	L1-L4, post-injection	286-291
	10/10/01	Griffin	STC	T4-T7, pre-injection	280-285
	10/10/01	Griffin	STC	T4-T7, post-injection	280-285
	10/12/01	Griffin	STC	L1-L4, pre-injection	274-279
	10/12/01	Griffin	STC	L1-L4, post-injection	274-279
	10/19/01	Griffin	STC	T4-T7, pre-injection	267-273b
	10/19/01	Griffin	STC	T4-T7, post-injection	267-273b
	10/30/01	Griffin	STC	L1-L3, pre-injection	261-266
	10/30/01	Griffin	STC	L1-L3, post-injection	261-266
	11/13/01	Griffin	STC	L1-L3, pre-injection	255-260
	11/13/01	Griffin	STC	L1-L3, post-injection	255-260
	11/21/01	Griffin	STC	T4-T7, pre-injection	249-254
	11/21/01	Griffin	STC	T4-T7, post-injection	249-254
6	11/28/00	Not documented	STC	L1-S5, lower extremities	159-162
	12/27/00	Leak	SSEP	Lumbar, including L2 and L3	153-154
7	11/21/00	Not documented	STC	L1-S5, lower extremities	379-384
	11/28/00	Leak	SSEP	Lumbar, including L2 and L3	377-378
	11/28/00	Leak	NCS	Sural sensory, peroneal and tibial motor	377-378
	06/01/01	Griffin	SSEP	Thoracic, including T8, T10, and T12	375-376
	06/05/01	Griffin	STC	T1-T12	369-374
	06/26/01	Griffin	STC	L1-L5, pre-injection	363-368
	06/26/01	Griffin	STC	L1-L5, post-injection	363-368
	07/18/01	Griffin	STC	L1-L5, pre-injection	357-362
	07/18/01	Griffin	STC	L1, L4, post-injection	357-362
	08/01/01	Leak	STC	L4-S2, pre-injection	351-356
	08/01/01	Leak	STC	L4-S2, post-injection	351-356
	08/14/01	Griffin	STC	L4-S1, pre-injection	343-350
	08/14/01	Griffin	STC	L4-S1, post-injection	343-350
	09/11/01	Griffin	STC	L4-S1, pre-injection	337-342
	09/11/01	Griffin	STC	L4-S1, post-injection	337-342
	09/21/01	Griffin	STC	L1-L4, pre-injection	331-336
	09/21/01	Griffin	STC	L1-L4, post-injection	331-336
	10/02/01	Griffin	STC	L1-L4, pre-injection	325-330
	10/02/01	Griffin	STC	L1-L4, post-injection	325-330

Pt	Date	Physician	Test	SSEP: Nerve Root Level(s) Tested NCS: Nerves Tested STC: Level(s)/Dermatome(s) Tested	Med Rcd Page No.
	12/04/01	Griffin	STC	T6-T8, pre-injection	319-324
	12/04/01	Griffin	STC	T6-T8, post-injection	319-324
	12/11/01	Griffin	STC	T6-T8, pre-injection	313-318
	12/11/01	Griffin	STC	T6-T8, post-injection	313-318
8	10/13/99	Not documented	STC	L1-S5, lower extremities	535-541
	10/14/99	Leak	SSEP	L4-S1	542-543
	10/14/99	Leak	NCS	Sural sensory, peroneal and tibial motor	542-543
	04/17/00	Not documented	STC	L1-S5, lower extremities	529-534
	08/15/01	Griffin	STC	C3-C6, upper extremities	523-528
	08/22/01	Leak	SSEP	Cervical, including C4 and C5	521-522
	08/22/01	Leak	NCS	Median and ulnar, sensory and motor	321-322
	10/26/01	Griffin	STC	L3-S1	518-520
	10/26/01	Griffin	STC	C4-C6	515-517
9	06/05/00	Leak	SSEP	Lumbar, including L2 and L3	321-322
	06/05/00	Leak	NCS	Sural sensory, peroneal and tibial motor	321-322
	06/08/00	Not documented	STC	L1-S5, lower extremities	315-318
	06/21/01	Griffin	STC	L1-S1	311-313
	07/19/01	Griffin	STC	L2-S1	308-310
10	04/06/01	Griffin	STC	L1-S5, lower extremities	103-108
11	10/06/99	Not documented	STC	C3-C6, upper extremities	601-607
	10/07/99	Leak	SSEP	L4-S1	624-624
	10/07/99	Leak	NCS	Sural sensory, peroneal and tibial motor	624-625
	10/08/99	Leak	SSEP	T4, T6, T8, and T10	622-623
	10/14/99	Not documented	STC	L1-S5, lower extremities	608-611
	05/15/00	Not documented	STC	Thoracic	596-600
	10/04/00	Not documented	STC	C3-C6, upper extremities	590-595
	10/06/00	Not documented	STC	L1-S5, lower extremities	580-585
	10/18/00	Leak	SSEP	Thoracic, including T8, T10, and T12	588-589
	11/03/00	Leak	SSEP	Lumbar, including L2 and L3	586-587
	11/03/00	Leak	NCS	Sural sensory, peroneal and tibial motor	586-597
	11/10/00	Leak	SSEP	Cervical, including C4 and C5	577-578
	11/10/00	Leak	NCS	Median and ulnar, sensory and motor	577-578
	07/18/01	Griffin	STC	T5-T9, pre-injection	571-576
	07/18/01	Griffin	STC	T5-T6, post-injection	571-576
	08/08/01	Griffin	STC	T4-T7, pre-injection	565-570
	08/08/01	Griffin	STC	T4-T8, post-injection:	565-570
	08/28/01	Not documented	STC	T4-T7, pre-injection	558-564
	08/28/01	Not documented	STC	T4-T7, post-injection	558-564
	09/18/01	Griffin	STC	T4-T7, pre-injection	552-557
	09/18/01	Griffin	STC	T4-T7, post-injection	552-557
	10/02/01	Griffin	STC	T4-T7, pre-injection	546-551
	10/02/01	Griffin	STC	T4-T7, post-injection	546-551
	10/23/01	Griffin	STC	T6-T10, pre-injection	540-545
	10/23/01	Griffin	STC	T6-T10, post-injection	540-545

Pt	Date	Physician	Test	SSEP: Nerve Root Level(s) Tested NCS: Nerves Tested STC: Level(s)/Dermatome(s) Tested	Med Rcd Page No.
	11/06/01	Griffin	STC	T4-T7, pre-injection	534-539
	11/06/01	Griffin	STC	T4-T7, post-injection	534-539
12	11/10/00	Not documented	STC	C3-C6, upper extremities	326-331
	11/28/00	Not documented	STC	L1-S5, lower extremities	320-325
	11/29/00	Not documented	STC	T1-T12	315-319
	11/30/00	Leak	SSEP	Cervical, including C4 and C5	313-314
	11/30/00	Leak	NCS	Median and ulnar, sensory and motor	313-314
	12/01/00	Leak	NCS	Sural sensory, peroneal and tibial motor	334-335
	12/01/00	Leak	SSEP	Lumbar, including L2 and L3	334-335
	12/05/00	Leak	SSEP	Thoracic, including T8, T10, and T12	332-333
13	06/29/00	Not documented	STC	L1-S5, lower extremities	171-173, 177
	07/05/00	Leak	SSEP	Cervical, including C4 and C5	170, 174
	07/05/00	Leak	NCS	Median and ulnar, sensory and motor	170, 174
	07/06/00	Not documented	STC	T1-T12	175-176
	07/10/00	Leak	SSEP	Thoracic, including T8, T10, and T12	168-169
	09/01/00	Leak	SSEP	Lumbar, including L2 and L3	166-167
	09/01/00	Leak	NCS	Sural sensory, peroneal and tibial motor	166-167
14	02/28/01	Griffin	STC	C3-C6, upper extremities	211-216
	03/06/01	Griffin	STC	T1-T12	202-204, 207-208
	03/07/01	Leak	SSEP	Cervical, including C4 and C5	209-210
	03/07/01	Leak	NCS	Median and ulnar, sensory and motor	209-210
	03/15/01	Leak	SSEP	Thoracic, including T8, T10, and T12	205-206
	06/22/01	Griffin	STC	T1-T3, pre-injection	196-201
	06/22/01	Griffin	STC	T1-T3, post-injection	196-201
	06/29/01	Griffin	STC	C3-C6, pre-injection	190-195
	06/29/01	Griffin	STC	C3-C6, post-injection	190-195
15	04/10/00	Not documented	STC	L1-S5, lower extremities	253-258
	04/19/00	Leak	SSEP	Lumbar, including L2 and L3	251-252
	04/19/00	Leak	NCS	Sural sensory, peroneal and tibial motor	251-252
	06/28/01	Griffin	STC	L1-L2	248-250
16	05/25/01	Griffin	SSEP	Lumbar, including L2 and L3	149-150
	05/25/01	Griffin	NCS	Sural sensory, peroneal and tibial motor	149-150
	05/28/01	Griffin	STC	L1-S5, lower extremities	143-148
	06/25/01	Griffin	STC	Lower extremities	140-142
	07/23/01	Leak	STC	Lower extremities	137-139
17	06/25/00	Not documented	SSEP	Cervical, including C4 and C5	318
	06/25/00	Not documented	NCS	Median and ulnar, sensory and motor	318
	07/28/00	Not documented	STC	C3-C6, upper extremities	312-317
	08/14/00	Leak	SSEP	Thoracic, including T8, T10, and T12	310-311
	08/23/00	Leak	SSEP	Lumbar, including L2 and L3	308-309

Pt	Date	Physician	Test	SSEP: Nerve Root Level(s) Tested NCS: Nerves Tested STC: Level(s)/Dermatome(s) Tested	Med Rcd Page No.
	08/23/00	Leak	NCS	Sural sensory, peroneal and tibial motor	308-309
	06/29/01	Griffin	STC	T5-T7, pre-injection	302 -307
	06/29/01	Griffin	STC	T5-T7, post-injection	302 -307
	08/27/01	Griffin	STC	T7-T10, pre-injection	296-301
	08/27/01	Griffin	STC	T7-T10, post-injection	296-301
	08/07/01	Griffin	STC	T6-T8, pre-injection	290-295
	08/07/01	Griffin	STC	T6-T8, post-injection	290-295
	07/24/01	Leak	STC	T5-T7, pre-injection	285-289
	07/24/01	Leak	STC	T5-T7, post-injection	285-289
	08/31/01	Griffin	STC	T7-T10, pre-injection	279-284
	08/31/01	Griffin	STC	T7-T10, post-injection	279-284
	09/28/01	Griffin	STC	L1-L5, pre-injection	269-275
	09/28/01	Griffin	STC	L1-L5, post-injection	269-275
	10/12/01	Griffin	STC	L1-L5, pre-injection	263-268
	10/12/01	Griffin	STC	L1-L5, post-injection	263-268
	11/16/01	Leak	STC	L1-S1	259-262
18	02/28/01	Griffin	STC	L1-S5	149, 151-152, 281
	03/13/01	Leak	SSEP	Lumbar, including L2 and L3	279-280
	03/13/01	Leak	NCS	Sural sensory, peroneal and tibial motor	279-280
19	09/20/00	Leak	SSEP	Lumbar, including L2 and L3	186-187
	09/20/00	Leak	NCS	Sural sensory, peroneal and tibial motor	186-187
	09/22/00	Not documented	STC	L1-S5	180-185
20	08/25/00	Leak	SSEP	Lumbar, including L2 and L3	358, 365
	08/25/00	Leak	NCS	Sural sensory, peroneal and tibial motor	358, 365
	08/30/00	Not documented	STC	L1-S5	359-364
21	08/29/00	Not documented	STC	C3-C6, upper extremities	616-621
	08/30/00	Not documented	STC	L1-S5, lower extremities	610-615
	09/18/00	Leak	SSEP	Lumbar, including L2 and L3	608-609
	09/18/00	Leak	NCS	Sural sensory, peroneal and tibial motor	608-609
	09/22/00	Leak	SSEP	Cervical, including C4 and C5	606-607
	09/22/00	Leak	NCS	Median and ulnar, sensory and motor	606-607
	07/13/01	Griffin	STC	C3-C6, pre-injection	600-605
	07/13/01	Griffin	STC	C3-C6, post-injection	600-605
	09/27/01	Griffin	STC	C3-C6	597-599
	09/28/01	Griffin	STC	C3-C6	594-596
	10/12/01	Griffin	STC	C3-C6, pre-injection	587-593
	10/12/01	Griffin	STC	C3-C6, post-injection	587-593
22	03/05/01	Leak	SSEP	Cervical, including C4 and C5	342-343
	03/05/01	Leak	NCS	Median and ulnar, sensory and motor	342-343
	03/06/01	Griffin	STC	C3-C6, upper extremities	336-341
	03/09/01	Griffin	STC	T1-T12	330-335

Pt	Date	Physician	Test	SSEP: Nerve Root Level(s) Tested NCS: Nerves Tested STC: Level(s)/Dermatome(s) Tested	Med Rcd Page No.
	03/13/01	Not documented	STC	L1-S5, lower extremities	325-329
	03/14/01	Leak	SSEP	Thoracic, including T8, T10, and T12	323-324
	03/19/01	Leak	SSEP	Lumbar, including L2 and L3	321-322
	03/19/01	Leak	NCS	Sural sensory, peroneal and tibial motor	321-322
	06/26/01	Griffin	STC	L4-S2	317-319
	07/12/01	Griffin	STC	L4- S2, pre-injection	311-316
	07/12/01	Griffin	STC	L4- S2, post-injection	311-316
	07/25/01	Leak	STC	T4-T9, pre- post-injection	305-310
	07/25/01	Leak	STC	T4-T9, post-injection	305-310
	07/31/01	Not documented	STC	T4-T8, pre-injection	299-304
	07/31/01	Not documented	STC	T4-T8, post-injection	299-304
	08/03/01	Leak	STC	T2-T7, pre-injection	293-298
	08/03/01	Leak	STC	T2-T7, post-injection	293-298
	09/19/01	Griffin	STC	T4-T7, pre-injection	287-292
	09/19/01	Griffin	STC	T4-T7, post-injection	287-292
	09/28/01	Griffin	STC	T4-T7, pre-injection	280-286
	09/28/01	Griffin	STC	T4-T7, post-injection	280-286
	10/19/01	Griffin	STC	T4-T7, pre-injection	274-279
	10/19/01	Griffin	STC	T4-T7, post-injection	274-279
23	03/30/01	Griffin	STC	L1-S5, lower extremities	101-106
	04/05/01	Leak	SSEP	Lumbar, including L2 and L3	99-100
	04/05/01	Leak	NCS	Sural sensory, peroneal and tibial motor	99-100

Allegation (1)(e)

101. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(e) as follows:

Assuming, *arguendo*, that EDX studies on Patients 1-5, 7-11, 14-19, and 21-23 were necessary, [Dr. Griffin] failed to perform or recommend and/or document the performance or recommendation of a needle EMG examination.

(St. Ex. 54A)

Use of Needle EMG

Testimony of Dr. Katirji

102. Dr. Katirji testified that needle EMG is performed by placing a needle into any of various muscles in the limbs. Dr. Katirji further testified, “[T]he patient is asked to activate the muscle, and then the size of the motor units are looked at.” Dr. Katirji testified, “[Y]ou can look at muscle disease by the needle EMG, but also you can look at nerve disease because

if the nerve's lost to that muscle, you'll see changes in that muscle that tell you that the axons on that muscle have disintegrated." (Tr. at 1022-1023)

103. Dr. Katirji testified that needle EMGs are about 85 percent accurate. Dr. Katirji testified that that means if a nerve is compressed in the back, as would be the case with radiculopathy, 85 percent of patients will have an abnormal result with needle EMG. (Tr. at 1154-1155; 1209-1212)
104. Dr. Katirji testified that needle EMG is nearly always performed in conjunction with a nerve conduction study. Dr. Katirji further testified that needle EMG *must* be performed in conjunction with nerve conduction studies in order to diagnose radiculopathy. That is because, in cases of radiculopathy, "the root lesion is at the spine level, and the nerve conduction studies do not really test the roots. They just test the limbs." Dr. Katirji further testified that, in order to diagnose radiculopathy, the results of the nerve conduction studies must be normal and the needle EMG abnormal. Moreover, if a patient has nerve compression in a limb rather than radiculopathy, as with carpal tunnel syndrome, the needle EMG result would be nearly normal. (Tr. at 1021-1023, 1154-1155, 1210-1212)

Dr. Katirji further testified that nerve conduction studies may be performed *without* needle EMG for conditions other than radiculopathy, such as peripheral neuropathy, carpal tunnel syndrome, myasthenia gravis, and Lou Gehrig's disease. Further, they may be performed without needle EMG in the event of an acute case when the patient has had the problem for less than a week. With regard to radiculopathy, however, Dr. Katirji testified that needle EMG must be performed because, in cases of radiculopathy, nerve conduction study results "are normal by definition." (Tr. at 1011-1012, 1157-1158)

105. In his August 8, 2006, report, and in his testimony at hearing, Dr. Katirji indicated that, of the medical records for Dr. Leak's patients that Dr. Katirji reviewed, about one-third of the patients suffered from radicular pain.¹⁶ All of those patients received nerve conduction studies, but none received needle EMG. Dr. Katirji testified that performing nerve conduction studies without needle EMG in patients who suffer from such symptoms falls below the minimal standard of care. Patients who exhibited radicular pain were:

- Patient 8. (St. Ex. 8 at 521-522, 542-543; St. Ex. 31; Bd. Ex. H; Tr. at 1079-1081)
- Patient 9. (St. Ex. 9 at 321-322; St. Ex. 31; Bd. Ex. H; Tr. at 1082-1083)
- Patient 11.¹⁷ (St. Ex. 11 at 577-578, 586-587, 624-625; St. Ex. 31; Bd. Ex. H; Tr. at 1092-1094)
- Patient 12. (St. Ex. 12 at 313-314, 334-335; St. Ex. 31; Bd. Ex. H; Tr. at 1096-1097)
- Patient 13. (St. Ex. 13 at 166-167; St. Ex. 31; Bd. Ex. H; Tr. at 1101-1102)
- Patient 14. (St. Ex. 14 at 209-210; St. Ex. 31; Bd. Ex. H; Tr. at 1106)
- Patient 18. (St. Ex. 18 at 279-280; St. Ex. 31; Bd. Ex. H; Tr. at 1116-1117)

¹⁶ Dr. Katirji testified that radiculopathy is characterized in part by pain radiating from the back or neck into a limb, and not by pain localized in a joint or limb. (Tr. at 1057)

¹⁷ Note that a needle EMG had been performed on Patient 11 on July 6, 1999, but the test had not been ordered by Dr. Leak or Dr. Griffin. (St. Ex. 11 at 626)

- Patient 19. (St. Ex. 19 at 186-187; St. Ex. 31; Bd. Ex. H; Tr. at 1118)
- Patient 20. (St. Ex. 20 at 365; St. Ex. 31; Bd. Ex. H; Tr. at 1119-1120)
- Patient 22. (St. Ex. 22 at 321-322, 342-343; St. Ex. 31; Bd. Ex. H; Tr. at 1119-1120)

Furthermore, Dr. Katirji testified that the remaining patients had complained only of joint pain or pain localized to the back. Dr. Katirji testified that those patients had not needed SSEPs or nerve conduction studies but nevertheless received them. Dr. Katirji testified that, accordingly, patients with radicular symptoms had had incomplete testing, and patients who did not have radicular symptoms had had unnecessary testing. (Tr. at 1142-1143, 1203-1208)

Testimony of Dr. Chelimsky

106. Dr. Chelimsky provided further testimony concerning the reasons that a needle EMG must be performed in conjunction with nerve conduction studies:

[T]he needle examination tells you whether the lesion is a demyelinating or an axonal lesion. It also tells you whether the lesion is occurring up at the root level or down at the nerve level. It fully complements—the nerve conduction study essentially gives you something is normal or something is abnormal, but it doesn't really do a very good job of localizing because you could have an abnormality anywhere along that nerve between the point you stimulate and the point you record, and you would have an abnormality. You need the needle examination to tell you the relevance of the finding.

* * * [I]f you're assessing a nerve root, you need to do both a motor and a sensory conduction. The reason for this is that the dorsal roots—how do I put this? The cell body is connected to the nerve, and the cell body is what determines whether a nerve dies or not.

Now, the cell bodies that belong to feeling or sensory neurons turn out that they're outside the spine. So if you have some problem like a disc or some other problem pushing on the nerve roots inside the spine, the sensory conduction will be fine. * * * Only the motor conduction will be affected because the cell body of the motor nerve is actually in the spinal cord.

* * * [I]n order for a nerve to die, you have to actually separate the cell body from the nerve axon. So because the sensory cell bodies are outside the spine, you will never get damage to a sensory nerve from a problem inside the spine. You just—they're too far away. They're about a half an inch away. But you will get damage to the motor. So you have to do motor and sensory conductions, and you have to have the needle examination to go with it.

(Tr. at 1585-1587) Moreover, Dr. Chelimsky testified that the standard of care requires performing a needle EMG along with nerve conduction studies: “To have nerve conduction studies by themselves is meaningless.” (Tr. at 1587)

Testimony of Dr. Bressi

107. Dr. Bressi testified that he does not believe that nerve conduction studies must be performed in conjunction with needle EMG at all times. However, Dr. Bressi did not address whether Dr. Griffin's use of nerve conduction studies had required concomitant use of needle EMG. (Tr. at 2376-2377)

Testimony of Dr. Leak

108. Referring to the July 23, 2001, EDX studies performed on Patient 1, Dr. Leak was asked why he had not performed or ordered needle EMG along with the SSEPs and nerve conduction studies. Dr. Leak replied that he had not performed needle EMG on Patient 1 because it had been unnecessary to do so. Dr. Leak further testified that EMGs do not provide any useful information concerning a patient's complaint of pain. Moreover, Dr. Leak testified:

The patient's complaint was one of subjective pain, and that's what we needed to prove.

The patient * * * had nerve conduction studies that indicated that there was already evidence of motor pathology. Nerve conduction studies are done independent of EMGs and independent of [SSEPs] as a matter of standard.

The need for EMG was not relevant to us because we had proven without doubt that the patient had sensory or painful pathology and, therefore, the EMG was not needed * * *. Pain is a sensory response. [If the] patient had developed a scenario of loss of function, motor function—that is, the capacity to move or to lift the arms, something like that—that would have been a different story. But for his complaint of pain, the EMG was not something that we considered as indicated, since we already had a good body of electrodiagnostic studies that gave us the answer.

(Tr. at 571-572) When asked if needle EMG would have provided a more accurate assessment of the nerve or nerve root, Dr. Leak replied:

Absolutely not. Needle EMGs look at muscle pathology per the nerve. And each muscle is supplied by multiple nerves. There's a paper that we're publishing on a patient that had four EMGs in this community by four different doctors. All of the results were different.

[P]art of the concern of EMG is the fact that if the patient doesn't relax, and it's not that easy to relax when somebody pokes you with a needle, then that will look like abnormal pathology. If they're shivering or being cold, and part of the EMG study is not easy to control the ambient environment, that can give variance to the results.

So, no, it is because of the wide variety of results in the same patients having the alleged same study, even in our community, which ha[s] relatively efficient electromyographers, we find the study not to be superior. In fact, it's non-contributory just for pain.

(Tr. at 573)

Testimony of Dr. Griffin

109. Dr. Griffin testified as follows concerning the necessity of needle EMG:

[I]t's essentially a fairly crude test for pain. It's good for motor, but motor is not sensory. Motor's motor. Pain is sensory. Pain, with a signal coming from the injury or chronic pain site to the spinal cord and going up, that's sensory afferent pain.

If you order an EMG, you're getting strictly outgoing signal to the muscle and the response of the muscle. So you're not getting—it's a little bit of a large leap to say that that is an indicator for pain. It's not.

So the SSEP came along, which was a real—it was a scientific attempt to get pain measurement. It doesn't measure pain, but it does measure injury to the nerve or nerve inadequacy. So that procedure is an afferent study for an afferent problem, so that makes more sense than an afferent study for an efferent system, which is just an outgoing study of one system for another.

The SSEP is a refinement. And for those of us that trained on EMGs or with the EMGs as the standard of the time, we had to kind of relearn the electrodiagnostic stuff with the SSEP now being the benchmark, so to speak. And it's a good test. It's not perfect, by any stretch of the imagination, but it's real good if you're trying to show that this patient's not lying to us or there's more to that problem than we suspected.

(Tr. at 3024-3025)

Dr. Griffin added that he has two patients who insist that their pain level actually increased as a result of having had needle EMGs performed. (Tr. at 3026)

Testimony of Dr. Boswell

110. Dr. Boswell believes that nerve conduction studies are valuable even if performed separately from a needle EMG. Dr. Boswell further testified that in individual circumstances it may be valuable to perform one or both. (Tr. at 58-61)

Allegation (1)(d)

111. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(d) as follows:

[Dr. Griffin] failed to identify and/or document an appropriate indication for the use of the EDX studies on Patients 1-5, 7-11, 14-19, and 21-23.

(St. Ex. 54A)

Indications for the Use of EDX Studies

Testimony of Dr. Katirji

112. Dr. Katirji criticized Dr. Leak and Dr. Griffin for failing to document the indications for performing EDX studies. Dr. Katirji testified: “Usually you suspect something. You say I’m worried about this, lets do the test to look for that.” However, Dr. Katirji could find no progress notes concerning why the EDX studies in question had been performed. Moreover, Dr. Katirji testified that there had been no mention in the progress notes of the results of the EDX studies. (Tr. at 1041-1044)

113. Dr. Katirji further testified that a statement that appeared in many of the medical records that Dr. Leak or Dr. Griffin would “plug [the patient] into [their] very extensive diagnostic process,” implies that tests were ordered without any thought process. (St. Ex. 31; Tr. at 1044, 1226-1227; See, e.g., St. Ex. 1 at 136; St. Ex. 2 at 231; St. Ex. 12 at 271)

114. With regard to a statement in his written report that EDX studies “were clearly performed with a ‘cookbook’ approach as evidenced by identical[] SSEPs and NCSs done on all patients regardless of symptoms,” Dr. Katirji testified :

What I meant in here is * * * within the nerve conduction studies * * * exactly the same set of conductions are done. We don’t do the same conductions on every patient the same way and we don’t need to do both sides in a person who has unilateral limb symptoms.

* * *

If you look at every upper limb, it’s exactly the same. Every lower limb, it’s exactly the same. [With regard to nerve conduction studies only, t]hey’re done bilaterally, the same number of nerves, the same number of reflexes. If you have limb pain on the left, why was the right done when the right was normal? So that’s what I’m talking about cookbook. And the nerves are the same. There are more nerves than are tested here. The exactly same nerve is done.

(Tr. at 1233-1235) Moreover, Dr. Katirji testified:

Obviously a technician did [the nerve conduction studies] and was told to do these nerves regardless of the problem. There's no thought process in it at all. It was done just like a cookbook. * * *

(Tr. at 1235)

Furthermore, with regard to SSEP studies, Dr. Katirji testified that, for example, if a patient complained of pain at the T6 level, the patient was tested at T2, T4, T6, T8, and T10. Moreover, Dr. Katirji testified that, at the cervical and lumbar spines, the same levels were always tested. Finally, Dr. Katirji testified that tests "have to be individualized. You can't just do exactly the same on everybody every time whatever the problem is." (St. Ex. 31; Tr. at 1041, 1236-1238)

115. Dr. Katirji testified that electrodiagnostic studies should be a continuation of the examination, and should only be performed based on a patient's symptoms and the limb affected. Moreover, Dr. Katirji testified that the performance of studies in limbs that were not part of the patient's complaint had been a deviation from the standard of care. Finally, Dr. Katirji testified that performing EDX tests on patients when such tests are not indicated constitutes a deviation from the standard of care. (Tr. at 1044-1045)

Testimony of Dr. Bressi

116. Dr. Bressi testified that pain is completely subjective and that physicians have to "validate the patient's subjective impression of their pain." Dr. Bressi further testified that validating a patient's subjective complaint of pain is "part of the art of medicine" and "a work in progress." It involves taking the patient's history and talking with the patient, a physical examination, and ordering diagnostic studies or reviewing records of past diagnostic evaluations. Moreover, Dr. Bressi testified that diagnostic tests "never are there to define the diagnosis. They're there to either support it or not support it * * *." (Tr. at 2265-2268)

Dr. Bressi testified that that would not be unusual for an interventional pain management physician to use diagnostic tests to determine whether a patient actually has pain. (Tr. at 2270)

117. Dr. Bressi testified that it is above the minimal standard of care for a physician to perform or order "broad testing to find out answers" concerning complex chronic pain patients. Dr. Bressi further noted that many of the patients he reviewed in this matter had pain issues that emanated from more than one location or condition. (Tr. at 2446)

Testimony of Dr. Griffin

118. Dr. Griffin disagreed with the allegation that he had utilized EDX studies without identifying or documenting an appropriate indication. Dr. Griffin testified that the need for the studies had been determined shortly after the patient's first visit when the treatment plan was formed. (Tr. at 3022-3024)

Dr. Griffin further disagreed that he had ordered unnecessary tests on patients. Dr. Griffin testified that the studies had been ordered to obtain objective evidence of the patients' subjective complaints of pain. Dr. Griffin further testified that the tests "never made the diagnosis." Dr. Griffin testified, "You've got a large amount of data that has to be included in the process of working out a differential diagnosis." (Tr. at 3020-3022)

Standing Orders for EDX Studies

Testimony of Dr. Griffin

119. Dr. Griffin testified that Dr. Leak had established standing orders to perform SSEPs, nerve conduction studies, and STCs on patients to determine, to the extent it was possible, whether "there was pathology to match the patient pain complaint." Dr. Griffin further testified that, if a patient was going to have a trigger point or chemoneurolytic injection, staff was to perform pre- and post-injection STC tests. (Tr. at 694-695, 765-766, 3013-3014)

Testimony of Dr. Chelimsky

120. Concerning standing orders for each patient to be tested with SSEPs, nerve conduction studies, and STCs, Dr. Chelimsky agreed that the medical records "certainly would reflect that, that every patient got the same diagnostic testing." (Tr. at 1607-1608) Dr. Chelimsky further testified:

[T]he core part of being a physician is selecting those diagnostic tests which are going to provide meaningful information in that patient's care. There are no two patients alike, let alone 24 patients who are alike. So it would reflect absence of conceptualization of patient problems to order the exact same diagnostic tests on 24 patients.

(Tr. at 1608)

Allegations (1)(g), (1)(h)

121. In its August 9, 2006, notice of opportunity for hearing, the Board alleged as follows:

Allegation (1)(g):

[Dr. Griffin] failed to properly document an appropriate comment on purported abnormal EDX study results for Patients 1, 3, 5, 7-9, 11-14, 17-19, 21 and 22.

Allegation (1)(h) [in part]:

[Dr. Griffin] failed to change and/or document a change in treatment or management of Patients 1, 3, 5, 7-9, 11-14, 17-19, 21 and 22 based on the abnormal results of EDX studies.

(St. Ex. 54A)

Comments on Abnormal EDX Study Results

Dr. Katirji's Testimony and Report

122. Dr. Katirji's written report and testimony indicates that a number of SSEP studies yielded abnormal results; however, with one exception,¹⁸ Dr. Leak and Dr. Griffin failed to comment in their progress notes concerning the abnormal results. Dr. Katirji testified that such lack of comment deviated from the standard of care. (Tr. at 1043-1044)

The hearing record contains the following information concerning abnormal results obtained from SSEP studies:

Pt¹⁹	Date	Abnormal Results	Physician²⁰	Citation to Hearing Record²¹
1	07/26/01	L5 and S1 left	Dr. Griffin	St. Ex. 1 at 214-215; Tr. at 1050
3	04/25/01	L4 and L5 bilaterally	Dr. Griffin	St. Ex. 3 at 332-333; Tr. at 1064
6	12/27/00	L4 left, L5 & S1 bilaterally	Dr. Leak	St. Ex. 6 at 153-154; Tr. at 1071-1072
7	11/28/00	L5 and S1 bilaterally	Dr. Leak	St. Ex. 7 at 377-378; Tr. at 1073
8	10/14/99	L5 and S1 bilaterally	Dr. Leak	St. Ex. 8 at 542-543; Tr. at 1076-1079
9	06/05/00	L5 and S1 bilaterally	Dr. Leak	St. Ex. 9 at 321-322; Tr. at 1081-1082
11	10/07/99	L4 left	Dr. Leak	St. Ex. 11 at 624-625; Tr. at 1086
11	10/08/99	T6 and T8 right	Dr. Leak	St. Ex. 11 at 622-623; Tr. at 1086
11	10/18/00	T2, T4, and T6 bilaterally	Dr. Leak	St. Ex. 11 at 588-589; Tr. at 1085
11	11/03/00	L4 left, L5 & S1 bilaterally	Dr. Leak	St. Ex. 11 at 586-587; Tr. at 1084
12	11/30/00	C4 – C6 right	Dr. Leak	St. Ex. 12 at 313-314; Tr. at 1094-1095
12	12/05/00	T2, T4, and T6 bilaterally	Dr. Leak	St. Ex. 12 at 332-333; Tr. at 1095

¹⁸ Dr. Katirji testified with regard to Patient 1's December 13, 2001, thoracic SSEP that a comment concerning the abnormal results had been documented in the chart. (St. Ex. 1 at 159-160; Tr. at 1048) That study was not included in this list.

¹⁹ These are the patient numbers as used in the Master Patient Key. The numbers differ from those used by Dr. Katirji in his written report. (St. Exs. 26, 31) See Board Exhibit H, which matches Dr. Katirji's patient numbers to the Master Patient Key.

²⁰ This is the name of the physician who ordered, performed, or interpreted the test.

²¹ State's Exhibit 31 and Board Exhibit H also apply to all cases in the table.

Pt ¹⁹	Date	Abnormal Results	Physician ²⁰	Citation to Hearing Record ²¹
12	12/01/00	L4 right, L5 & S1 bilaterally	Dr. Leak	St. Ex. 12 at 334-335; Tr. at 1096
13	07/10/00	T8 right could not be obtained	Dr. Leak	St. Ex. 13 at 168-169; Tr. at 1099
13	07/05/00	C6 and C7 left	Dr. Leak	St. Ex. 13 at 170-171; Tr. at 1099-1101
14	03/07/01	C8 right	Dr. Leak	St. Ex. 14 at 209-210; Tr. at 1103
14	03/15/01	T2, T4, and T6 right	Dr. Leak	St. Ex. 14 at 205-206; Tr. at 1102-1103
17	08/14/00	T6 bilaterally	Dr. Leak	St. Ex. 17 at 310-311; Tr. at 1113-1114
18	03/13/01	L4 and L5 left	Dr. Leak	St. Ex. 18 at 279-280; Tr. at 1116
19	09/20/00	L5 and S1 left	Dr. Leak	St. Ex. 19 at 186-187; Tr. at 1117-1118
21	09/18/00	S1 bilaterally	Dr. Leak	St. Ex. 21 at 608-609; Tr. at 1121
22	03/19/01	S1 left	Dr. Leak	St. Ex. 22 at 321-322; Tr. at 1123
22	03/14/01	T6 bilaterally	Dr. Leak	St. Ex. 22 at 323-324; Tr. at 1124

Testimony of Dr. Griffin

123. Dr. Griffin disagreed that he had failed to document an appropriate comment concerning abnormal test results. Dr. Griffin testified:

[I]deally, yes, you document what you do, but at the same time, you—I mean, that’s in the chart. It’s available. All you’ve got to do is look at it and it’s got an interpretation on it. So it seems a little silly to say the same thing over again when we have a clear pattern. Like a second visit is a diagnostic review. We go through all the material that’s ordered and some of the past material.

So it’s possible, I suppose, that we would not make a direct comment about it, but it was always looked at and always included in the process of working out a differential diagnosis.

(Tr. at 3026-3027)

Change in Management Based on the Abnormal Results of EDX Studies

Dr. Katirji’s Testimony

124. Dr. Katirji stated that he could find no evidence of any change in the course of treatment or management of the patients based upon abnormal SSEP results. (Tr. at 1143)

125. Dr. Katirji acknowledged that, if EDX testing confirms a suspected diagnosis, and “[i]f it confirms the exact level that you’ve treated,” it is not necessary to alter treatment based on the abnormal test results. (Tr. at 1266-1267)
126. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(i) as follows:

[Dr. Griffin] failed to form and/or document the formation of an overall clinical impression for Patients 1-5, 7-10, and 12-24.

(St. Ex. 54A)

Lack of Overall Clinical impression

Testimony and Written Report of Dr. Chelimsky

127. In his January 31, 2005, written report, Dr. Chelimsky offered the following opinion concerning the care rendered by Drs. Griffin and Leak as documented in the medical records for Patients 1 through 24:

The history was difficult to locate in the chart. It consisted usually of some nurse’s notes, a patient questionnaire that was extensive but not annotated or referenced (in its content) by either the nurse or the physician and usually a brief dictated note which referenced the presence of a history and physical examination in the chart but detailed little history or examination findings itself. The physical examination consisted of a pre-printed form with hand-written notations of normal and abnormal findings by which one could reasonably ascertain the results of the examination.

However, a major downfall occurs in the impression and plan. One cannot find a handwritten or typed formulation, impression, or differential diagnosis, and there is no documentation of synthesis of the clinical facts. A similar comment applies to the diagnostic and therapeutic management plan, which most often simply states, “the patient will undergo our extensive diagnostic testing.” The record reflects no reconstruction of the available information into a cohesive clinical picture. Since such an evaluative process forms the basis of the practice of medicine and surgery in Ohio, its absence clearly constitutes a great violation of minimal standard of care. This was true in every single record reviewed, except that of [Patient 11], where a reasonable impression was dictated by Dr. Griffin. * * *

(St. Ex. 28 at 1)

Moreover, Dr. Chelimsky testified that the standard of care requires that a physician document in the medical record “some kind of thinking expressed by the physician about what the problem is and how they plan to address it.” (Tr. at 1583)

128. Dr. Chelimsky testified that the plan for each patient had always been the same. Dr. Chelimsky explained: “The patient would undergo extensive diagnostic testing. It wasn’t clear what for. And then it’s not clear how that was being used.” Furthermore, Dr. Chelimsky testified that the treatment documented in the medical records seemed like

a series of disconnects. The patient would present, then there was a disconnect between the presentation and the impression, a disconnect between the impression and the plan, which is the extensive diagnostic testing, and then a disconnect between the test results and what was done afterwards. So everything’s disconnected. I’m talking about conceptually disconnected, not physically in the chart.

(Tr. at 1584)

Testimony of Dr. Bressi

129. Dr. Bressi testified with regard to PCC’s medical recordkeeping that, although the records were not perfect, they included the necessary information concerning diagnoses, consent forms, medications, and the doctors’ reasons for putting patients on pain medications and for changing patients’ medications. Dr. Bressi testified that he had had no difficulty in locating the patient histories in the 24 charts that he reviewed, although he acknowledged that he had not been familiar with Dr. Leak’s and Dr. Griffin’s recordkeeping and had to “hunt and peck” his way around the charts. However, Dr. Bressi testified that there was no standard of care from 1999 to 2001 that required medical records to be kept in any particular order. (Tr. at 2309, 2347)

Dr. Bressi further testified that he had found an impression and plan in each of the patient records that he reviewed. Dr. Bressi further testified that the impressions and plans recorded were “well within the minimal standards of care.” Dr. Bressi explained: “They listed diagnoses. They listed plans. They thoroughly introduced the patient to what was expected of them and what they should expect of the chronic pain team. They wrote down diagnostic lists, and they had inclusions in the charts of results or test results that helped them form their diagnostic lists.” (Tr. at 2348-2349)

Testimony of Dr. Leak

130. Dr. Leak believes that the experts who reviewed his charts for the State misunderstood his medical records. Dr. Leak further testified that that is understandable because the patient record exhibits do not look like his medical records. Dr. Leak testified:

In our medical chart, we have dividers that will tell you what’s where, so it’s sort of easy on a given day to go to this section on admission, this section on the discharge note, this section on the procedure note, this section on our office note.

In this—these are my records and I have a little challenge finding things because it doesn't look like a chart, like a medical chart. So if things are all separated by hundreds of pages, one might see how someone could be mistaken. But that just means you have to look a lot harder.

(Tr. at 2878)

Testimony of Dr. Griffin

131. Dr. Griffin testified that he “completely disagree[s]” with the allegation that he had failed to form or document forming an overall clinical impression of certain patients. Dr. Griffin added that “[t]hat is an amazing allegation” because every chart had a treatment plan in it. (Tr. at 3029-3030)

Medical Records

132. The majority of the medical records contain a single-page, handwritten flowchart labeled as a treatment plan. For example, the treatment plan for Patient 5 states “TX PLAN” at the top, underlined, below which “SPINAL DIFF” was written. Three arrows were drawn below that pointing toward the left, directly below, and toward the right.

- Beneath the left arrow is written “LUMBAR.” Nothing else is written below that.
- Beneath the center arrow is written “THORACIC,” below which is written “PROV DISCO T9 10 T12L1,” and “DONE,” below which is an arrow pointing to the right. Nothing appears at the end of that arrow. Another arrow points down to “3 STAGE” and “DONE,” and yet another arrow points down to nothing.
- Beneath the right arrow is written “CERVICAL” below which is written “PROV DISC C₃₄ C₆₇.” An arrow points down from there to “Z JOINTS C₃₄ – C₆₇.” An arrow points down from there to nothing.

(St. Ex. 5 at 30) Other documents labeled as treatment plans may be found at St. Ex. 2 at 19a; St. Ex. 3 at 13a; St. Ex. 4 at 20; St. Ex. 7 at 8a; St. Ex. 8 at 51, 54; St. Ex. 9 at 14a; St. Ex. 11 at 22, 25; St. Ex. 12 at 16a; St. Ex. 13 at 9; St. Ex. 14 at 15, (at 19 labeled “Dx Review”); St. Ex. 15 at 13; St. Ex. 16 at 13; St. Ex. 17 at 9; St. Ex. 18 at 23; St. Ex. 19 at 13b; St. Ex. 20 at 9a; St. Ex. 21 at 18; St. Ex. 22 at 19; and St. Ex. 23 at 10a. Some are dated, others are not; none are signed or identified as the product of any particular physician.

Allegation (1)(a)

133. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(a) as follows:

[Dr. Griffin] failed to refer or timely refer and/or document the referral or timely referral of Patients 1-4, 9-21, 23 and 24 for psychological consultation.

(St. Ex. 54A)

Referral for Psychological Consultation

Testimony and Report of Dr. Chelimsky

134. In his January 31, 2005, report, Dr. Chelimsky stated that the “minimal standard of care for chronic pain is early involvement of a psychologist in all cases.” (St. Ex. 28 at 3)

At hearing, Dr. Chelimsky testified that, in chronic pain patients, the standard of care requires that a referral for a psychological examination be made within three months of the patient presenting to the practice, and that the referral be documented in the medical record. (Tr. at 1602-1603) Moreover, Dr. Chelimsky testified:

One would expect to do it more quickly because 90 percent of these patients are depressed, so, you know, the ten percent who aren't, you're not going to do them any harm by getting an evaluation, and you may be wrong. I've often been wrong about thinking who's depressed and who isn't. But 90 percent, you're surely going to help.

(Tr. at 1603)

Testimony of Dr. Bressi

135. Dr. Bressi testified that there is no standard or requirement that every pain patient be referred for a psychological consult within a certain period of time, and that it is within the physician's discretion to refer or not refer patients. Dr. Bressi further testified that chronic pain patients are often already being treated for depression, and they are often being treated for that condition by their family doctor rather than by a psychiatrist or psychologist. Moreover, Dr. Bressi testified that, in his opinion, Dr. Leak and Dr. Griffin met the standard of care in their referrals of patients for psychological consults. (Tr. at 2314-2315, 2317-2318, 2383-2384)

Dr. Bressi testified that, among the 24 patient records he reviewed, he found no patient whom Dr. Leak or Dr. Griffin failed to refer for a psychological consult when there should have been such a referral. (Tr. at 2385)

Testimony of Dr. Leak

136. Dr. Leak testified that the situation in which a behavioral medicine consultation is “absolutely, positively” required, by protocol and policy, are “patients in which there are neuromodulation devices being used. And there's a specific standard by which that is required.” Dr. Leak testified that all other cases are within the judgment of the physician. (Tr. at 2750-2751)

Dr. Leak further testified that a patient who is threatening suicide is clearly in need of psychological help. However, a patient who simply asks for relief from pain may not need a psychological consultation. (Tr. at 2754-2755)

Moreover, Dr. Leak testified that he is unaware of a standard of care that requires a behavioral consult for all pain patients. Finally, Dr. Leak testified that, like the use of any other type of consultations, behavioral consultations should be utilized on a patient-by-patient basis depending upon each patient's individual condition. (Tr. at 2757)

Testimony of Dr. Griffin

137. In contradiction of Dr. Leak's testimony, Dr. Griffin testified, "It was a standing order at the first visit that a consult was made to behavioral medicine." Dr. Griffin testified that that was the case with every patient. When asked if that information had been documented in the medical records, Dr. Griffin testified: "Sometimes it [was] not. We've got a lot of information coming and going, and it's hard to remember to put every single drivel of information into the chart." (Tr. at 782-783)

Dr. Griffin testified that "[e]very single patient that came in the door was given a referral to a psychologist who had kind of a specialty in pain management, even to the point of knowing some of what we did interventionally." (Tr. at 3017)

Patient-Specific Evidence re: Psychological Referrals

138. Evidence concerning psychological referrals for specific patients includes the following:

- **Patient 1:** On the form for Patient 1's May 23, 2001, initial consultation and evaluation, the following notation appears next to the heading Psychiatric Admissions/Outpatient Evaluations: "Dr. Wallenbrock - gave [patient] antidepressants/sleep aide/depression." (St. Ex. 1 at 253)

Dr. Leak testified that, at the time Patient 1 had first come to him, Patient 1 was being treated for depression and sleep deprivation by another practitioner. Accordingly, Dr. Leak did not feel a need to refer Patient 1 for a psychiatric consultation. However, Dr. Leak acknowledged that his medical record does not indicate when Patient 1 had received the referenced psychiatric treatment. (Tr. at 576-578)

Dr. Leak further testified that he had interpreted the results of Patient 1's "McGill examination" and concluded that Patient 1 did not require a psychological referral. (St. Ex. 1 at 247; Tr. at 577-578)

- **Patient 2:** Dr. Leak testified that he believes that Patient 2 had been referred for psychological counseling, but that that had occurred outside the time period relevant to this hearing. (Tr. at 603-604)

- **Patient 3:** The regional workup sheet, a document that lists the tests and consults ordered, can be found in each patient's medical record. The regional workup sheet for Patient 3 has check marks that indicate that Patient 3 had been referred for a behavioral medicine consult and that the consult had been completed. However, the dates were not noted and no psychological report is included in the chart. (St. Ex. 3 at 18; See also Tr. at 603-604)
- **Patient 4:** Dr. Leak's medical records indicate that a psychological consult had been ordered for Patient 4, but do not indicate that the consult was completed. (St. Ex. 4 at 19; Tr. at 612-613)
- **Patient 7:** The initial evaluation of Patient 7 took place on May 31, 2000, and he was referred for psychological consultation on August 18, 2000, about 2 1/2 months later. Dr. Chelimsky stated that the standard of care requires a psychology referral within three months of the initiation of care for a patient with chronic pain. Accordingly, in Patient 7's case, the standard of care had been met. (St. Ex. 29 at 1)
- **Patient 8:** In his May 2, 2006, report, Dr. Chelimsky stated that the standard of care for psychological referrals had been met in the case of Patient 8. (St. Ex. 29 at 1)
- **Patient 9:** Dr. Leak acknowledged that there is no record that Patient 9 had been referred for psychological counseling. However, Dr. Leak testified that Patient 9 had suffered from "real pathology" and had not been in need of psychological services. (Tr. at 1350-1351)
- **Patient 10:** A nurse's note dated March 19, 2001, that involves a medication issue includes handwritten notations concerning psychological, dental, and nephrology care. Concerning psychological care, the note states, "Psych - Rebecca Ware OSU" and lists a telephone number. (St. Ex. 10 at 61)

On a consultation and evaluation form for Patient 10 dated March 27, 2001, it is noted that Patient 10 had been self-admitted for psychiatric care for five days in December 1999, and for seven days in March 2000. The consultation and evaluation form did not indicate the reasons for the admissions, the diagnoses, or treatment rendered. (St. Ex. 10 at 124)

The medical record contains no documentation that Patient 10 had been referred for a psychological consult. (St. Ex. 10)

- **Patient 11:** Patient 11's first visit to PCC occurred on August 31, 1999. (St. Ex. 11 at 716)

A July 30, 2001, discharge summary for Patient 11 includes a note referring Patient 11 for a neuropsychological consult. (St. Ex. 11 at 117a)

An August 15, 2001, letter from Dr. Marzella, a psychologist, and Ms. Schrim, a counselor, reports the result of their evaluation of Patient 11. Among other things, their letter states that Patient 11 “reports he currently attends psychotherapy with Moundbuilders in Heath, Ohio to address interpersonal difficulties.” (St. Ex. 11 at 374)

In his May 2, 2006, written report, Dr. Chelimsky stated that the July 2001 referral had fallen below the standard of care because it had not been made until two years after Patient 11 had first been seen by PCC. (St. Ex. 29 at 1)

Dr. Griffin acknowledged that Patient 11’s referral for a psychological consultation took place about two years after PCC started treating Patient 11. However, Dr. Griffin further testified that Patient 11 had been under the care of a psychologist already. Nevertheless, that information was not documented in the patient record prior to the August 2001 letter from Dr. Marzella and Ms. Schrim. (Tr. at 3106; St. Ex. 11)

- **Patient 12:** Patient 12 first visited PCC on October 25, 2000. Although a record of a psychological referral around the time of her first visit does not appear to be included in the medical record, a December 12, 2000, note by a medical assistant indicates that Patient 12 had canceled her appointment that week with Dr. Bryan, a psychologist. Subsequently, a discharge summary dated February 23, 2001, states in part that Patient 12 had asked to see a psychologist regarding depression. (St. Ex. 12 at 104a, 148, 381)

In his May 2, 2006, report, Dr. Chelimsky stated with regard to Patient 12: “[S]he was first seen [on October 25, 2000] and she was not referred [to a psychologist] until 2/23/01 about four months and this was only at the patient’s request, not because the doctor felt this was necessary. This again fell below the standard as it exceeded 3 months.” (St. Ex. 29 at 1)

Dr. Leak testified that PCC had attempted to schedule Patient 12 for a psychological consult but that Patient 12 had cancelled the appointment. Dr. Leak added that, on February 23, 2001, Patient 12 had been scheduled for another appointment with a psychologist. Dr. Leak acknowledged, however, that his records do not indicate whether Patient 12 attended the appointment. (St. Ex. 12 at 104a, 148; Tr. at 1389-1402)

- **Patient 13:** The medical record contains no documentation that Patient 13 had been referred for a psychological consult. (St. Ex. 13)
- **Patient 14:** Patient 14 first visited PCC on February 9, 2001. The regional workup sheet for Patient 14 indicates that Patient 14 was referred for a behavioral medicine consult on February 9, 2001, and that it had been completed March 9, 2001. (St. Ex. 14 at 18)

- **Patient 15:** The medical record for Patient 15 indicates that he had first been seen at PCC around March 3, 2000. A nurse's note dated March 3, 2000, states, among other things, "Dr. Darrel Brush, MD, Psych – appt Apr 7, 00." (St. Ex. 15 at 124a)
- **Patient 16:** Patient 16 first visited PCC around May 15, 2001. A document entitled *The Role of Psychologist in Behavioral Medicine*²² was signed by Patient 16 and dated May 15, 2001. The document advises Patient 16 of the frequent need for psychological services by patients who have chronic pain, and the services that are offered. The name of the psychologist that the document refers to does not appear on the document. There is no indication that Patient 16 was ever specifically referred to psychological services or that he actually received psychological services. (St. Ex. 16 at 133)
- **Patient 17:** In his May 2, 2006, report, Dr. Chelimsky stated that the psychological aspect of Patient 17's case was not addressed in the medical record until one year after her care began. Nevertheless, no referral was made even at that time. Dr. Chelimsky stated that that had fallen below the standard of care. (St. Ex. 29 at 1)
- **Patient 18:** Patient 18 first visited PCC on or about October 7, 1998. A regional workup sheet for Patient 18 indicates that she was referred for a behavioral medicine consult on February 14, 2001, and that that had been completed March 7, 2001. (St. Ex. 18 at 14, 273, 275)

Dr. Chelimsky testified that Patient 18 did not receive a referral for psychological care until almost three years after she began treatment by PCC. Dr. Chelimsky further testified that Patient 18 had clearly been depressed and was in need of those services. (Tr. at 1762) In his May 2, 2006, report, Dr. Chelimsky stated that this had been "well below the standard of care." (St. Ex. 29 at 1)

Dr. Bressi testified that the medical record for Patient 18 states that, on September 15, 1998, she was referred for psychological services. (Tr. at 2409-2411) The document that Dr. Bressi referred to was from The Ohio State Pain Center and not from Dr. Leak or Dr. Griffin. However, it does appear that she had been referred by someone to psychological services at that time. (St. Ex. 18 at 134-136; See St. Ex. 18 at 135 under "Treatment")

- **Patient 19:** Patient 19 was first seen by PCC on or about June 27, 2000. The document entitled *The Role of Psychologist in Behavioral Medicine* was signed by Patient 19 and dated June 27, 2000. The document advises Patient 19 of the frequent need for psychological services by patients who have chronic pain, and the services that are offered. The name of the psychologist that the document refers to does not

²² This document purports to be a message to a generic patient from an unnamed psychologist or psychiatrist. The document discusses the association between chronic pain and the need for psychological intervention in a very general way. It also suggests that the services of the unidentified author are available should the generic patient so desire.

appear on the document. There is no indication that Patient 19 was ever specifically referred to psychological services or that he actually received psychological services. (St. Ex. 19 at 176)

- **Patient 20:** Patient 20 was first seen by PCC on or about November 8, 1999. (St. Ex. 20 at 467)

In his May 2, 2006, report, Dr. Chelimsky stated that Patient 20 had not been referred to a psychologist until 1 1/2 years after he began treatment with PCC. Dr. Chelimsky testified that this falls below the minimal standard of care. (St. Ex. 28 at 3; St. Ex. 29 at 1)

- **Patient 21:** Dr. Leak testified that, during his treatment of Patient 21, Patient 21 had been referred for a behavioral medicine consultation. (Tr. at 2857-2858) It is difficult to tell from the medical record when Patient 21 had first visited PCC. However, she had been treated at PCC since at least September 9, 1999. (St. Ex. 21 at 310a-311b)

The regional workup sheet for Patient 21 is blank concerning behavioral medicine referrals. However, a series of psychology case notes authored by Dr. Bryan begin on April 13, 2001. The first note states that Patient 21 had been seen on an emergency basis at the request of Dr. Griffin. (St. Ex. 21 at 684-690)

- **Patient 23:** Patient 23 was first seen by PCC around February 9, 2001. The document entitled The Role of Psychologist in Behavioral Medicine was signed by Patient 23 and dated February 9, 2001. The document advises Patient 23 of the frequent need for psychological services by patients who have chronic pain, and the services that are offered. The name of the psychologist that the document refers to does not appear on the document. There is no indication that Patient 23 was ever specifically referred to psychological services or that he actually received psychological services. (St. Ex. 23 at 87, 97)
- **Patient 24:** Patient 24 was first seen by PCC on August 30, 2000. A discharge summary dated August 30, 2000, indicates that Patient 24 had been referred for a behavioral medicine consultation with Dr. Bryan. The record contains no other information regarding that referral. (St. Ex. 24 at 80b)

Allegation (1)(b):

139. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(b) as follows:

[Dr. Griffin] failed to refer Patients 20 and 23 to an addiction medicine specialist and/or obtain toxicology screens despite signs of drug abuse and/or diversion.

(St. Ex. 54A)

Evidence Specific to Patient 20

Drug-Seeking Behavior

140. A copy of a report from the Obetz Police Department states that on February 18, 2001, Patient 20 had reported to police that he had lost his medication, consisting of 25 tablets of OxyContin. The report also states, “Doctor will not refill his prescription without a report.” Finally, it indicates that, a few days later, Patient 20 reported the event to PCC on February 23, 2001. (St. Ex. 20 at 42)

A handwritten, undated note on a copy of two prescriptions issued by Dr. Hoogendoorn on February 19, 2001, states: “Opioid Transition Pack. ‘Meds lost.’ ‘Police won’t take report.’ Lost or overtook meds in January.” (St. Ex. 20 at 38) (Emphasis in original)

A Discharge Summary dated February 21, 2001, states, “We will not prescribe opioids until we have a police report and we may change your medication.” (St. Ex. 20 at 99a) A written note by Dr. Griffin describes the episode in greater detail. (St. Ex. 20 at 175) Similarly, a nursing assessment that date concerned Patient 20’s effort to get a police report. (St. Ex. 20 at 100a)

141. Subsequently, on February 23, 2001, Patient 20 and his spouse saw Harry Bryan, Ph.D. Dr. Bryan’s Psychology Case Note primarily concerns Patient 20’s marital problems, but Dr. Bryan also noted that Patient 20 had brought a copy of the police report. Dr. Bryan further noted that that had been a second occurrence of lost medication for Patient 20. (St. Ex. 20 at 177)

142. A progress note dated March 15, 2001, states that Patient 20 had been seen that date for a follow-up. The note further states, in part:

Unfortunately for [Patient 20] he has increased his methadone [a] couple of tablets here and there and he ran out two days ago. This is becoming a pattern for him. He states that he did not realize that it was self-endangering, and the increase did not seem to help. He also is stating that he is not sleeping well and he also states that he has not been taking his Vioxx and he has run out of his Doxepin today. * * *

(St. Ex. 20 at 183)

The note further indicates that Dr. Hoogendoorn, under the supervision of Dr. Griffin, had discussed with Patient 20 his excessive use of prescribed opioid medication. His treatment regimen was adjusted and the note states that he was verbally reprimanded for mismanaging his medications and thereby endangering himself. (St. Ex. 20 at 183)

Testimony of Dr. Chelimsky

143. Dr. Chelimsky testified that after Patient 20 had reported losing his medication and increasing his medication on his own he should have had a toxicology screen and been referred to an addiction specialist. Dr. Chelimsky further testified that neither was documented. Dr. Chelimsky testified that that deviates from the standard of care. (Tr. at 1767-1769)

144. Regarding the necessity for addictionology consult, Dr. Chelimsky testified:

I think it's very hard as a single practitioner to both be the prescribing doctor and the assessing doctor. You need somebody, another pair of eyes, to take a look at this person and get another perspective and see what's really happening here. And I think a lot of these patients, a psychologist can unearth issues about addiction that you cannot. You feel for them and you want to do what's right for them, so you get bamboozled, I think.

(Tr. at 1625)

Testimony of Dr. Leak

145. Dr. Leak acknowledged that it would appear from the medical record that Patient 20 either had a diversion issue or pseudoaddiction. When asked why Patient 20 had not been referred to an addiction medicine specialist, Dr. Leak replied that the problem presented by Patient 20 had been within the scope of PCC's management. Dr. Leak further testified that he believes that Drs. Griffin and Hoogendoorn had handled the situation appropriately. Moreover, Dr. Leak testified that, in 2001, "referral for pain and addiction medicine specialists in this community would be like sending a text message. There would be nowhere for it to go because the technology had not been developed or the capacities to handle these issues were not well defined." Finally, Dr. Leak testified that he does not believe that a toxicology screen had been required under Patient 20's circumstances. (Tr. at 1435-1438)

146. Dr. Leak testified that, if he believes that a patient may be diverting his or her medication, the patient is given an "opioid transition pack" to move them off of opioid medication. (Tr. at 1434)

Evidence Specific to Patient 23

Drug-Seeking Behavior

147. Patient 23 first visited PCC on February 14, 2001. He filled out a patient history form that states, among other things, that he is a "recovering cocaine addict." In the space labeled "How Long Ago," he responded "15 yrs." In addition, under the heading, "Methadone/Detox Programs," Patient 23 responded, "Recovering alcoholic for 3 yrs,

1998. 1986: cocaine.” Finally, Patient 23 indicated that he “smokes marijuana seldom,” once per month. (St. Ex. 23 at 116-117)

A nursing assessment dated February 14, 2001, states, among other things, that Patient 23’s history of marijuana use was discussed. A urine toxicology screen was evidently discussed or ordered as well; the note states, “tox screen at Leak Labs.” (St. Ex. 23 at 60a) However, the results of the toxicology screen are not included in the medical record. (St. Ex. 23; Tr. at 1468)

148. A note dictated by Dr. Griffin concerning an April 3, 2001, visit states that Patient 23 had “fallen short with his Vicodin” by two days. The note further stated that Patient 23 had recently been through treatment adherence training [TAT]. The note states that Dr. Griffin discussed with Patient 23 the laws of the State and the requirements of PCC. Moreover, the note states that the Patient 23 is aware that he cannot increase his medication without Dr. Leak’s or Dr. Griffin’s approval. Finally, the note states:

[A]t this point in a humane effort to manage his pain better, we will keep him on the Norco for breakthrough and add OxyContin 10 mg [twice per day] as a better base. This might make him more comfortable. He is trying to continue to work and we also recommended a kneepad to him. He has forward movement and has been making good efforts. He knows he has to maintain forward progress.

(St. Ex. 23 at 67)

149. A nursing assessment dated April 24, 2001, states, among other things, that Patient 23 had reported losing a prescription for OxyContin #46 given to him during a previous visit on April 12, 2001. The note states that Patient 23 had also visited the office on April 17, 2001, but had not mentioned the loss of his script at that time out of fear that he would “get in trouble.” In addition, the note states that that had been the second time that Patient 23 had reported losing a prescription. (St. Ex. 23 at 39b)

Moreover, the discharge summary for that visit states that Patient 23 was instructed “to bring script for OxyContin to next visit. Bring in police report. No further opioids will be given.” The discharge summary was signed by Dr. Griffin, among others. (St. Ex. 23 at 40b)

150. On the first page of the medical record for Patient 23 there is a note with the heading, “MEDICAL ALERT,” that states “*OPIOID WARNING” and “4/2/01 – SHORT.” It also indicates that the patient lost prescriptions twice and that both prescriptions were found. (St. Ex. 23 at 1a; Tr. at 2964-2965)
151. Dr. Leak testified that PCC had treated Patient 23 for only three months. (Tr. at 1468)

Testimony of Dr. Chelimsky

152. Dr. Chelimsky testified that, in the specialty of pain management, all physicians have to deal with the issue of determining which patients are seeking narcotics for illegitimate purposes. Dr. Chelimsky noted that it is a very difficult problem for any physician to deal with. (Tr. at 1622-1623) However, Dr. Chelimsky testified:

I think there were certain red flags in these charts, people losing prescriptions over and over, not taking the other prescribed medications. There was evidence that potentially these patients were actually diverting medications, not using them themselves, but using them to sell them or whatever. So there should have been either a psych referral or a tox screen or both done whenever the realization occurs.

(Tr. at 1623) Dr. Chelimsky further testified, however, that he could find no documentation in the medical records for Patients 20 or 23 that either had been seen by a psychologist or had submitted to toxicology screens. (Tr. at 1623-1624)

153. When asked what the standard of care requires if a patient refuses to see an addictionologist or psychologist, Dr. Chelimsky replied:

[O]nce you've requested them to do that, then you need to stop the opiates if they refuse to do what it is you've asked them to do. If they go, then that's fine, then you can continue the opiates until they've either been cleared from an addiction issue or until they've been found to be addicted, in which case you're going to stop it anyway. But anytime there's a suspicion of diversion, then you need to take action. That would be those things I've described. And if they refuse, then you would stop the opiate.

You have a choice as to how to stop the opiate. You can either stop it cold and give them some Clonidine and some other medications for withdrawal, or you can hospitalize them and put them on some buprenorphine taper. But you need to stop it relatively immediately.

(Tr. at 1625-1626)

154. Dr. Chelimsky testified that Patient 23 was at a very high risk for drug abuse and possibly diversion due to his past substance abuse problems. Following Patient 23's overuse of his Vicodin, a toxicology screen should have been obtained and either opiate prescribing should have ceased or the patient should have been referred to an addiction specialist. Dr. Chelimsky testified that neither of those things occurred. (Tr. at 1785-1786)

Testimony of Dr. Bressi

155. Dr. Bressi testified that he runs one of the largest pain centers in the country, and that his practice issues thousands of prescriptions per week. Dr. Bressi testified that most of the time when a patient who comes in for an initial evaluation, he or she will get a urine screen. Urine screens are also performed periodically when the provider feels the need to do one. Dr. Bressi testified that urine screens on established patients should show the medications that are being prescribed, and should not show illegal substances. In addition to urine screens, Dr. Bressi testified that his pain center does pill counts. Patients are asked to bring their medications to the office and the pills are counted to determine if the patients are adhering to the prescription policy. (Tr. at 2311-2312)

However, Dr. Bressi noted that a pill count that does not come out exactly right does not necessarily mean the patient is misusing medication. Likewise, a urine screen that fails to show a medication that the patient is taking does not necessarily mean that the patient is noncompliant or diverting the medication. It *does* mean, however, that there is an issue that the provider must discuss with the patient. (Tr. at 2312-2314)

156. Dr. Bressi testified that a patient losing a prescription once is not necessarily a sign of diversion. However, if it happens twice, it is a problem, and the physician must determine the best way to approach it. Dr. Bressi testified to the effect that the physician needs to discuss the issue with the patient to determine the reason why the patient is inappropriately seeking medication. (Tr. at 2455-2457)

157. Dr. Bressi was asked with regard to the period 1999 to 2001 whether there had been standards to ensure that patients were not “gaming the system to get more meds.” He replied that there was no standard, and that it was up to the physician to determine whether something needed to be investigated further. (Tr. at 2314)

Dr. Bressi testified that toxicology screens are somewhat controversial in pain medicine because of the possibility of false negatives for medications the patient is supposed to be taking. This can lead to a false conclusion that the patient is diverting the medication. Dr. Bressi further testified:

[A]round the country innocent patients have been discharged [from physicians’ practices] because of being negative on a urine drug screen, for instance, for Percocet or Hydrocodone, which are short-acting, narcotic-based pain medicines. The problem is that it clears so fast that by the time they take the medicine and then go down and do the urine drug screen, whatever time that is, the medicine may have passed through and may not be in the urine. So they may be legitimately taking the medicine, but it’s not in the urine.

(Tr. at 2312-2313) Dr. Bressi testified that toxicology screens are therefore not used by all pain medicine physicians, and are not required by the standard of care. (Tr. at 2314)

158. Dr. Bressi testified that, in his opinion, Dr. Leak and Dr. Griffin referred patients to addiction services in accordance with the standard of care. (Tr. at 2316)
159. Dr. Bressi testified that, despite the history of drug abuse, losing prescriptions, and increasing his dosage without approval, Patient 23 did “not necessarily” require a consultation with an addictionologist. Dr. Bressi noted that recovering addicts have often already been through treatment and counseling. Dr. Bressi further testified that the treatment of such patients for chronic pain is very complex, and that many physicians would refer such a patient for addiction services; however, depending on the physician and the physician’s interaction with the patient, it is not absolutely required. (Tr. at 2944-2945)
160. Dr. Bressi testified that a patient reporting occasional use of marijuana would not stop him from providing pain management services, especially if the patient was honest and up-front about it. However, Dr. Bressi testified that he will not continue to treat a patient who continues to use illegal substances. If such a patient wishes to remain a patient at Dr. Bressi’s pain center, the patient must quit using illegal substances. (Tr. at 2461-2462)

Testimony of Dr. Leak

161. In light of Patient 23’s previous struggles with alcohol and cocaine and his then-current use of marijuana, Dr. Leak was asked why Patient 23 had not been referred to an addiction medicine specialist. Dr. Leak replied that they had treated Patient 23 as someone who suffered from pain. Dr. Leak further testified: “There has to be some tolerance and personal understanding with people. And before you label and get an individual who has a job and private insurance labeled as an addict again, which has dire consequences, you attempt to give them enough rope and give them credit for the possibility of pseudoaddiction.” (Tr. at 1460) Dr. Leak further testified:

[Considering] the intensity with which Dr. Griffin handled this, that it was within the scope of our practice and within the scope of pain medicine as we were expected also to be able to monitor and medicate in the addicted patient.

* * * This gentleman needed an enormous amount of education, and it looks as though that was afforded to him in a very appropriate manner.

(Tr. at 1461)

162. Dr. Leak testified that he interprets Dr. Griffin’s April 3, 2001, note to mean that Patient 23 potentially had signs of diversion, but also that he may have pseudoaddiction and require re-education. Dr. Leak further testified that pseudoaddiction occurs when a patient is treated for pain but not given enough medication to control the pain. Under those circumstances, patients can start to behave like addicts when, in fact, they are not. Dr. Leak opined that Dr. Griffin had treated Patient 23 as having pseudoaddiction, and attempted to better control Patient 23’s pain and educate him. (Tr. at 1458-1463)

163. With regard to Patient 23's ongoing use of marijuana, Dr. Leak testified: "As subspecialists, we end up having to treat the addicted patient for pain. In this scenario, marijuana alone is not a stopping point. Cocaine and heroin would have made a significant difference if he had indicated that was an ongoing concern." (Tr. at 1462)

Further Testimony of Dr. Chelimsky

164. Dr. Chelimsky testified that the term "pseudoaddiction" refers to a patient who behaves as though he or she is addicted when in fact there is another cause for the behavior. Dr. Chelimsky testified that the cause is usually an escalating level of pain, increasing tolerance to the opiate's pain-relieving effect, or a desire for more pain relief. However, Dr. Chelimsky testified that some studies show that patients who exhibit pseudoaddiction do not report that they have lost a prescription or their medication. They are much more likely to be straightforward and ask the physician for more pain medication. The physician then must determine if the patient is addicted or actually has a legitimate medical need for more medication. (Tr. at 1627-1628)

Further Testimony of Dr. Bressi

165. Dr. Bressi testified that pseudoaddiction occurs when a patient's pain is not controlled well enough and the patient seeks to get control. Dr. Bressi further testified that, once pain control is obtained, the patient stops engaging in that behavior. Moreover, Dr. Bressi testified that "pseudo addiction is probably the most common behavior pattern that causes suspicion and alarm. Addiction is much rarer. (Tr. at 2315-2316)

Testimony of Dr. Griffin

166. Dr. Griffin testified that PCC relied more upon its in-house psychologist²³ than referrals to an addiction medicine physician. Dr. Griffin testified, "We had great difficulty getting anybody to any of the M.D. addictionology people to do an assessment on the patients." (Tr. at 793-794)

167. Dr. Griffin testified that the toxicology screen mentioned in the February 14, 2001, note was based on a "[s]tanding order for labs." However, Dr. Griffin further testified that the results of toxicology screens were not always recorded in the medical record. Dr. Griffin further testified, "I think one of the great weaknesses of the practice was the inability to get all the information into the record." (Tr. at 791-793)

168. Dr. Griffin testified that a patient who smokes marijuana can be treated in a pain medicine practice. Dr. Griffin added, "It doesn't mean we gave him medications, but we don't necessarily deny them the opportunity to have their pain relieved by interventional techniques." (Tr. at 795-796)

²³ Dr. Griffin was probably referring to Dr. Bryan. However, Dr. Leak testified that Dr. Bryan had his own office and was not an employee of PCC. (Tr. at 1403-1407)

169. Dr. Griffin testified that if he obtained information that a patient was possibly misusing medication, the standard practice was to “discuss that with the patient and strongly recommend that they see an addictionologist.” However, Dr. Griffin testified that patients sometimes would simply not go. Dr. Griffin testified that, in those cases, the patients were not just dismissed from the practice. Dr. Griffin testified that PCC would wean the patient from opioids but would continue to treat the patient with interventional techniques. (Tr. at 3019-3020)
170. Dr. Griffin testified that prescriptions were typically issued to last one month with no refills. Dr. Griffin testified that they did so in order to maintain tight control on the patients’ medication and to give the physicians an opportunity to evaluate the patients for side effects. (Tr. at 3050-3051)

Allegation (1)(l):

171. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(l) as follows:

[Dr. Griffin] excessively prescribed morphine to Patient 3 and failed to consider and/or document the consideration of the interaction of the combination of daily use of Topamax and opiates despite evidence of development of cognitive dysfunction in the patient.

(St. Ex. 54A)

Patient 3 Medical Records

172. From October 22 through December 10, 2001, the last visit included in State’s Exhibit 3, Patient 3 had been prescribed increasing doses of morphine sulfate.²⁴ On her pain picture for each visit during that time, she noted her pain to be between 8 and 9½ on a scale of one to 10. (St. Ex. 3 at 70a-86b)

The medical record contains a copy of a prescription dated October 22, 2001, issued to Patient 3 by Dr. Griffin for morphine sulfate CR 60 mg #80, with instructions to take two tablets twice per day. In addition there are several undated copies of prescriptions for increasing doses of morphine sulfate, including a prescription for morphine sulfate 60 mg #60 with the following patient instructions: “Currently taking 2 tablets three times per day. Increase by 1 tablet every 48 hours to a max of 4 tablets 3 times per day.” Another undated prescription for morphine sulfate CR 60 mg #180 states that Patient 3 “may take up to 12 tablets daily.” (St. Ex. 3 at 28-29, 32-33, 38)

²⁴ Prior to October 22, 2001, Patient 3 had been prescribed OxyContin. (St. Ex. 3 at 86a; See also St. Ex. 3 at 201-219)

In addition, copies of prescriptions indicate that Dr. Griffin had concurrently prescribed Topamax 100 mg to Patient 3 with instructions to take two per day. (St. Ex. 3 at 36, 39, 46, 49)

Excessive Morphine

Testimony of Dr. Chelimsky

173. Dr. Chelimsky criticized Dr. Griffin's use of opiate medication in his treatment of Patient 3. Dr. Chelimsky testified that, taking into consideration the tolerance level of chronic pain patients to narcotic analgesics, one would expect that a patient receiving a daily dose of between 100 and 250 mg of opiate (methadone, oxycodone, morphine) should have significantly reduced levels of pain. A patient who started with a "9" on the pain scale should be down to a "6."²⁵ (Tr. at 1621-1622)

However, Dr. Chelimsky testified that, in the case of Patient 3, she had been taking 720 mg of morphine sulfate per day and reporting a pain level of 9. Dr. Chelimsky testified, "[T]o me, [that] means that the opiate's not working. Let's taper it. Let's get rid of it. Because opiates are dangerous substances. * * * So if they're not relieving pain, which is their main job, then they really should be stopped." (Tr. at 1622)

Testimony of Dr. Bressi

174. Dr. Bressi testified that, in his opinion, Patient 3 had not been prescribed an excessive amount of morphine. Dr. Bressi further testified that, in the normal population, the amount of morphine that Patient 3 received would seem excessive. However, in a patient with chronic pain and tolerance to the medication, it is not excessive. (Tr. at 2419-2420)

Dr. Bressi testified that the prescribing of medication to Patient 3 had complied within the standard of care. (Tr. at 2420-2425)

Evidence of Development of Cognitive Dysfunction

Patient 3 Medical Records

175. Dr. Griffin's dictated notes evidence concern regarding Patient 3's cognitive state. For example, a note dated August 20, 2001, states, in part:

[Patient 3] presents today with pain behavior and tearful, great difficulty moving, and some change in grooming.

At last visit there was discussion about her grading of her pain on the pain scale and the fact that it never really altered. The conclusion was made,

²⁵ Dr. Chelimsky testified that medication alone will generally not get a patient below a pain level of "6" and that functional measures have to be employed to do so. (Tr. at 1621-1622)

therefore, that medications really do not work for her. This appeared to be a valid statement given the data at hand. I believe, however, we now have additional data to add to the general picture.

With the removal of her opioids, her pain level on the same scale of 1-10 is now 12. She has run out of medication for four days and is showing evidence of withdrawal symptoms. This is complicated and her care is complicated by the fact that she is intellectually challenged. She does have difficulty with some of the simplest directives. It is always a challenge when caring for [Patient 3].

(St. Ex. 3 at 160) In addition, a note dictated by Dr. Griffin concerning a September 6, 2001, visit states, in part, “I think that she has cognitive issues that preclude her ability to accurately record her pain scale.” (St. Ex. 3 at 158)

Dr. Chelimsky’s January 31, 2005, Report

176. In his January 31, 2005, report, Dr. Chelimsky wrote, “[Patient 3], is taking 720 mg/day of morphine, develops cognitive dysfunction, and there is no consideration that results from the combination of opiate and Topamax, which these practitioners prescribed.” (St. Ex. 28 at 4)

Testimony of Dr. Bressi

177. Dr. Bressi testified that he had found nothing in the medical record indicating that Patient 3 had shown evidence of the development of cognitive dysfunction. (Tr. at 2420)

Testimony of Dr. Griffin

178. Dr. Griffin testified that Topamax is an anti-seizure medication that is also useful in treating pain. Dr. Griffin testified concerning his protocol for prescribing Topamax to patients:

I tell my patients that any medicine can do anything on any given day, and all medicines are poisonous. We give the patient personal, eyeball to eyeball, instructions on how to take the meds, the morphine and the Topamax, for instance. But included in that conversation is, when the medicine makes you stupid, back off, because the [anti-seizure medications] disconnect—I mean, this is where they disconnect the pain perception, but unfortunately they’re not selective to pain fibers. They disconnect all neural synapses.

(Tr. at 3032-3033)

Allegation (1)(m):

179. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(m) as follows:

[Dr. Griffin] excessively prescribed OxyContin to Patient 11.

(St. Ex. 54A)

Patient 11 Medical Records

180. A discharge summary dated August 31, 1999, indicates that Patient 11 suffered from “Mechanical back pain.” (St. Ex. 11 at 233a)

181. On October 18, 2001, Dr. Griffin issued a prescription to Patient 11 for OxyContin 80 mg #480 with instruction to Patient 11 to take three tablets when he wakes up, two tablets at noon, and three tablets in the evening, a total of 640 mg per day. (St. Ex. 11 at 36) Further, a medication list dated November 6, 2001, indicates that Patient 11 had been taking eight tablets of OxyContin 80 mg per day. (St. Ex. 11 at 293)

182. A diagnosis list for Patient 3 dated October 11, 2000, lists the following diagnoses: thoracic spondylosis, thoracic radiculopathy, intervertebral disc disease, sinus tarsiitis bilateral, hallux limitus, and plantar fasciitis. Further, the following diagnoses were added on December 4, 2000: cervical spinal stenosis, C5-6 and C4-5 cord compression, cervical herniated disc disease, lumbar spinal stenosis, facet arthropathy, abnormal gait, myofacial pain, and autonomic dysfunction. (St. Ex. 11 at 17)

Testimony and written report of Dr. Chelimsky

183. In his January 31, 2005, report, and in his testimony, Dr. Chelimsky indicated that Patient 11 had been prescribed an excessive amount of OxyContin for mechanical low back pain. (St. Ex. 28 at 4; Tr. at 1730-1733)

Testimony of Dr. Bressi

184. Dr. Bressi testified that it been appropriate for Patient 11 to have been taking 640 mg of OxyContin per day. Dr. Bressi added that, to most doctors and lay people, that might seem like a dose for “Shamu the whale.” However, Dr. Bressi testified that many chronic pain patients take opioid medication for years and build up a tolerance to the medication, which means that larger doses are required for pain relief. In addition to increasing tolerance to pain medication, the patients may have escalating pain levels. Therefore, medication dosages that most physicians would consider normal are no longer effective. In addition, Dr. Bressi testified: “OxyContin, like other opioids, is what we call a nonceiling dose narcotic or opioid. Nonceiling dose means there is no upper limit dose, meaning you can titrate it up to infinity due to tolerance.” (Tr. at 2351-2353)

Dr. Bressi acknowledged that OxyContin 640 mg per day was a high dose; however, he maintained that in a chronic pain patient with tolerance to the medication, it was not an unusual dose. Dr. Bressi testified that, in his opinion, Dr. Leak's and Dr. Griffin's care of Patient 11 was within the minimal standard of care. (Tr. at 2354-2355)

Testimony of Dr. Griffin

185. Dr. Griffin testified that he recalls treating Patient 11. Dr. Griffin testified that Patient 11 had been injured in the first Gulf War and, from that time on, had suffered from "severe, unremitting pain that resisted treatment." (Tr. at 3035-3036)

Dr. Griffin testified that he completely disagrees with the allegation that he had prescribed excessive amounts of OxyContin to Patient 11. Dr. Griffin further testified that he and Dr. Leak had expended much effort to educate patients concerning the use of pain medication, which Dr. Griffin indicated was well beyond what other practitioners had been doing. Dr. Griffin further testified that he and Dr. Leak had always started patients on a low dose of pain medication, and took great care in selecting the medication and adjusting the dosages. (Tr. at 3073-3076)

Allegation (1)(h):

186. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(h) as follows:

[Dr. Griffin] failed to follow up and/or document follow up on a large mean corpuscular volume finding for Patient 20.

(St. Ex. 54A)

Patient 20 Medical Records

187. The medical record for Patient 20 indicates that a blood sample taken on October 2, 2000, tested high for MCV [mean corpuscular volume]. The result was 97.9 cubic micra with a reference range of 80.0 to 94.0 cubic micra. Subsequently, the results of a blood sample taken on November 13, 2000, tested high for MCV with a result of 96.2 cubic micra (same reference range). (St. Ex. 20 at 395, 399)

The results of those abnormal MCV tests were not addressed in Dr. Griffin's discharge summaries or dictated notes for visits following receipt of the test results, nor is there documentation of a referral to Patient 20's primary care physician. (St. Ex. 20 at 109a-120b; 191-196)

Testimony of Dr. Chelimsky

188. Dr. Chelimsky testified that MCV stands for “mean corpuscular volume,” which refers to the size of the patient’s red blood cells. Dr. Chelimsky testified that “the red cells get bigger when a person is lacking things like folic acid or Vitamin B-12.” Dr. Chelimsky further testified: “A Vitamin B-12 deficiency would clearly contribute to a pain syndrome. So a person could be in a lot more pain if they’re Vitamin B-12 deficient. They could also have a neuropathy, losing nerve function.” Finally, Dr. Chelimsky testified that that finding should have been followed up. (Tr. at 1595-1596)

Testimony of Dr. Bressi

189. Dr. Bressi testified that, in his opinion, Dr. Griffin did not violate the minimal standard of care by failing to make an attempt to correct Patient 20’s large MCV result. Dr. Bressi testified that family doctors run lab tests at least once per year on their patients. Further, Dr. Griffin is a subspecialist in pain, and would not adopt the family practitioner’s role by working up a large MCV. Moreover, Dr. Bressi testified, “Our job is to let them know if we find an abnormality” that the primary care physician should be aware of. (Tr. at 2382-2383)

Testimony of Dr. Griffin

190. Dr. Griffin disagreed with the allegation that he had failed to follow-up or to document any follow-up to a lab finding that Patient 20 had a large MCV. Dr. Griffin further testified that an MCV with an abnormal but near-normal value is not a big issue, particularly if the concentration is normal. Nevertheless, Dr. Griffin also testified that he would advise the patient to follow up the abnormal MCV with the patient’s primary care physician.²⁶ (Tr. at 3028-3029)

Allegation (1)(k):

191. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(k) as follows:

[Dr. Griffin] engaged in and/or supervised the excessive use of invasive techniques and blocks, including: chemoneurolytic and other injections into the splenius capitis, levator scapulae, trapezius, superior trapezius, cervical erector spinae, thoracic erector spinae, lumbar erector spinae, latissimus dorsi, paraspinal, and/or rhomboid muscles, and/or the interspinous ligament, and/or greater trochanter in Patients 1-5, 7-9, 11, 12, 14, 15, 17, 18, and 20-22.

(St. Ex. 54A)

²⁶ This advice is not documented in the medical record for Patient 20. (St. Ex. 20 at 109a-120b; 191-196)

Testimony and Written Report of Dr. Chelimsky

192. In his January 31, 2005, report, Dr. Chelimsky wrote, “Interventions played an inappropriately prominent role in the treatment of the patient[s] in this practice and the use of invasive techniques and blocks is clearly excessive.” (St. Ex. 28 at 3)
193. With regard to Dr. Leak’s and Dr. Griffin’s use of interventional modalities such as trigger point injections, chemoneurolytic injections, and radiofrequency lesioning, Dr. Chelimsky testified:

[I]nterventions in and of themselves are entirely appropriate to use in chronic pain, and the issue is how do you use them and how many. And so in general * * * the most effective gain for the patients from an intervention will occur if it’s done in the context of a functional goal.

So you want to have a specific—like something simple. I can’t stand up at my sink and wash my dishes. I want to wash my dishes for 15 minutes at a time instead of three minutes at a time. That’s a specific functional goal that you agree to. But I think even more than that, certainly for an intervention, you need to have some kind of pain relief goal. How long? How much? How much pain is acceptable? How much pain relief is acceptable? What are we going to call success? What are we going to call a failure?

The notes primarily reflected, well, the person liked the block, didn’t like the block, but there’s no sense of even some kind of objectivization of, okay, they could do such and such afterwards which they couldn’t do before or their pain dropped so much. I mean, I think there were occasions. I’m not saying every single case they didn’t measure pain, but in general, that was not objectivized.

So those are the points that address how the blocks were done. They were just done in a way—in an almost seemingly haphazard way in relation to function. The other point is there were huge numbers of blocks done, enormous numbers of blocks done.

(Tr. at 1612-1613)

Furthermore, Dr. Chelimsky testified that, if a patient simply receives pain-relieving injections every one or two weeks for two years: “at the end of the two years, you’re in exactly the same place you started from. You haven’t actually done anything for the patient. So that’s why coupling with function is so critical.” (Tr. at 1614)

Procedures – Trigger Point Injections

194. Dr. Chelimsky testified that a trigger point is a place on the body that, if pressed, triggers pain that is felt in a different area than that being pressed. For example, a trigger point in

the shoulder, if pressed, can cause pain that travels into the elbow and finger. Dr. Chelimsky testified that a trigger point injection is an injection of anesthetic, and possibly a steroid or other anti-inflammatory agent, into a trigger point. Dr. Chelimsky further testified that a physician needs to perform a physical examination to find trigger points. The physician palpates areas that are likely to have trigger points, which includes the shoulder areas, over the shoulder blades, along the mid-portion of the spine, and the hip and buttock regions. The physician can distinguish between trigger points and tender points by asking the patient if the pain travels. Further, Dr. Chelimsky testified that a trigger point “will usually have a little bit of an indurated feel to it.” (Tr. at 1572-1574)

Dr. Chelimsky testified that trigger points are different from tender points. Tender points are areas of localized pain that, if pressed, do not produce pain in other areas of the body. Dr. Chelimsky believes that many of the procedures documented as trigger point injections in the patient records were actually tender point injections. Dr. Chelimsky testified that the records do not document searches for trigger points, and that no patient could have 30 or 40 trigger points as some of the procedure notes would indicate. (Tr. at 1573, 1618-1619)

195. In addition, Dr. Chelimsky testified that an excessive number of injections had been administered. Moreover, with regard to injections that contained a steroid such as Depo-Medrol, Dr. Chelimsky testified that the amount of steroid required to give, for example, 40 injections, at a quarter to a half of a cc per injection, becomes a very large combined dosage. (Tr. at 1618-1620)

Dr. Chelimsky testified that the amount of steroid that a patient receives over a period of time must be limited. Giving an excessive amount of steroids can cause suppression of the body’s ability to make its own cortisone, increase the risk of osteoporosis, and/or create the risk of infection. (Tr. at 1615-1616)

When asked how many steroid-containing trigger point injections would approach the limit of the standard of care, Dr. Chelimsky replied, “Well, certainly doing 30 or 40 in a person would be below the standard of care * * * [i]n the time frame of a month or two, in the time frame of a year, even. One wouldn’t do that many injections.” (Tr. at 1616-1617)

Testimony of Dr. Bressi

196. The testimony of Dr. Bressi concerning the issue of trigger points versus tender points was largely consistent with that of Dr. Chelimsky. Dr. Bressi also testified that trigger points are typically near the places where muscles insert onto bone. (Tr. at 2250-2251)

Dr. Bressi testified that tender points are more often felt in the belly of a muscle rather than near an insertion point. Dr. Bressi noted that tender points are characteristic of fibromyalgia, which is a syndrome that “is still very controversial in the medical field.” Dr. Bressi stated that the techniques for performing trigger point and tender point injections are essentially the same. (Tr. at 2318-2319, 2440-2441)

Testimony of Dr. Leak

197. When asked for a description of a tender point, Dr. Leak replied:

A tender point is a—an amorphously described area when people don't agree on whether it's a trigger point or not. Trigger points have not exactly been ubiquitous in their definition. And when people talk about tender point versus trigger point, contrary to some, the treatment is pretty much the same.

(Tr. at 2921)

Dr. Leak further testified that it is “absolutely” appropriate to inject tender points “if it takes the pain away[.]” (Tr. at 2921)

Testimony of Dr. Griffin

198. Dr. Griffin disagreed that he had utilized or supervised the excessive use of invasive techniques and blocks in his patients. Dr. Griffin testified that, when faced with a patient in pain, he would not withhold helpful treatment. (Tr. at 3030-3031)

199. Dr. Griffin testified that the term “trigger point injection” as used in the patient records had been “used a little bit loosely.” Dr. Griffin further testified that, although there are actual trigger points, the term was also used to describe injections into tender muscle areas. The purpose was to anesthetize the chronic pain area and stop the “pain cycle.” (Tr. at 670)

Procedures – Excessive Number of Trigger Point Injections – Respondent’s Defense – “Fanning the Needle”

Testimony of Dr. Leak

200. Dr. Leak testified that, when a trigger point injection is made, the needle is inserted and then pointed north, then south, then east, then west. Medication is injected in each direction without removing the needle. Dr. Leak further testified that his fellows had been instructed to count each movement of the needle as one injection, so that this would have been documented as four injections. (Tr. at 2875-2876)

Dr. Leak further testified that, for example, with regard to injections for neck pain, there are three layers of muscles around the neck, and each layer would be injected in four directions, totaling twelve injections. Moreover, Dr. Leak testified that one needle placement could result in 20 injections, as the needle is “fanned out” at each muscle layer. Further, Dr. Leak testified that a procedure note indicating that 40 injections had been made could have resulted from two or three sites of entry. (Tr. at 2876-2878)

201. Dr. Leak testified that the fanning of the needle and injecting of different layers through a single needle entry may not have been documented. (Tr. at 2922-2923)

Testimony of Dr. Bressi

202. Dr. Bressi testified that, when he performs trigger point injections, he uses the four-quadrant approach described by Dr. Leak. (Tr. at 2961-2962)

Procedures – Chemoneurolytic Injections

Testimony of Dr. Chelimsky

203. Dr. Chelimsky testified that chemoneurolysis is the use of agents to destroy nerve tissue. Dr. Chelimsky further testified: “It’s sometimes used for an attempt to relieve pain, the concept being that if the pain is actually being generated by the nerve, destruction of the nerve would make the pain go away. It’s not been studied in any rigorous way, although it’s been reported many times.” (Tr. at 1574)

Dr. Chelimsky further testified that some of the records indicate that the chemoneurolytic injections were made into muscle tissue. For example, the medical record for Patient 2 indicates that on April 4, 2001, Dr. Hoogendoorn, under the supervision of Dr. Griffin, had performed “chemoneurolysis of the right levator scapulae muscle and sensory fibers” using Sarapin and bupivacaine. (St. Ex. 2 at 186; Tr. at 1683) Dr. Chelimsky testified:

This is a chemoneurolysis. One would normally do that in the neighborhood of a nerve. I don’t see that a particular nerve was really injected. I think the assumption here is that they’re just getting fibers, they’re getting nerve fibers that are coursing through the muscle in this area. This is, I would say, a relatively unproven way to approach this.

(Tr. at 1683)

Testimony of Dr. Leak

204. Dr. Leak testified that there are two categories of chemoneurolytics: nondestructive agents such as Sarapin, which is used to neutralize nerve fibers and is “the same as injecting a local anesthetic or * * * a bunch of [lidocaine] which is chemodenervation”; and destructive chemoneurolytic agents such as phenol which actually destroy nerve tissue. Dr. Leak testified that, unlike Sarapin, the use of phenol as a chemoneurolytic agent requires using an operating room and fluoroscopic guidance. Dr. Leak testified that, unlike destructive agents, Sarapin “is a slow, slow-moving agent that goes with local anesthetic. And it’s just like—it’s literally an intramuscular injection that will hopefully neutralize the nerve fibers that penetrate the muscle.” (Tr. at 446-448)

Testimony of Dr. Griffin

205. Dr. Griffin testified that Sarapin is derived from the pitcher plant and is “the most benign chemoneurolytic agent[.]” Dr. Griffin further testified that it is supposed to destroy nerve

tissue, but that “it’s not aggressive enough to suit [him].” When asked if Sarapin actually destroys nerve tissue, Dr. Griffin replied, “It is supposed to.” (Tr. at 701)

Procedures – Radiofrequency Lesioning

Testimony of Dr. Chelimsky

206. Dr. Chelimsky testified that radiofrequency lesioning [RFL] is an alternative method of performing neurolysis. He further testified that it is performed by placing a special type of needle that is used to heat the nerve to either disrupt its activity or to destroy it. (Tr. at 1647-1648)

Testimony of Dr. Leak

207. Dr. Leak testified that he had performed “stereotactic radiofrequency lesioning.” Dr. Leak further testified that the term “stereotactic” refers to the use of “calculated axes to hit a neural target.” Dr. Leak noted that it is performed in an operating room under fluoroscopy. The purpose is to carefully place a probe into an area of sensory nerve tissue along the neural pathway of a painful area of the patient’s body. Once the proper location is reached, a radiofrequency current is sent through the probe to destroy some of the nerve tissue. (Tr. at 581-585)

Dr. Leak testified that, because radiofrequency lesioning is a destructive procedure, it is only used after a patient has first received diagnostic or prognostic injections of anesthetic into the target area and reported relief from pain. (Tr. at 585-586)

208. Dr. Leak testified that the results of radiofrequency lesioning last forever in some patients; in others it is ineffective. (Tr. at 585)

Additional Procedures Listed in the Table Below that were Performed by Dr. Leak Only

209. Dr. Leak testified that provocative discography is an invasive radiographic study that involves placing a needle into a disc and injecting contrast fluid. The purpose is for “determining whether there’s a painful disc or an aberrant disc morphology. Whether the disc looks ugly, looks bad, leaks, or where it hurts.” In addition, the purpose is to determine whether the patient experiences pain “when that additional fluid is injected into the disc.” (Tr. at 1349-1350)

210. Dr. Leak testified that a zygapophyseal arthrogram is performed by placing a needle into a zygapophyseal joint and injecting contrast fluid followed by anesthetic. If the patient experiences pain relief, “then you see how long it lasts.” Dr. Leak testified that the procedure is diagnostic. If the procedure is effective in relieving pain, it becomes prognostic. (Tr. at 594-596)

211. Dr. Leak testified that a vertebral corpectomy is the removal of a portion of a vertebra. (Tr. at 606)

212. Dr. Leak testified that an aspiration nucleotomy is performed to reduce the size of a herniated disc. Dr. Leak further testified that it is performed by placing a trocar into the herniated disk to “pull the nucleus out.” Dr. Leak further testified that a radiofrequency probe is then placed in the disc to create a burn lesion, which increases the blood flow to the disc and causes it to heal faster. Dr. Leak testified that, in performing the radiofrequency lesioning, “you do it in an effort not to hit the spinal fluid and not to hit the nerves and not to hit the aorta or bladder or other targets which you don’t want to encounter.” (Tr. at 609-610)
213. Dr. Leak testified that arthrodesis is a procedure to treat pain that is “associated with an anatomic anomaly that would either be cancer of a bone or collapse of a bone or post-radiation disease of a bone.” The procedure involves the injection of an acrylic, polymethylmethacrylate, into a vertebra. Within ten minutes, it hardens into a material that is harder than the bone itself. (Tr. at 607-608)

Dr. Leak further described arthrodesis:

[The] application [of] an internal device which stiffens or reduces the articulation; meaning that if I have two bones, and bones are not dead tissue. They are live and they are tympanic, like a tympani drum. So if I stiffen one, then the adjacent joints above and below are then reduced in their capacity to create tympanic motion, which is the presumption of the mechanism of pain in people who have collapsed vertebrae.

(Tr. at 606-607)

214. In his January 31, 2005, report, Dr. Chelimsky opined that “Dr. Leak should not be performing arthrodesis ([Patient 3], 5/3/01, p. 237), this is the province of an orthopedic surgeon.” (St. Ex. 28 at 4)
215. The following is a table of the invasive procedures engaged in or supervised by Dr. Leak or Dr. Griffin:

Pt	Date	Procedure Type/ Medication²⁷	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
1	08/22/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral deltoids, superior margin of trapezius, splenius capitis, levator scapulae bilaterally, (15 injections)	144
	08/29/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Griffin	Splenius capitis, trapezius, supraspinatus, and levator scapula bilaterally	143
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of splenius capitis, levator scapula, trapezius, and erector spinae	108

²⁷ Medications are identified in this table for trigger point and chemoneurolytic injections only.

Pt	Date	Procedure Type/ Medication²⁷	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
	11/29/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Griffin	Erector spinae, latissimus dorsi, gluteus maximus	142
2	02/21/01	Provocative discography, psoas injection	Leak	Provocative discography at L2-3, L3-4, L4-5, and L5-S1. Psoas injection at L2-S1, right.	298-299
	02/28/01	Trigger point injection/ <i>bupivacaine</i>	Griffin	Levator scapulae bilaterally	290
	03/06/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapulae bilaterally	289
	03/13/01	Trigger point injection/ <i>Solu-Medrol, bupivacaine</i>	Griffin	Trapezius, right	314
	03/16/01	Trigger point injection/ <i>Solu-Medrol, bupivacaine</i>	Griffin	Levator scapulae, supraspinatus, and trapezius, left	187
	03/21/01	Zygapophyseal arthrogram	Leak	L3-L4, L4 -L5, L5-S1, bilaterally	282-283
	04/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	"[R]ight levator scapulae muscle"	186
	04/12/01	Zygapophyseal arthrogram	Leak	L3-L4, L4-L5, right; L3-L4, L4-L5, left	266
	04/25/01	RFL, lumbar plexus injection	Leak	RFL of dorsal root ganglion at L2, L3, and L4; RFL of the medial branches at L2, L3, L4, right; lumbar plexus injection at L2, L3, L4, L5.	256-258
	05/15/01	RFL	Leak	Dorsal ganglia at L2, L3, L4, left; medial branch, posterior primary ramus of the spinal nerve L2, L3, L4, left	236-238
	05/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Griffin	Levator scapula	315
	06/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Griffin	Cervical region with trapezius, splenius capitis, and serratus posterior superior	313
	10/16/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Lumbar erector spinae, latissimus dorsi	177
3	03/12/01	Chemoneurolysis/ <i>Phenol</i>	Leak	"[S]ympathetic chain to rami communicans at L2-L3"	255-256
	04/05/01	Aspiration nucleotomy, RFL at L3-L4	Leak	L3-L4	265-266
	04/19/01	Aspiration nucleotomy, RFL at L4-L5	Leak	L4-L5	268-270
	05/03/01	Arthrodesis	Leak	L3	237-238
	10/17/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae and latissimus dorsi, right	156
	11/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Thoracic and lumbar latissimus dorsi	152
4	10/04/00	Provocative discography	Leak	C2-C6	335-336
	10/11/00	RFL	Leak	C2-C3	326-327
	11/28/00	Zygapophyseal arthrogram	Leak	C2-C6, bilaterally	248
	12/13/00	RFL	Leak	Medial branches at the cervical level, left	277-278
	12/27/00	RFL	Leak	Dorsal ganglion in medial branch at C2-C7, right	258-259

Pt	Date	Procedure Type/ Medication ²⁷	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
	01/10/01	Lumbar sympathetic block	Leak	Lumbar, bilaterally	231-232
	02/14/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Leak	Intraspinal, ²⁸ paraspinal muscles (five injections)	153
	03/02/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group, bilaterally	146
	03/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle groups, lumbar	145
	05/01/01	Myelography, epidural	Leak	T3-T4	235-237
	11/05/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Griffin	"[S]uperior and posterior serratus, the insertions of the levator scapula bilaterally with thoracic, erector spinae group, and trapezius"	226a
	11/20/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Griffin	Trapezius, superior serratus, erector spinae, and levator scapula, left	225
5	05/25/01	Chemoneurolytic injection	Griffin	The paraspinal musculature, cervical region, trapezius, levator (dictation ended)	166
	06/01/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Paraspinal muscles of the thoracic region ("The needle was * * * introduced into the skin at 24 separate locations")	164
	06/08/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Cutaneous nerves to the erector spinae muscle complex and intraspinous ligament	163
	06/15/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae, paraspinal muscles, levator scapula, and splenius capitis (injections into each of 10 areas of maximal tenderness")	162
	06/29/01	Chemoneurolytic injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Cutaneous nerves of the erector spinae group, lumbar region (20 injections)	160
	07/06/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Griffin	"[A]long the paravertebral region from the nuchal line down to the midscapular line down across the tops of the trapezius into the insertion of levator scapula"	229
	07/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Griffin	"[A]long the paraspinal group and then out into the subscapularis and latissimus even involving the rhomboids in the trapezius additionally," bilaterally	230
	10/10/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of left thoracic erector spinae musculature	158

²⁸ Dr. Hoogendoorn disagreed with a statement in the procedure report, which he testified had been dictated by Dr. Leak (although Dr. Hoogendoorn's name and initials are printed at the bottom). Dr. Hoogendoorn acknowledged that he had performed trigger point injections into the *paraspinal* muscles, but denied that he had performed injections into the *intraspinal* muscles. Dr. Hoogendoorn further testified that, although he has no memory of this particular procedure, he remembers that he "never injected any intrathecal or intraspinal medications." (Tr. at 144-150)

Pt	Date	Procedure Type/ Medication²⁷	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
	10/19/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation to thoracic erector spinae muscle group	157
	11/21/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Griffin	Trapezius, serratus posterior and superior, rhomboids, erector spinae group, and subscapularis	228
7	08/15/00	Sacroiliac arthrogram	Leak	Sacroiliac joint	293-294
	00/00/00	Sacroiliac arthrogram ²⁹	Leak	Sacroiliac joint	274-275
	11/08/00	RFL	Leak	S2-S4, left	233-234
	06/19/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Leak	Bilateral erector spinae and latissimus dorsi, lumbar region (eight injections)	158
	06/26/01	Trigger point injection/ <i>No medication noted</i>	Griffin	Latissimus dorsi, and gluteus maximus, bilaterally	157
	07/02/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Griffin	Latissimus dorsi, gluteus maximus, erector spinae group	156
	07/18/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae and latissimus dorsi, right lumbar region (six injections)	154
	08/01/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Leak	Dorsal cutaneous innervation of the left latissimus dorsi and erector spinae muscle group (seven injections)	153
	08/14/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the interspinous ligament, erector spinae, and paraspinal musculature, left (five injections)	152
	09/21/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae and latissimus dorsi, lumbar region	150
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the lumbar erector spinae and latissimus dorsi	149
8	02/20/01	“L5-S1 right-sided decompression, adhesion, and excision of scar, chemoneurolysis 10% sodium chloride and 6% phenol with a 50x microscope”	Leak	L5-S1, right	430-431
	02/21/01	Decompression adhesiolysis	Leak	L5-S1	428
	05/01/01	Psoas compartment lumbar plexus injection	Leak	L3-L5, right	407-408
	10/26/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Splenius capitis, levator scapula	261
9	07/12/00	Discography	Leak	T12-S1	288-289
	10/18/00	Nucleotomy and RFL	Leak	L3-S1	266-267
	02/09/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right greater trochanter area (seven injections)	260

²⁹ The language of this operative report differs from the August 15, 2000, procedure, and therefore does not appear to be a duplicate. (St. Ex. 7 at 274-275, 293-294)

Pt	Date	Procedure Type/ Medication²⁷	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
	02/16/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Leak	Right greater trochanter area and gluteal area (six injections)	170
	03/09/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right greater trochanter area (four injections)	169
11	03/29/00	Mechanical decompression	Leak	T7-T8	432-433
	05/28/01	Trigger point injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae complex, thoracic region (approximately eight injections)	246
	06/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group, lumbar thoracic region (approximately 20 separate locations)	245
	06/19/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae group (six injections)	244
	08/09/01	Trigger point injection/ <i>bupivacaine</i>	Griffin	Erector spinae group, rhomboids, latissimus dorsi, trapezius, right	428
	08/28/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right erector spinae, trapezius	239
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	“Dorsal cutaneous innervation of thoracic, erector spinae, and trapezius”	238
	10/23/01	Chemoneurolytic injection/ <i>bupivacaine</i>	Griffin	Dorsal cutaneous nerves, right posterior thorax	427
12	03/12/01	Dorsal ganglion injection	Leak	C2	296-297
	04/02/01	Dorsal root ganglion injection	Leak	C2	289-291
14	04/05/01	Ganglion injection	Leak	C2, right	166-167
	04/19/01	Ganglion injection	Leak	C2, right	145-146
	04/24/01	Trigger point injection/ <i>“analgesia and steroid”</i>	Griffin	Levator scapula, trapezius	105
	05/01/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right erector spinae complex, rhomboids, and trapezius	103
	05/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right trapezius, erector spinae, and rhomboid (injections into 10 areas of maximal tenderness)	102
	05/22/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Right levator scapula, rhomboids, and trapezius (six injections)	101
	06/05/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Griffin	Trapezius, levator scapula, splenius capitis, and supraspinatus	143
	06/15/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Right levator scapula, latissimus dorsi, splenius capitis, and rhomboid (approximately 15 separate injections)	100
	06/22/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapula, erector spinae, rhomboid, and trapezius, right (approximately 11 separate injections)	99
	07/06/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Griffin	Levator scapula, splenius capitis, trapezius, and supraspinatus	98

Pt	Date	Procedure Type/ Medication²⁷	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
15	08/07/00	Provocative discography, psoas injection	Leak	L2-S1	217-218
17	01/19/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn	Paraspinal muscles, thoracic region (10 separate injections)	175
	01/26/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn	Erector spinae muscle groups bilaterally, thoracic lumbar region	174
	02/06/01	Chemoneurolytic injection ³⁰ / <i>Sarapin,</i> <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	“Trigger point injections with Sarapin, thoracic and lumbar spine, most specifically the erector spinae muscles” (20 separate injections)	173
	02/09/01	Chemoneurolytic injection/ <i>Sarapin, Depo-Medrol,</i> <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group bilaterally (approximately 20 separate injections at 1 cm intervals along each side of spine totaling approximately 40 injections)	171
	02/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Leak	Paraspinal muscle group (40 separate injections)	170
	02/23/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral erector spinae musculature from midscapular to lumbosacral region (40 separate injections)	169
	03/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle groups bilaterally (40 separate injections)	167
	03/09/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group (40 separate injections)	166
	03/23/01	Trigger point injection/ <i>Solu-Medrol, bupivacaine</i>	Griffin	Erector spinae group	165
	04/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group (approximately 40 separate injections)	162
	04/11/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, thoracic and lumbar region (approximately 40 separate injections)	161
	04/18/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group: “20 injections with approximately 0.5 cc each were injected along the vertebral column in the erector spinae muscle complex and rhomboid area”	160
	04/25/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex bilaterally (approximately 40 separate injections)	159
	05/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, lumbar and thoracic regions bilaterally (approximately 40 separate injections)	158
	05/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, lumbar and thoracic regions bilaterally (approximately 40 separate injections)	157

³⁰ Many of the procedural notes for Patient 17 indicate that a trigger point injection was performed; however, Sarapin, a mild chemoneurolytic agent, was used. Accordingly, these procedures have been identified in this table as chemoneurolytic injections. (St. Ex. 17 at 173; see also pages 169-171)

Pt	Date	Procedure Type/ Medication²⁷	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
	06/20/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae muscle groups, lumbar and thoracic regions (approximately 20 separate injections)	156
	06/29/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae muscle groups, lumbar and thoracic region, bilaterally (approximately 40 injections)	155
	07/09/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the paraspinals in the erector spinae muscle complex bilaterally, thoracic and lumbar regions (approximately 40 separate injections)	154
	07/24/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Leak	Dorsal cutaneous innervation of the erector spinae complex, lumbar, cervical, and thoracic regions	152
	08/07/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the erector spinae complex, low cervical, thoracic, and lumbar regions	151
	09/28/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	“[E]rector spinae in the cervical, lumbar and thoracic regions as well as trapezius, rhomboids, and latissimus dorsi, their dorsal cutaneous innervation”	149
18	01/11/99	Decompression adhesiolysis	Leak	L5-S1, left	236-237
20	10/05/00	Zygapophyseal arthrogram	Leak	L2-L3 bilaterally, L3-L4 right, L4-L5 and L5-S1 bilaterally	336-338
	10/23/00	Zygapophyseal arthrogram	Leak	Right L4-L5 and L5-S1 and left L3-L4, L4-L5, and L5-S1	327
	11/14/00	RFL	Leak	Dorsal ganglia and medial branches of right L3, L4, L5, S1, and left L2, L3, L4, L5, and S1	301-302
21	10/23/00	Provocative discography	Leak	C2-C7	343
	10/30/00	RFL	Leak	C4-C5	506-507
	05/23/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Splenius capitis, erector spinae, and levator scapula, bilaterally (10 separate injections)	328
	06/01/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapula, splenius capitis, and trapezius, right side (approximately 10 separate injections)	327
	06/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapula, splenius capitis, and trapezius, bilaterally (approximately 20 separate injections)	326
	07/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the splenius capitis and superior trapezius, bilaterally (approximately 20 separate injections)	324
	09/28/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapula and splenius capitis, right	319

Pt	Date	Procedure Type/ Medication²⁷	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
	10/12/01	Trigger point injection/ <i>bupivacaine</i>	Griffin	Trapezius, splenius capitis, and levator scapula, cervical region	500
22	07/25/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Leak	Thoracic and cervical trapezius and erector spinae muscle group (approximately 20 separate injections)	188
	07/31/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Leak	Rhomboids and erector spinae groups, bilaterally (20 separate injections)	187
	09/07/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral splenius capitis, erector spinae, levator scapula, and trapezius (approximately 10 separate injections)	185
	09/19/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn	Thoracic erector spinae, rhomboids, and trapezius	183
	09/28/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Thoracic rhomboid, erector spinae, and trapezius	182
	10/19/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral erector spinae, latissimus dorsi, and trapezius, thoracic region	181

Allegation (1)(j):

216. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (1)(j) as follows:

[Dr. Griffin] inappropriately used and/or supervised a podiatrist to engage in the use of, destructive modalities of treatment such as chemolytic agents indiscriminately on nerves and muscles on Patients 1-5, 7, 11, 14, 17, 21.

(St. Ex. 54A)

Supervising a Podiatrist to Engage in the Use of Destructive Modalities of Treatment

217. The medical records indicate that Dr. Griffin used, or supervised Dr. Hoogendoorn in the use of, destructive modalities of treatment such as chemoneurolytic agents as follows:

Pt	Date	Procedure Type/ Medication	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
1	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of splenius capitis, levator scapula, trapezius, and erector spinae	108
2	04/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	“[R]ight levator scapulae muscle”	186

Pt	Date	Procedure Type/ Medication	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
3	11/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Thoracic and lumbar latissimus dorsi	152
4	03/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle groups, lumbar	145
5	06/01/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Paraspinal muscles of the thoracic region (24 injections)	164
	06/08/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Cutaneous nerves to the erector spinae muscle complex and intraspinous ligament	163
	06/15/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae, paraspinal muscles, levator scapula, and splenius capitis (10 injections)	162
	06/29/01	Chemoneurolytic injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Cutaneous nerves of the erector spinae group, lumbar region (20 injections)	160
	10/10/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of left thoracic erector spinae musculature	158
	10/19/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation to thoracic erector spinae muscle group	157
7	07/18/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae and latissimus dorsi, right lumbar region (six injections)	154
	08/14/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the interspinous ligament, erector spinae, and paraspinal musculature, left (five injections)	152
	09/21/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae and latissimus dorsi, lumbar region	150
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the lumbar erector spinae and latissimus dorsi	149
11	06/19/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae group (six injections)	244
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	"Dorsal cutaneous innervation of thoracic, erector spinae, and trapezius"	238
14	05/22/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Right levator scapula, rhomboids, and trapezius (six injections)	101
	06/15/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Right levator scapula, latissimus dorsi, splenius capitis, and rhomboid (approximately 15 injections)	100

Pt	Date	Procedure Type/ Medication	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
17	02/06/01	Chemoneurolytic injection ³¹ / <i>Sarapin</i> , <i>Depo-Medrol</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	“Trigger point injections with Sarapin, thoracic and lumbar spine, most specifically the erector spinae muscles” (20 injections)	173
	02/09/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>Depo-Medrol</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group bilaterally (approximately 40 injections)	171
	02/23/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral erector spinae musculature from midscapular to lumbosacral region (40 injections)	169
	03/02/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle groups bilaterally (40 injections)	167
	03/09/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group (40 injections)	166
	04/04/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group (approximately 40 injections)	162
	04/11/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, thoracic and lumbar region (approximately 40 injections)	161
	04/18/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group: “20 injections with approximately 0.5 cc each were injected along the vertebral column in the erector spinae muscle complex and rhomboid area”	160
	04/25/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex bilaterally (approximately 40 injections)	159
	05/04/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, lumbar and thoracic regions bilaterally (approximately 40 injections)	158
	05/16/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, lumbar and thoracic regions bilaterally (approximately 40 injections)	157
	06/20/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae muscle groups, lumbar and thoracic regions (approximately 20 injections)	156
	06/29/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae muscle groups, lumbar and thoracic region, bilaterally (approximately 40 injections)	155
	07/09/01	Chemoneurolytic injection/ <i>Sarapin</i> , <i>bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the paraspinals in the erector spinae muscle complex bilaterally, thoracic and lumbar regions (approximately 40 injections)	154

³¹ Many of the procedural notes for Patient 17 indicate that a trigger point injection was performed; however, Sarapin, a chemoneurolytic agent, was used. Accordingly, these procedures have been identified in this table as chemoneurolytic injections. (St. Ex. 17 at 173; see also pages 169-171)

Pt	Date	Procedure Type/ Medication	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
	08/07/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the erector spinae complex, low cervical, thoracic, and lumbar regions	151
	09/28/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	“[E]rector spinae in the cervical, lumbar and thoracic regions as well as trapezius, rhomboids, and latissimus dorsi, their dorsal cutaneous innervation”	149
21	07/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the splenius capitis and superior trapezius, bilaterally (approximately 20 injections)	324

Testimony of Dr. Chelimsky

218. Dr. Chelimsky testified that chemoneurolytic injections are medical procedures that require the use of medical judgment, knowledge of the anatomic structure of muscles and blood vessels around the injection site, knowledge concerning the doses being injected, and knowledge of the potential risks that go along with the injections. Dr. Chelimsky further testified that chemoneurolytic and trigger point injections “require an individualized assessment of each patient, because trigger points vary from location to location in different patients. The risks also are different from patient to patient and the agent choice will vary from one patient to the next.” (Tr. at 1658-1663)

Testimony of Dr. Leak

219. Dr. Leak testified that there are two categories of chemoneurolytics: nondestructive agents such as Sarapin, which is used to neutralize nerve fibers and is “the same as injecting a local anesthetic or * * * a bunch of [lidocaine] which is chemodenervation”; and destructive chemoneurolytic agents such as phenol which actually destroy nerve tissue. Dr. Leak testified that, unlike Sarapin, the use of phenol as a chemoneurolytic agent requires using an operating room and fluoroscopic guidance. (Tr. at 446-447)

Testimony of Dr. Griffin

220. Dr. Griffin testified that Sarapin is derived from the pitcher plant and is “the most benign chemoneurolytic agent[.]” Dr. Griffin further testified that it is supposed to destroy nerve tissue, but that “it’s not aggressive enough to suit [him].” When asked if Sarapin actually destroys nerve tissue, Dr. Griffin replied, “It is supposed to.” (Tr. at 701)

Allegation (2)(a):

221. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (2)(a) as follows:

During the period in or about August 2000 through in or about November 2001, [Dr. Griffin] aided and abetted Kyle Elliott Hoogendoorn, D.P.M., in the unlawful practice of medicine and surgery by permitting and/or supervising Dr. Hoogendoorn in administering chemoneurolytic and other injections into the splenius capitis, levator scapulae, trapezius, superior trapezius, cervical erector spinae, thoracic erector spinae, lumbar erector spinae, latissimus dorsi, paraspinal, and/or rhomboid muscles, and/or the intraspinous ligament, and/or greater trochanter, and/or gluteal area, and/or zygapophyseal joint of Patients 1-5, 7-9, 11, 14, 17, and 20-22.

(St. Ex. 54A)

222. The medical records indicate that Dr. Griffin had permitted and/or supervised Dr. Hoogendoorn in administering chemoneurolytic and other injections into areas of patients' bodies that would not be within the scope of practice of podiatric medicine:

Pt	Date	Procedure Type/ Medication	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
1	08/22/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral deltoids, superior margin of trapezius, splenius capitis, levator scapulae bilaterally, (15 injections)	144
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of splenius capitis, levator scapula, trapezius, and erector spinae	108
2	03/06/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapulae bilaterally	289
	04/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	“[R]ight levator scapulae muscle”	186
	10/16/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Lumbar erector spinae, latissimus dorsi	177
3	10/17/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae and latissimus dorsi, right	156
	11/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Thoracic and lumbar latissimus dorsi	152
4	03/02/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group, bilaterally	146
	03/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle groups, lumbar	145

Pt	Date	Procedure Type/ Medication	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
5	06/01/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Paraspinal muscles of the thoracic region (24 injections)	164
	06/08/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Cutaneous nerves to the erector spinae muscle complex and intraspinous ligament	163
	06/15/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae, paraspinal muscles, levator scapula, and splenius capitis (10 injections)	162
	06/29/01	Chemoneurolytic injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Cutaneous nerves of the erector spinae group, lumbar region (20 injections)	160
	10/10/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of left thoracic erector spinae musculature	158
	10/19/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation to thoracic erector spinae muscle group	157
7	07/18/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae and latissimus dorsi, right lumbar region (six injections)	154
	08/14/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the interspinous ligament, erector spinae, and paraspinal musculature, left (five injections)	152
	09/21/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae and latissimus dorsi, lumbar region	150
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the lumbar erector spinae and latissimus dorsi	149
8	10/26/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Splenius capitis, levator scapula	261
9	02/09/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right greater trochanter area (seven injections)	260
	03/09/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right greater trochanter area (four injections)	169
11	05/28/01	Trigger point injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae complex, thoracic region (approximately eight injections)	246
	06/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group, lumbar thoracic region (approximately 20 injections)	245
	06/19/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae group (six injections)	244
	08/28/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right erector spinae, trapezius	239
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	"Dorsal cutaneous innervation of thoracic, erector spinae, and trapezius"	238

Pt	Date	Procedure Type/ Medication	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
14	05/01/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right erector spinae complex, rhomboids, and trapezius	103
	05/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Right trapezius, erector spinae, and rhomboid (10 injections)	102
	05/22/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Right levator scapula, rhomboids, and trapezius (six injections)	101
	06/15/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Right levator scapula, latissimus dorsi, splenius capitis, and rhomboid (approximately 15 injections)	100
	06/22/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapula, erector spinae, rhomboid, and trapezius, right (approximately 11 injections)	99
17	01/19/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Paraspinal muscles, thoracic region (10 injections)	113a, 175
	01/26/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle groups bilaterally, thoracic lumbar region	110a, 174
	02/06/01	Chemoneurolytic injection ³² / <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	"Trigger point injections with Sarapin, thoracic and lumbar spine, most specifically the erector spinae muscles" (20 injections)	173
	02/09/01	Chemoneurolytic injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group bilaterally (approximately 40 injections)	171
	02/23/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral erector spinae musculature from midscapular to lumbosacral region (40 injections)	169
	03/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle groups bilaterally (40 injections)	167
	03/09/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group (40 injections)	166
	04/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group (approximately 40 injections)	162
	04/11/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, thoracic and lumbar region (approximately 40 injections)	161
	04/18/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle group: "20 injections with approximately 0.5 cc each were injected along the vertebral column in the erector spinae muscle complex and rhomboid area"	160
	04/25/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex bilaterally (approximately 40 injections)	159
	05/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, lumbar and thoracic regions bilaterally (approximately 40 injections)	158

³² Many of the procedural notes for Patient 17 indicate that a trigger point injection was performed; however, Sarapin, a chemoneurolytic agent, was used. Accordingly, these procedures have been identified in this table as chemoneurolytic injections. (St. Ex. 17 at 173; see also pages 169-171)

Pt	Date	Procedure Type/ Medication	Physician(s)	Location of Procedure (Number of Injections, if Documented)	Medical Rcd. Pg.
	05/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Erector spinae muscle complex, lumbar and thoracic regions bilaterally (approximately 40 injections)	157
	06/20/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae muscle groups, lumbar and thoracic regions (approximately 20 injections)	156
	06/29/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the erector spinae muscle groups, lumbar and thoracic region, bilaterally (approximately 40 injections)	155
	07/09/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the paraspinals in the erector spinae muscle complex bilaterally, thoracic and lumbar regions (approximately 40 injections)	154
	08/07/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous innervation of the erector spinae complex, low cervical, thoracic, and lumbar regions	151
	09/28/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	"erector spinae in the cervical, lumbar and thoracic regions as well as trapezius, rhomboids, and latissimus dorsi, their dorsal cutaneous innervation"	149
21	05/23/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Splenius capitis, erector spinae, and levator scapula, bilaterally (10 injections)	328
	06/01/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapula, splenius capitis, and trapezius, right side (approximately 10 injections)	327
	06/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapula, splenius capitis, and trapezius, bilaterally (approximately 20 injections)	326
	07/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Dorsal cutaneous nerves of the splenius capitis and superior trapezius, bilaterally (approximately 20 injections)	324
	09/28/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Levator scapula and splenius capitis, right	319
22	09/07/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral splenius capitis, erector spinae, levator scapula, and trapezius (approximately 10 injections)	185
	09/19/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Thoracic erector spinae, rhomboids, and trapezius	94a, 183
	09/28/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Thoracic rhomboid, erector spinae, and trapezius	182
	10/19/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Bilateral erector spinae, latissimus dorsi, and trapezius, thoracic region	181

Testimony and January 31, 2005, Report of Dr. Chelimsky

223. Dr. Chelimsky testified that Dr. Hoogendoorn had performed procedures that were beyond the scope of practice of a podiatric physician. Dr. Chelimsky testified that chemoneurolytic and trigger point injections require the exercise of judgment based on medical knowledge. Dr. Chelimsky further testified that they require an individual assessment of each patient because trigger points vary in location from patient to patient, the risks are different from patient to patient, “and the agent choice will vary from one patient to the next.” Dr. Chelimsky further testified that they cannot be performed without a need for complex observations or critical decisions. Finally, such procedures “require repeated medical assessments to look at the results of the injection as far as pain is concerned, and also to make sure there hasn’t been a serious complication.” (Tr. at 1634, 1657-1665)

Finally, Dr. Chelimsky testified concerning Dr. Hoogendoorn’s performance of injection procedures that his opinion does not change if Dr. Hoogendoorn had been performing these injections as a fellow because “that would imply he’s training to perform it, eventually.

* * * The point of a fellowship program is to train somebody to do what they’re eventually going to do.” (Tr. at 1648-1649)

Testimony of Dr. Bressi

224. Dr. Bressi believes that it had been appropriate for Dr. Hoogendoorn to administer trigger point and chemoneurolytic injections in the context of his pain fellowship. Dr. Bressi testified: “For podiatry it is extremely important that they get a handle on chronic pain because * * * many, if not the bulk, of their problems deal with pain in the feet. But not all the pain in the feet comes from the feet, and they have to be familiar with generalized systems.” (Tr. at 2320-2323, 2479-2480)
225. Dr. Bressi testified that trigger point injections “could be catastrophic if you’re not careful.” For example, “in the thoracic area you have to watch that you don’t go too deep because you can collapse a lung[.]” Further, “[y]ou don’t want to get a [blood] vessel. You can have a seizure or somebody can stroke.” Dr. Bressi further testified that either Dr. Leak or Dr. Griffin had to have been in the room with Dr. Hoogendoorn at first to show him how they are done and observe his performance. After that, they would not necessarily have to be in the room with him. (Tr. at 2480-2482)

Dr. Bressi further testified that, in his opinion, Dr. Hoogendoorn had been competent to perform trigger point injections and chemoneurolytic injections under the supervision of Dr. Leak or Dr. Griffin. (Tr. at 2486)

226. Dr. Bressi testified that, in his opinion, Dr. Hoogendoorn had not practiced medicine without a certificate by performing injections under the supervision of Dr. Leak or Dr. Griffin. Dr. Bressi testified that the basis of that opinion was that Dr. Hoogendoorn had been in a fellowship at the time he engaged in those activities. (Tr. at 2486-2487)

Testimony of Dr. Griffin

227. Dr. Griffin testified that Dr. Hoogendoorn had joined the fellowship when Dr. Griffin was a second-year fellow. Dr. Griffin testified that Dr. Leak had asked him, as a second-year fellow, to supervise and teach Dr. Hoogendoorn about pain medicine. Dr. Griffin noted that he had been aware that Dr. Hoogendoorn was a podiatrist. (Tr. at 3005-3007)

Dr. Griffin testified that he had supervised Dr. Hoogendoorn's performance of procedures because Dr. Hoogendoorn had been a fellow and was there to learn about pain medicine. Dr. Griffin further testified that he had done so based on "many, many discussions with Dr. Leak[,]” whom Dr. Griffin testified “ran a pretty tight ship.” (Tr. at 647-648, 3006-3008)

Dr. Griffin added: “We were trying to teach him about pain management, [the] pharmacological side, and the interventional side as far as he could take it, with the idea that it was his choice as to how to implement that into a podiatry practice.” (Tr. at 815-816)

Testimony of Dr. Hoogendoorn

228. Dr. Hoogendoorn testified that he had believed that the procedures he performed that were beyond his podiatric scope of practice had been performed under the scope of practice of the attending physician. Dr. Hoogendoorn further testified that he had recognized both Dr. Leak and Dr. Griffin as his attending physicians. (Tr. at 278)

Dr. Hoogendoorn further testified that every podiatric residency program in Ohio and in the country includes rotations through services that would be beyond the scope of podiatry, such as surgery, general medicine, and anesthesiology. Dr. Hoogendoorn added that residents in these programs are not just permitted but are required to scrub in on surgeries for non-podiatric conditions. Dr. Hoogendoorn testified that, although podiatrists' practices are limited in scope, they need to become familiar with the body as a whole to recognize non-podiatric conditions that their patients may suffer from. (Tr. at 281-287)

229. Dr. Hoogendoorn testified as follows concerning the training he received at PCC prior to being allowed to perform injection procedures:

During that first period of several months of shadowing and even before—even after that, before any invasive procedure was ever done, whether a trigger point or chemoneurolytic injection, the attending would show me exactly how to do it; what we would have to know; what he would expect me to know; what medications were going in; why we were using those; why we were using certain local anesthetics versus others; if we're adding anything to it, like a steroid, why that was being done; placement, choice of placement along the muscle or muscle belly or the insertion; how to prep the patients; gauge of syringe and needle to use. We'd go over it from top to bottom.

(Tr. at 2512)

230. Dr. Hoogendoorn testified that he had injected only soft tissue during his fellowship. Dr. Hoogendoorn further testified that he never performed spinal injections beyond the muscles that surround the spinal column. (Tr. at 2516-2517)

Dr. Hoogendoorn also testified that he never performed epidurals or placed spinal stimulators, although he had assisted in such procedures. When asked why he had been taught to perform some interventional pain management procedures but not others, Dr. Hoogendoorn replied:

Trigger point and chemoneurolytic injections are easily transferred from the back into the foot and ankle area in the soft tissues. The same principles apply. * * *

It was never intended that for any reason I was going to be doing epidurals, sympathetic blocks; implant stimulators * * *. * * * It was more for me to learn technique, instrumentation, to develop that and bring it down to the foot and ankle where appropriate.

(Tr. at 2518-2519)

Level of Supervision of Dr. Hoogendoorn during Procedures

Testimony of Dr. Leak

231. Dr. Leak testified that it is possible that Dr. Hoogendoorn had been allowed to perform chemoneurolytic injections using Sarapin as the chemoneurolytic agent without an attending present in the same room. Dr. Leak further testified that Sarapin “is a slow, slow-moving agent that goes with local anesthetic. And it’s just like—it’s literally an intramuscular injection that will hopefully neutralize the nerve fibers that penetrate the muscle.” (Tr. at 446-448)

Later in the hearing, Dr. Leak testified that he had been present with Dr. Hoogendoorn whenever Dr. Hoogendoorn was performing trigger point or chemoneurolytic injections. Dr. Leak further testified that Dr. Griffin had spent more time with Dr. Hoogendoorn, and that Dr. Leak had left to Dr. Griffin’s judgment how Dr. Griffin “would staff” Dr. Hoogendoorn. (Tr. at 2768)

Testimony of Dr. Griffin

232. Dr. Griffin testified that, when he had supervised Dr. Hoogendoorn during a procedure, he had been “at [Dr. Hoogendoorn’s] elbow.” Dr. Griffin further testified that he doubts that there was any occasion when he had supervised a procedure performed by Dr. Hoogendoorn when he had not been present in the room. (Tr. at 671-672, 3059-3060)

233. Dr. Griffin added that, having had years of experience as a deputy sheriff, he had “absolutely not” believed that he was aiding and abetting Dr. Hoogendoorn in the commission of a crime. Moreover, Dr. Griffin testified that if he *had* been aware that he was aiding and abetting the commission of a crime he would not have supervised Dr. Hoogendoorn, even if that had meant leaving the fellowship. (Tr. at 3007-3009)

Testimony of Dr. Hoogendoorn

234. Dr. Hoogendoorn testified that Dr. Leak or Dr. Griffin had been in the room with him when he had performed a procedure “[t]he first couple times.” Dr. Hoogendoorn stated that after he had been “found to be capable of doing them from a prior experience,” then he would be permitted to perform such procedures without Dr. Leak or Dr. Griffin in the room. However, Dr. Hoogendoorn testified that at least one of them had always been present in the clinic when he performed non-podiatric procedures. (Tr. at 97-99)

Later in the hearing, Dr. Hoogendoorn testified that, whenever Dr. Griffin had supervised Dr. Hoogendoorn in performing an injection, Dr. Griffin had been at Dr. Hoogendoorn’s elbow. Dr. Hoogendoorn further testified that, whenever Dr. Leak had supervised him performing an injection, Dr. Leak had been in the room with him. (Tr. at 2514-2515)

Allegation (2)(b):

235. In its August 9, 2006, notice of opportunity for hearing, the Board alleged in Allegation (2)(b) as follows:

During the period in or about August 2000 through in or about November 2001, [Dr. Griffin] aided and abetted Kyle Elliott Hoogendoorn, D.P.M., in the unlawful practice of medicine and surgery by permitting and/or supervising Dr. Hoogendoorn in prescribing controlled and noncontrolled medications, including, but not limited to, Nicotrol, Wellbutrin, Neurontin, Propranolol, Vioxx, Zyprexa, Ultram, Oxycontin, Clonazepam, Duragesic, Depakote, Senokot, Trazadone, hydrocodone, methadone, Transderm Scop, Celebrex, Zanaflex, Catapres, Zithromax, propoxyphene, oxazepam and/or methylphenidate to Patients 2, 7, 11-14, 18, 20, 23, and 24 for the treatment of non-podiatric conditions.

(St. Ex. 54A)

Dr. Hoogendoorn's Prescribing of Medications for Non-Podiatric Patients

236. The medical records indicate that Dr. Hoogendoorn issued the following prescriptions to patients for non-podiatric conditions:

Pt	Date	Supervising Physician	Discharge Summary Signed?/Name/ Page Number	Medication and Strength	Medical Rcd. Pg.
2	01/23/01	Griffin ³³	Yes/Griffin/148a	propranolol HCL 10 mg #60 Neurontin 300 mg #360 Vioxx 25 mg #60 Zyprexa 5 mg #60 Ultram 50 mg #80	79, 148a 80, 148a 80, 148a 81, 148a 81, 148a
	03/06/01	Griffin	Yes/Griffin/136a	"Nicotrol 15MG/16HR PT24" #1 box of 14 patches Wellbutrin SR 150 mg #60	75, 289 76, 289
7	02/20/01	Griffin	No	OxyContin 40 mg #90 clonazepam 0.5 mg #30	37, 164 37, 164
11	10/18/00	Griffin ³⁴	Yes/Griffin/154	Zithromax 250 mg #2 Z-Paks	64, 154
12	11/16/00	Griffin	Yes/Griffin/139a	Neurontin 100 mg #60	70, 203
	01/18/01	Griffin	Yes/Griffin/118a	hydrocodone APAP 10/325 mg #16	53, 191
	02/08/01	Griffin	Yes/Griffin/110a	OxyContin 80 mg #42 OxyContin 20 mg #30	47, 188 46, 188
	02/16/01	Griffin	Yes/Leak/108a	Duragesic 50 mcg/hr #1 box of 5 patches	34, 186
14	02/23/01	Griffin	Yes/Leak/86a	Vioxx 12.5 mg #30 Duragesic 25 mcg/hr #2 boxes of 5 patches Neurontin 300 mg #126 Zyprexa 2.5 mg #40	36, 108 37, 108 37, 108 38, 108
23	03/05/01	Griffin	Yes/Griffin/53a	hydrocodone APAP 10/325 #90 Neurontin 300 mg #240 Celebrex 200 mg #60 Zyprexa 2.5 #30	26, 68 26, 68 25, 68 25, 68
24	01/25/01	Griffin	Yes/Griffin/47a	methylphenidate 10 mg #20	34, 47a, 88

³³ Although Dr. Hoogendoorn's January 23, 2001, progress note does not mention a supervisor, the discharge summary appears to bear Dr. Griffin's initial "G." (St. Ex. 1 at 148a, 189)

³⁴ Although Dr. Hoogendoorn's October 18, 2000, progress note does not mention a supervisor, the discharge summary appears to bear Dr. Griffin's initial "G." Further, Dr. Hoogendoorn testified that Dr. Griffin had directed him to issue this prescription. (St. Ex. 1 at 154, 265; Tr. at 202)

Pt	Date	Supervising Physician	Discharge Summary Signed?/Name/ Page Number	Medication and Strength	Medical Rcd. Pg.
	02/09/01	Griffin	No	Zanaflex 2 mg #10	33, 86

No refills were authorized for any prescription listed above.

Testimony of Investigator McCafferty

237. David Shawn McCafferty testified that he is an Investigator for the Board, and that he has been so employed for over twelve years. He testified that his duties include investigating complaints against the Board's licensees. (Tr. at 295-296)

Investigator McCafferty testified concerning his investigation of Dr. Hoogendoorn:

[On April 6, 2001], I met with Dr. Hoogendoorn and discussed his prescribing of Zyprexa, Ritalin, Oxycontin, and Methadone. Dr. Hoogendoorn advised me that he would prescribe Zyprexa for pain. He would also prescribe Ritalin for pain due to depression.

He would further prescribe Methadone as part of a weaning pack in an effort to control people from abusing drugs or people that he felt were misusing controlled medications. He would then turn around and then provide them with a wean pack to wean them off, which may include Methadone.

Dr. Hoogendoorn advised that he was doing this under a pain fellowship with Pain Net Incorporated. We concluded our conversation by him advising that he would send documentation to the Medical Board of his fellowship with Pain Net Incorporated, which he did at a later date.

(Tr. at 296-297)

238. Investigator McCafferty testified that Dr. Hoogendoorn advised that he had treated patients for various pain conditions under the supervision of Dr. Leak and Dr. Griffin as part of the PCC fellowship. (Tr. at 321-322)

Testimony of Dr. Chelimsky Concerning Medications Prescribed by Dr. Hoogendoorn

239. Dr. Chelimsky testified as follows concerning some of the medications that Dr. Hoogendoorn prescribed at PCC:

- Wellbutrin is used to treat depression, and the treatment of depression is beyond the scope of the practice of podiatry. Although some antidepressants are effective in treating chronic pain, Wellbutrin is not. (Tr. at 1675-1678)

- Neurontin is an anti-epileptic medication that can be used to manage pain, and its use constitutes the practice of medicine. (Tr. at 1678-1679)
- Zyprexa is a mild, sedating anti-psychotic medication used primarily to treat patients who suffer from hallucination. It is also useful as a sleep aid for chronic pain patients. Dr. Chelimsky is not aware of any use for Zyprexa to treat podiatric conditions. (Tr. at 1679-1680)
- Duragesic patch contains the opiate Fentanyl, and is prescribed to relieve pain. (Tr. at 1743)
- “Zanaflex is an anti-spastic agent that’s sometimes used for chronic pain, sometimes used for migraine.” It could be used for podiatric conditions such as a muscle spasm in the foot or ankle. However, Dr. Chelimsky found no such symptoms in the medical records for Patients 18 and 20, the patients who had received Zanaflex from Dr. Hoogendoorn. (Tr. at 1754-1755)
- Propranolol is an antihypertensive medication which is used almost exclusively for the control of high blood pressure. Its use is beyond the scope of practice of podiatry. (Tr. at 1764)
- Methylphenidate is the generic for Ritalin, an amphetamine-like substance used to treat attention deficit disorder and narcolepsy. Its use is beyond the scope of practice of podiatry. (Tr. at 1787-1788)

Testimony of Dr. Hoogendoorn

240. Dr. Hoogendoorn testified that Zithromax is a brand name for azithromycin, an antibiotic. Dr. Hoogendoorn testified that Dr. Griffin had directed him to prescribe two packages of Zithromax (Z-Paks) to Patient 11 to treat Lyme’s disease. Dr. Hoogendoorn noted that he has prescribed Zithromax to his podiatric patients for podiatric conditions since leaving the fellowship. (Tr. at 202-203, 206-207, 2525)

Dr. Hoogendoorn testified that Neurontin is a “neuromembrane stabilizer.” Dr. Hoogendoorn further testified that “[i]t works to dampen the nervous system, in a sense, so it takes more stimulation for you to feel pain.” Dr. Hoogendoorn also stated that it is a centrally-acting drug that can affect memory and balance. He testified that he has prescribed Neurontin since leaving his fellowship for the purpose of controlling neuropathic pain in the foot and ankle. (Tr. at 118-119)

Dr. Hoogendoorn testified that hydrocodone APAP is generic Vicodin, a combination of hydrocodone and acetaminophen, used to control pain. Dr. Hoogendoorn testified that he does utilize hydrocodone APAP in his podiatric practice to treat podiatric conditions. (Tr. at 213-214)

241. Dr. Hoogendoorn testified that, prior to issuing a prescription, he had seen and evaluated the patient and made recommendations to Dr. Leak or Dr. Griffin. He stated that Dr. Leak or Dr. Griffin had approved in advance all prescriptions that he issued. In addition, Dr. Hoogendoorn testified that either Dr. Leak or Dr. Griffin had reviewed each printed prescription to be sure it was printed correctly prior to the prescription being handed to a patient. (Tr. at 2508-2509)

Moreover, Dr. Hoogendoorn testified that one can tell from the medical record that either Dr. Leak or Dr. Griffin had approved a prescription by reviewing the discharge summary for the patient visit. Dr. Hoogendoorn testified that the discharge summaries had been countersigned by either Dr. Leak or Dr. Griffin. (Tr. at 2509)

Further Testimony of Dr. Chelimsky

242. Dr. Chelimsky testified that the medical records reflect that Dr. Hoogendoorn had prescribed or changed medications that were utilized for non-podiatric conditions. Dr. Chelimsky further testified that, although Dr. Hoogendoorn had in many cases dictated progress notes indicating that he had prescribed these medications under the direct supervision of Dr. Leak or Dr. Griffin, there were no signatures on those progress notes from Dr. Leak or Dr. Griffin documenting their agreement with the new treatment. Dr. Chelimsky opined that Dr. Hoogendoorn had thus engaged in practice that was beyond the scope of his practice as a podiatrist. (St. Ex. 28 at 4-5; Tr. at 1632-1643)

Dr. Chelimsky subsequently testified that, in cases where Dr. Leak signed the discharge summary for a patient visit where Dr. Hoogendoorn had treated a patient, he would not consider it inappropriate. However, Dr. Chelimsky further testified that, if Dr. Griffin had signed the note and had also been a fellow at that time, he considers it inappropriate because the issuance of the prescription must be approved by an attending physician in charge of the patient. Dr. Chelimsky testified that one fellow cannot sign another fellow's notes. (Tr. at 2001-2003) Dr. Chelimsky further testified:

Either you have a fellowship with clearly defined fellows and clearly defined attendings and the attendings are teaching the fellows. If you have a fellowship program and a second-year fellow is signing a first-year fellow's note, that's not appropriate.

(Tr. at 2003)

Testimony of Dr. Bressi

243. Dr. Bressi testified that, as a fellow, if Dr. Hoogendoorn had recommended a particular prescription and gained approval from Dr. Griffin or Dr. Leak, Dr. Hoogendoorn could have signed the prescription himself because he was a licensed physician with a DEA registration. Dr. Bressi further testified that he did not find that to be inappropriate. (Tr. at 2478-2479)

Dr. Bressi further testified that he had reviewed the list of medications contained in the Board's notice letters to Dr. Leak, Dr. Griffin, and Dr. Hoogendoorn. Dr. Bressi testified that he did not find that any of those medications would have been inappropriate for Dr. Hoogendoorn to have prescribed under the supervision of Dr. Leak or Dr. Griffin in the context of Dr. Hoogendoorn's fellowship. (Tr. at 2482-2486)

Testimony of Dr. Leak

244. With regard to the supervision Dr. Hoogendoorn received when he wrote prescriptions for non-podiatric conditions, Dr. Leak testified:

Dr. Hoogendoorn would present a patient and make recommendations. That's the nature of training. If the attending makes all the decisions, there is very little hope that the trainee will absorb much of anything. So they—he would present and, if supported by the attending, those were the prescriptions that were written.

(Tr. at 448-449)

Dr. Leak further testified that Dr. Hoogendoorn had received training concerning the medications he prescribed and how they affected the body. (Tr. at 449)

Testimony of Dr. Griffin

245. With regard to Dr. Hoogendoorn's issuance of prescriptions for non-podiatric conditions, Dr. Griffin testified: "The patient would come into the clinic. The nursing staff would do vital signs, put them in a room. If [Dr. Hoogendoorn] saw the patient, he would go see the patient, do a history and physical, form a treatment plan, which included medications on occasion. And then he would bring it to me." Dr. Griffin would then examine the patient and, if he agreed with Dr. Hoogendoorn's treatment plan and choice of medication, he would approve the prescription(s) that Dr. Hoogendoorn had suggested. Dr. Griffin testified that Dr. Hoogendoorn had not issued prescriptions for non-podiatric conditions until Dr. Griffin or Dr. Leak had had a chance to examine the patient and determine whether the prescription was acceptable, and that, if a prescription "made it out of the building," either Dr. Leak or Dr. Griffin had approved it. (Tr. at 676, 807-809)

246. Dr. Griffin testified that for a short time Dr. Hoogendoorn had issued prescriptions under his own name, after the prescriptions had been approved by Dr. Griffin or Dr. Leak. Dr. Griffin further testified that, after about two weeks, during a regular meeting at PCC, Dr. Leak and Dr. Griffin determined they would rather issue the prescriptions under their names "because certainly we were responsible anyway[.]" (Tr. at 3051-3053)

Further Testimony of Dr. Hoogendoorn

247. Dr. Hoogendoorn testified that PCC had used a computerized prescription program and that his name had been added to the computer for only a short time, which allowed prescriptions

to be issued under his name. Dr. Hoogendoorn testified that his name was later removed, however, because pharmacists had called the clinic wondering why the medication was being prescribed by a podiatrist. (Tr. at 2506-2507) Dr. Hoogendoorn further testified:

[T]hey were confused on why a podiatrist would be writing for—because it designated me as Kyle Hoogendoorn, D.P.M. They were confused on why a podiatrist would be writing some of the medications that they directed me to write for. When they called the office, my understanding is they talked with the office manager or one of the attendings and explained, you know, he's a pain fellow, he's in a training program, that's what this is for.

And it seemed to cause a little bit of an issue. So rather than have that hold up clinic and people not get their prescriptions filled possibly and that kind of thing, they decided that we'd discontinue that form of training.

(Tr. at 2510)

Dr. Hoogendoorn testified that he had signed prescriptions for only a short time, in or about February and March 2001. After he discontinued, all prescriptions had been issued by Dr. Leak or Dr. Griffin. (Tr. at 2510)

Dr. Griffin's Participation in the PCC Fellowship

Testimony of Dr. Griffin

248. Dr. Griffin testified that he had developed an interest in pain medicine as an emergency medicine physician. He further testified that he had made an effort to learn about that field and applied some of the techniques while practicing in the ER. Dr. Griffin stated that when he received the offer to join Dr. Leak's fellowship, he had "jumped on it." Dr. Griffin entered the fellowship in August 1999. Dr. Griffin further testified that, after he had completed his first year of fellowship, he had "begged" to stay a second year. Dr. Griffin testified that he remained in the fellowship until 2001. (Tr. at 800, 2995-2998, 3004)

Dr. Griffin testified that he had mostly received surgical training during his second year, which he described as the "true interventional side. * * * I really wanted what Dr. Leak was able to give me, which is truly an international level, expert level of pain management and interventional pain management." (Tr. at 3005)

249. Dr. Griffin testified that he had used the fellowship training he received at PCC to obtain ABMS-recognized specialty certification in pain medicine. (Tr. at 800-802)

As discussed earlier in this report, information obtained by the State from the ABMS World Wide Web site indicates that Dr. Griffin holds subspecialty certification in pain medicine through the American Board of Physical Medicine and Rehabilitation. (St. Ex. 57)

Testimony of Dr. Hoogendoorn

250. Dr. Hoogendoorn testified that, to his knowledge, Dr. Griffin had been a fellow in the PCC program from August 2000, when Dr. Hoogendoorn entered the fellowship, through November 2001. (Tr. at 2530)

Testimony of Dr. Katirji

251. Dr. Katirji was unaware that Dr. Griffin had been a fellow in Dr. Leak's program until being so advised during cross-examination at hearing. When asked whether his opinion concerning Dr. Griffin would change if the evidence shows that Dr. Griffin had been a fellow in Dr. Leak's program from 1999 to 2001, Dr. Katirji replied, "Well, if he's a fellow, he's technically following orders, I guess, somehow." (Tr. at 1286-1287)

*Dr. Hoogendoorn's Participation in the PCC Fellowship*Testimony of Dr. Hoogendoorn Concerning Podiatric Residency Training

252. Dr. Hoogendoorn opined that his performance during the PCC fellowship should be likened to podiatric residency training. Dr. Hoogendoorn testified that, during podiatric residency training, residents rotate through various services and participate in the management of patients who suffer from non-podiatric conditions. (Tr. at 85-92)

Dr. Hoogendoorn stated that, during his residency, he had rotated through various services including internal medicine, dermatology, anesthesiology, wound care, emergency medicine, and podiatric surgery. Dr. Hoogendoorn further stated that he had managed patients suffering from a variety of non-podiatric conditions, including emphysema and congestive heart failure. Moreover, Dr. Hoogendoorn testified that, during rotations at Columbus Community Hospital [CCH], he had performed a general surgery rotation wherein that he had assisted in various procedures such as laparoscopic "[g]allbladder excisions" during which he created portals, inserted instruments, stapled off arteries, and closed. Dr. Hoogendoorn added that he had assisted in thoracotomy. When asked what a thoracotomy is, Dr. Hoogendoorn replied: "It's an open heart procedure. The chest is actually opened. The ribs are separated. The pleural cavity is exposed." Dr. Hoogendoorn stated: "When we got to that level, I helped retract. I also closed on leaving. So [I] sutured ribs back together, deep tissues, skin." (Tr. at 85-92) (Note that Dr. Hoogendoorn spent only one year in podiatric residency. [Resp. Ex. 103H])

253. Dr. Hoogendoorn testified that, during his residency, he had been expected to do the same work during rotations as the allopathic and osteopathic residents. (Tr. at 2184-2185)

Testimony of Dr. Weiner Concerning Podiatric Residency Training

254. Richard D. Weiner, D.P.M., testified on behalf of the Respondents. Dr. Weiner obtained his podiatric medical degree from the Ohio College of Podiatric Medicine. He performed his residency at the California College of Podiatric Medicine, which is affiliated with the

University of Southern California Medical Center in Los Angeles. Since about 1997, Dr. Weiner has been the director of the podiatric residency program at OhioHealth Grant Medical Center in Columbus, and is also in private practice. (Tr. at 2089-2090, 2164)

255. Dr. Weiner testified that the Council of Podiatric Medical Education [CPME] mandates that podiatric residents be given exposure to a variety of medical conditions rather than limiting their training to conditions of the foot and ankle. (Tr. at 2094) Dr. Weiner explained: “The rationale is because the foot and ankle is connected to the rest of the body. It’s not an isolated structure. So in order to competently treat that, one must understand how what they’re doing affects the rest of the body.” (Tr. at 2120-2121)
256. Dr. Weiner testified that podiatric residency training in Ohio currently consists of either a two-year or three-year program. Dr. Weiner testified that, the first year, residents rotate through a number of different areas such as family medicine, internal medicine, radiology, emergency medicine, and endocrinology. During the second year the residents focus on foot and ankle both clinically and surgically, and also continue generalized rotations such as plastics and orthopedics. The third year is a continuation of the second and may include electives such as general surgery. (Tr. at 2091-2092)

Dr. Weiner testified that, when performing rotations, the residents function under the direct supervision of the podiatric, osteopathic, or allopathic physician who is in charge of the rotation. The residents also answer to the hospital’s graduate medical education committee and the bylaws of the hospital. (Tr. at 2093)

257. Dr. Weiner testified that all podiatric residents receive some training in either general surgery or some other surgical field such as vascular surgery or orthopedic surgery, depending on the institution. Moreover, Dr. Weiner testified that podiatric residents assist in all surgical procedures that their rotations cover, including non-podiatric surgeries. (Tr. at 2101-2102)

Testimony of Dr. Loftus Concerning Podiatric Residency Training

258. Todd C. Loftus, D.P.M., testified on behalf of the Respondents. Dr. Loftus obtained his podiatric medical degree in 2000 from the Ohio College of Podiatric Medicine. From 2000 to 2003, Dr. Loftus participated in a podiatric residency at Salt Lake City Veterans Hospital in Salt Lake City, Utah. Dr. Loftus testified that his residency had consisted of 12 months of medicine and 24 months of surgery. Dr. Loftus currently practices as a junior associate in a four-partner podiatric practice. (Tr. at 2544-2545)

Dr. Loftus testified that he is past central chapter president of the Ohio Podiatric Medical Association [OPMA]. Dr. Loftus further testified that he is familiar with the laws and rules that govern the practice of podiatry in Ohio. (Tr. at 2554)

259. Dr. Loftus’ testimony concerning his training as a podiatric resident was consistent with the testimony of Dr. Hoogendoorn and Dr. Weiner. (Tr. at 2551-2554)

Testimony of Dr. Bastawros Concerning Podiatric Fellowship Training

260. David S. Bastawros, D.P.M., testified on behalf of the Respondents. Dr. Bastawros testified that he had obtained his podiatric medical degree from the Ohio College of Podiatric Medicine in 1997, and, from 1997 to 1998, participated in a podiatric residency at the Veterans Administration Medical Center in Boston, Massachusetts. Dr. Bastawros further testified that his residency program had been affiliated with Harvard Medical School and Brigham and Women's Hospital. (Tr. at 2640-2641)

Dr. Bastawros testified that he is currently engaged in the solo practice of podiatric medicine and surgery in Richardson, Texas. In addition to his private practice, Dr. Bastawros is also a Physician Investigator for the Texas State Board of Podiatric Medical Examiners [Texas Board]. Dr. Bastawros has worked with the Texas Board since June 2002. Moreover, Dr. Bastawros is Chairman of the Patient Safety Committee at Richardson Regional Medical Center, and a member of the Executive Advisory Board for the North Texas Healthcare Fraud Working Group. (Resp. Ex. 109H; Tr. at 2640-2645)

Dr. Bastawros testified that he is licensed to practice podiatric medicine and surgery in Texas. (Tr. at 2643)

261. Dr. Bastawros testified that the scope of podiatric practice in Texas is limited to the treatment of the bone and joints in the foot and ankle and soft tissues "all the way up into the leg area." Dr. Bastawros further testified that, unlike Ohio, Texas podiatrists cannot treat superficial lesions of the hand. Moreover, Dr. Bastawros testified that he gained familiarity with the scope of podiatric practice in Ohio through his education at the Ohio College of Podiatric Medicine.³⁵ (Tr. at 2647-2648)

262. Dr. Bastawros testified that he is familiar with podiatric fellowship programs. Dr. Bastawros further testified that they have unaccredited as well as accredited podiatric fellowships in Texas, and that the issue of podiatrists training in an unaccredited fellowship has never been a basis for concern with the Texas Board. Dr. Bastawros indicated that it would not be of concern as long as the podiatric fellow is appropriately supervised. (Tr. at 2656-2660)

Dr. Bastawros testified concerning "appropriate supervision" of a podiatric fellow:

[A]s long as the fellow is being appropriately supervised by their attending, whether it's another podiatrist, whether it's a medical doctor, whether it's a

³⁵ During the hearing, counsel for the State raised an objection that the statute defining the scope of practice of podiatric medicine and surgery in Ohio, R.C. 4731.51, had been amended since Dr. Bastawros finished medical school in Ohio in 1998. (Tr. at 2648-2649)

The current version of R.C. 4731.51 became effective on April 10, 2001. The only changes from the previous version of the statute, which had been in effect since December 14, 1967, were to change "podiatry" to "podiatric medicine and surgery," and to change "he" to "the applicant." No substantive change was made to the scope of practice. (See Sub. H.B. 585, 123rd General Assembly [148 v H 585])

doctor of osteopathic medicine, that fellow must work under the direct orders of that physician. And as a fellow, they're receiving further training. They many times will be performing or providing care outside their initial scope of practice because they're working—if they're working under a medical doctor, as long as that medical doctor is comfortable and as long as that medical doctor is providing supervision and providing orders and feels comfortable with their care, then that fellow can—they're delegated the authority to provide whatever treatments are necessary, once again, as long as they're being appropriately supervised.

(Tr. at 2663-2664) Furthermore, Dr. Bastawros testified that the attending physician would decide the level of supervision required, such as direct or on-site. (Tr. at 2664-2665)

Dr. Bastawros further explained that, when a podiatrist is providing services as a fellow, he or she is actually practicing under the license of the attending physician, whether the physician is an allopath, osteopath, or podiatrist. (Tr. at 2665)

263. On cross-examination, Dr. Bastawros acknowledged that he and Dr. Hoogendoorn are good friends. Dr. Bastawros further acknowledged that he had gone to podiatric medical school with Dr. Hoogendoorn and that he talks to Dr. Hoogendoorn about once or twice per week. (Tr. at 2668-2669)

The PCC Fellowship

Testimony of Dr. Hoogendoorn

264. Dr. Hoogendoorn testified that he had been offered a position in the PCC fellowship in 2000. Dr. Hoogendoorn testified that Dr. Griffin, who was himself a fellow at that time, had recommended Dr. Hoogendoorn for the program. (Tr. at 2208-2209, 2215)
265. Dr. Hoogendoorn testified that he had entered the PCC fellowship in August 2000. He remained in the program until around November 2003. (Tr. at 2498, 2528)
266. When asked why he had been interested in joining the fellowship program, Dr. Hoogendoorn replied:

One, it was a fantastic opportunity for myself. Podiatry has always struggled to be accepted amongst M.D.s and D.O.s, and I worked with a lot of M.D.s while I was at the program and gained their confidence and worked with them very closely. So it kind of was exciting to be brought into that.

Also, there's a lot of things that they've done or currently still do that they may do in the low back; but I've also taken it now and do it down in the foot and ankle, which has proved to be very successful. The training was at that point one of a kind, so to speak; and I thought it was an excellent opportunity

to increase my base knowledge of pain and expand on it in the private practice within the podiatric scope.

(Tr. at 2209-2210)

267. Dr. Hoogendoorn testified that, after he entered the PCC program, he had sought and obtained accreditation for the program from the Council on Podiatric Medical Education [CPME]. Dr. Hoogendoorn further testified that CPME accreditation had required linking the program with the Ohio College of Podiatric Medicine. PCC and the OCPM entered into an agreement to that effect, dated September 13, 2001. (Resp. Ex. 119H; Tr. at 2218-2221)

By letter dated January 8, 2002, the CPME notified Dr. Leak that, effective January 1, 2002, the PCC fellowship program had been granted approval as a podiatric fellowship in pain management. (Resp. Ex. 121H)

268. Dr. Hoogendoorn testified that the CPME would not recognize or give credit for the time he had spent in the fellowship prior to January 8, 2002. Therefore, he repeated that time and remained in the fellowship until September 2003. (Tr. at 2222-2224, 2535)
269. Dr. Hoogendoorn testified that there had been no difference in the training he received at the PCC fellowship between the times prior to and after CPME accreditation. (Tr. at 2224)
270. Dr. Hoogendoorn described at length his responsibilities during the fellowship and his purpose in participating in the fellowship:

This was harder than my residency. You were required to have self-directed learning on top of directed learning. You were to evaluate as many patients as you can in clinic and present them to the attending and then the attending would ask you questions and then you would be given direction to look up new educational information or techniques or other things.

You would have to know pharmacology. You'd have to know nerve blocks, nerve roots, dermatomes, sclerotomes, why certain medications work and why some don't, some drug interactions. You would have to do research on topics. You were required—I believe I was required every two or three weeks to give a presentation and it was a PowerPoint presentation that you had to produce, a publication that had to be done by the end of your fellowship program or presented for publication, pretty much you had to know as much as you possibly could.

You also had to understand patient relations in the sense of, you know, not everybody [who] goes to a pain clinic is 100 percent legit; and we try to focus on how do we spot people who are faking, basically. Had to know why you ordered certain diagnostics, you had to know what certain diagnostics to order

and when. You had to know how to come up with a treatment plan; how, you know, pain presents in the different ways and why. So it's a very hard question to put a net around because the typical patient that would come to a pain management group has already seen at least four or five other people; and, surprisingly, I would say it was not—it wasn't far off—20 percent of them had chronic foot and ankle painful conditions.

So it's one of these things where it definitely had relevance to podiatry, definitely had application. It might—you know, doing this whole program, it was never the intent for me to come out after I was done to give epidurals, injections above and beyond the scope of practice for podiatry. It was to learn what they do; evaluate what can be brought down to the foot and ankle that we currently aren't using; for better techniques to treat patients with chronic painful conditions; and advance podiatry, so to speak, take it to another level that is currently not there.

And that's what I expected to learn and expected to do in this. You know, neither David Leak, Brian Griffin, or anybody else in the facility ever thought for a second I was going to come out and start doing epidural injections or selective nerve root injections or anything above and beyond the scope and practice of podiatry.

(Tr. at 2212-2214)

Testimony of Dr. Leak

271. Dr. Leak testified that, during the time that Dr. Hoogendoorn rotated through CCH as a podiatric resident, he had worked with Dr. Hoogendoorn and been impressed by Dr. Hoogendoorn's curiosity and desire to learn. He eventually invited Dr. Hoogendoorn to join the PCC fellowship. Dr. Leak testified that, after Dr. Hoogendoorn joined the PCC fellowship, Dr. Hoogendoorn had been limited in his activities only to the degree that he had wanted to be limited. Dr. Leak testified that, for example, Dr. Hoogendoorn had not been interested in learning how to implant spinal cord stimulators because he would not be doing those in his practice as a podiatrist. Aside from that, Dr. Hoogendoorn was put through the same curriculum as the other fellows. (Tr. at 384-386, 2762-2764)

When asked whether he had had any concerns that, while in the fellowship, Dr. Hoogendoorn would be practicing outside the scope of podiatry, Dr. Leak likened fellowship training to podiatric residency training wherein podiatric residents receive training that is beyond the scope of podiatry. Dr. Leak noted that he had gained exposure to podiatric residency training at CCH and that podiatric residents rotated through various services including anesthesiology and general surgery. Moreover, Dr. Leak testified that he had reviewed the curriculum for podiatric residents at CCH. Dr. Leak testified that that curriculum "was broad enough to include our service * * *" and that CCH administrators had asked that podiatric residents be allowed to rotate through Dr. Leak's pain medicine service. (Tr. at 385-386, 401-407) Dr. Leak further testified:

As a physician, in our world, it was a seamless progression, because the hospital which was in our community and accredited—we were working literally in the same place, so it did not occur that if he was operating with us and within our clinic on March 31st that he would not be able to operate in our clinic on April 5th, because it was the same continuum, same physical facility, and just more information that should have resulted in a better trained and educated individual.

We did have an expectation and an understanding that, just like all the other podiatry residents and surgical residents, that once they completed training with us, that they would then go back to what they understood and what we understood to be their scope of practice once they were outside our venue.

(Tr. at 385-386)

272. Dr. Leak testified that Dr. Hoogendoorn had been the only podiatrist who participated in the PCC fellowship. (Tr. at 384, 2767)

Testimony of Dr. Griffin

273. Dr. Griffin testified that when Dr. Hoogendoorn entered the PCC fellowship, Dr. Griffin had been a second-year fellow. Dr. Griffin acknowledged that he had supervised Dr. Hoogendoorn in the performance of tasks that were outside the scope of practice of podiatric medicine. However, Dr. Griffin testified that it had been his understanding that, while training as a fellow at PCC, Dr. Hoogendoorn had been allowed to perform medical tasks that were outside the scope of practice for podiatric medicine. (Tr. at 824)

With regard to his supervision of Dr. Hoogendoorn, Dr. Griffin testified:

It's tradition in teaching. It's just always been that way. It was that way for me. You start at the bottom and you've got to work your way up. They start off by doing histories and physicals, and then as they get—show [in]dependence, they get a little more involved with the patients. But we all went through that training process where you're low man on the totem pole until you step up a step, internship, residency, and then you teach the guy beneath you.

(Tr. at 824)

Testimony of Dr. Chelimsky

274. Dr. Chelimsky testified that he had had trouble understanding why Dr. Hoogendoorn was in the PCC fellowship because fellows “normally would be trained to do things they're going to do in the future.” However, Dr. Chelimsky testified that a podiatrist would not perform trigger point injections because there are no trigger points in the foot or the

supporting structures of the foot. Dr. Chelimsky further testified that, if a technique would be beyond the scope of a podiatrist's eventual practice, the podiatrist should not be taught that technique in a fellowship. Moreover, Dr. Chelimsky testified that the standard of practice is that a fellowship teaches only those things that may be used by the fellow in his or her area of licensure. (Tr. at 1838-1839, 1894, 1983)

In addition, Dr. Chelimsky testified that, if Dr. Griffin or Dr. Leak had always been at Dr. Hoogendoorn's side when he performed a procedure and had always reviewed and approved Dr. Hoogendoorn's treatment plans, it would not change his opinion concerning Dr. Hoogendoorn's participation in the fellowship. Dr. Chelimsky testified:

I think the fundamental question I have is was this just a way of getting more procedures done and just get more money passed through, or was there a true fellowship program happening with true education, some percentage of time allotted to Dr. Hoogendoorn that would be his fellowship time? The whole thing has a very unusual appearance to it, as best I can gauge from the notes, from '99 to 2001.

(Tr. at 1992)

Furthermore, Dr. Chelimsky testified that, the only attestation in the patient records concerning supervision had been a line dictated by Dr. Hoogendoorn that Dr. Leak or Dr. Griffin had been supervising. Dr. Chelimsky testified that "that would be entirely inadequate in any medical record review." Dr. Chelimsky testified that an attestation is required by the supervising physician that he or she was present at the time of the procedure. Ideally, the supervising physician's note would also include information concerning the patient's progress or "[s]ome evidence that there was some thought put in by the person doing the training." (Tr. at 1831-1834)

275. With regard to Dr. Chelimsky's knowledge of the PCC fellowship program, the following exchange took place:

Q. [By Mr. Graff] The fellowship program hours of Dr. Griffin were accepted by the American Board of Anesthesia for the purposes of board certification examination in pain medicine. Are you aware of that?

* * *

A. [By Dr. Chelimsky] No.

* * *

Q. That, in fact, the fellowship program of Dr. Leak was used for the purposes of providing the educational hours necessary for the subspecialty of pain medicine; are you aware of that?

A. I was not aware of that.

Q. And that those hours as certified during the period that is under review are those that were the basis to allow a physician to sit for examination who is now certified in the subspecialty of pain medicine; are you aware of that?

A. I thought I just said that.

- Q. Are you aware that the same program without change was certified the following year as an accredited fellowship by the Ohio College of Podiatric Medicine and certified the hours of Dr. Hoogendoorn?
- A. I was not aware of that.
- Q. Having this additional information available to you now, does it change your opinion?
- A. I think I would still need to look at the structure of the program to understand what the program's about and what the teaching hours were and so on.
- Q. So that your opinion as expressed in your testimony to date is lacking the foundation necessary, in your opinion, of the fellowship program itself to being fully accurate?
- A. As far as the structure of the fellowship program.
- Q. Correct.
- A. Yes.

(Tr. at 2008-2010)

Testimony of Dr. Bressi

276. Dr. Bressi testified that he does not believe that it had been inappropriate for Dr. Griffin, a second year fellow in Dr. Leak's program, to have supervised Dr. Hoogendoorn, a first year fellow, even though Dr. Hoogendoorn was a podiatrist. Dr. Bressi testified that "[i]t's perfectly reasonable and it does not deviate from any standard of care." (Tr. at 2432-2433)

Signed Discharge Summaries for Procedures

277. The following table lists the invasive procedures performed by Dr. Hoogendoorn, whether the discharge summary was signed, by whom it was signed,³⁶ and the medical record page number for the discharge summary:

Pt	Date	Procedure Type/ Medication	Physician(s)	Discharge Summary Signed By Dr. Leak or Dr. Griffin?/ Name	Dch.Sum at Page
1	08/22/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	67a
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	68a
2	03/06/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	136a
	04/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	121a
	10/16/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	95a

³⁶ An example of Dr. Leak's signature appears at State's Exhibit 41 at 8. (Tr. at 455-460) An example of Dr. Griffin's signature appears at State's Exhibit 2 at 326. (Tr. at 673) An example of Dr. Hoogendoorn's signature appears at St. Ex. 9 at 97a, to the left of Dr. Griffin's initial "G." (Tr. at 200)

Pt	Date	Procedure Type/ Medication	Physician(s)	Discharge Summary Signed By Dr. Leak or Dr. Griffin?/ Name	Dch.Sum at Page
3	10/17/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	87a
	11/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	76a
4	03/02/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	85a
	03/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	83a
5	06/01/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	93a
	06/08/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	90a
	06/15/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	87a
	06/29/01	Chemoneurolytic injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	No	78a
	10/10/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	65a
	10/19/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	59a
7	07/18/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	86a
	08/14/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	82a
	09/21/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	75a
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	73a
8	10/26/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	127a
9	02/09/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	76a
	03/09/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	72a
11	05/28/01	Trigger point injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	No	132a
	06/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	No	129a
	06/19/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	127a

Pt	Date	Procedure Type/ Medication	Physician(s)	Discharge Summary Signed By Dr. Leak or Dr. Griffin?/ Name	Dch.Sum at Page
	08/28/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	113a
	10/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	109a
14	05/01/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	No	62a
	05/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Possibly/Griffin	60a
	05/22/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	58a
	06/15/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	54a
	06/22/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	No	52a
17	01/19/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn	Yes/Griffin	113a
	01/26/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn	Yes/Griffin	110a
	02/06/01	Chemoneurolytic injection ³⁷ / <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Leak	107a
	02/09/01	Chemoneurolytic injection/ <i>Sarapin, Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	104a
	02/23/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Possibly/Leak	98a
	03/02/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Possibly/Leak	96a
	03/09/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Leak	94a
	04/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	90a
	04/11/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	88a
	04/18/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	86a
	04/25/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	84a
	05/04/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	82a
	05/16/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	80a
	06/20/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	77a

³⁷ Many of the procedural notes for Patient 17 indicate that a trigger point injection was performed; however, Sarapin, a chemoneurolytic agent, was used. Accordingly, these procedures have been identified in this table as chemoneurolytic injections. (St. Ex. 17 at 173; see also pages 169-171)

Pt	Date	Procedure Type/ Medication	Physician(s)	Discharge Summary Signed By Dr. Leak or Dr. Griffin?/ Name	Dch.Sum at Page
	06/29/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	75a
	07/09/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	73a
	08/07/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	67a
	09/28/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	54a
21	05/23/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	No	170a
	06/01/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	No	166a
	06/08/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	No	163a
	07/13/01	Chemoneurolytic injection/ <i>Sarapin, bupivacaine</i>	Hoogendoorn/ Griffin	No	154a
	09/28/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	139a
22	09/07/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	98a
	09/19/01	Trigger point injection/ <i>bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	94a
	09/28/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	92a
	10/19/01	Trigger point injection/ <i>Depo-Medrol, bupivacaine</i>	Hoogendoorn/ Griffin	Yes/Griffin	90a

Additional Information

Testimony of Dr. Boswell Concerning Dr. Leak

278. Dr. Boswell testified that he has a very good opinion of Dr. Leak's knowledge base and clinical skills in interventional pain medicine. (Tr. at 50)

Dr. Boswell testified that he has been on lectures with Dr. Leak and has shared a podium with him. Dr. Boswell further testified that he had been an editor of a textbook in which Dr. Leak had written a chapter. (Tr. at 34-36)

Testimony of Dr. Boswell Concerning Approaches to Pain Medicine: Neurology vs. Anesthesiology

279. Dr. Boswell testified that he believes that there is a difference in philosophy between the ways that neurology and anesthesiology look at pain medicine. Dr. Boswell further testified:

The neurology approach is more medication and less intervention.
Anesthesiology has always been more interventional in the sense of doing

nerve blocks and stimulators and pumps, things like that. Things that Leak was doing that I wanted my fellows to observe or learn about back in 1996. That's why I had the original affiliation with Leak.

(Tr. at 43-44)

Dr. Boswell agreed that physicians who are in different specialties see the work of others through their own viewpoint rather than those within the same specialty. Dr. Boswell testified: "[I]t's a difference in philosophy. Probably a difference in knowledge base as well. I mean, [anesthesiology and neurology are] just different specialties." Dr. Boswell noted that, when he had worked at CWRU, he and Dr. Chelimsky had had interdisciplinary meetings, discussed patients and worked together. Dr. Boswell further testified that they did not always agree on approaches but that they had a collegial relationship and formulated good plans for the patients that they co-managed. Moreover, Dr. Boswell testified that both he and Dr. Chelimsky were within the standard of care even though they viewed patients differently and had differences of opinion concerning treatment.

(Tr. at 44-45)

Testimony of Dr. Boswell Concerning the Use of EDX Studies in Interventional Pain Management

280. Dr. Boswell testified that the subspecialty of pain medicine is a relatively young subspecialty. Dr. Boswell further testified:

[T]he specialty's constantly changing. And there are numerous areas of controversy and uncertainty about the value of the diagnostic tests, what the results mean, the appropriate treatment options, the interventional procedures, and so forth. We're not sure.

It's all evidence-based and some of the evidence is not very strong. The best evidence we have for pain medicine treatments right now would be considered a level two evidence with some randomized control trials.

(Tr. at 55-56)

Dr. Boswell testified that, under such circumstances, a clinician uses the diagnostic techniques that he or she believes to be of value. (Tr. at 57-58)

Testimony of Dr. Griffin

281. Dr. Griffin testified concerning his current practice of interventional pain management:

I do a thorough history and physical. I review their past records and current records, whatever they are, MRI's, x-rays. And when the data is returned, we do kind of a diagnostic review and work out treatment plan for the patient, which includes meds. But then that side is the clinical.

And then in the surgical side or procedural side, I take a needle, put it down at the level of nerve, whether it's spinal cord or an individual nerve, and I put chemicals in at that spot. The chemical depends on where we are in the treatment plan. A lot of steroid use and some neurodestructive procedures. But if it hurts, I do it, head to foot.

(Tr. at 2989-2990)

282. Dr. Griffin testified that he currently only performs about one trigger point injection per week. Dr. Griffin explained, "As my experience and training kind of progressed, there's more that I can do for the patients in the O.R. now than when I first started." (Tr. at 2991)

In addition, Dr. Griffin testified that he performs on average two tender point injections per week and at least 20 nerve blocks per week. Dr. Griffin further testified that he has approximately 30 surgical cases per week that include about four epidural injections. (Tr. at 2991-2994)

283. Dr. Griffin testified that, by successfully taking and passing the examination for additional qualifications in pain medicine through an ABMS-approved board, he had proved to himself that he had the knowledge to do excellent care in that field. (Tr. at 3009-3011)
284. Dr. Griffin offered the following opinion concerning Dr. Leak:

[Dr. Leak is] brilliant. Doesn't always run the clinic the way I would. He's amazing with his hands and has the ability to correctly adjust in O.R. I've seen him invent new procedures on the spot to counter a problem that the patient had anatomically. It was—every time you work with the guy is a learning experience.

(Tr. at 3077)

Dr. Hoogendoorn's use of knowledge gained in fellowship

285. Dr. Hoogendoorn testified that he is board-certified by the American Academy of Pain Management, and explained how he has used the knowledge gained during the fellowship. Dr. Hoogendoorn stated:

I sit on their education advisory committee. Since then I've applied it to the foot and ankle. I've written—I'm published. I've written textbook chapters on pain management for major podiatry texts. I lecture for a spinal cord stimulator company to podiatrists so they understand how this can build—not build but help their patient population and what to look for. I've lectured for drug companies that are used for chronic pain from the podiatrist's perspective. I've made the most of what could possibly be made from that educational experience, and I have a constant referral source for chronic painful conditions of the foot and ankle only.

(Tr. at 2519-2520)

286. Dr. Hoogendoorn testified that, since completing his fellowship, he has developed a “niche practice” treating chronic podiatric pain. Dr. Hoogendoorn further testified that it is a referral-based practice from other physicians, allopaths, osteopaths, and podiatrists.

(Tr. at 2528-2529)

FINDINGS OF FACT

1. From in or about 1999 to in or about 2001, in the routine course of his practice, Brian Frederic Griffin, M.D., undertook the treatment of 23 patients. In treating those patients, Dr. Griffin failed to form and/or document the formation of an overall clinical impression, and/or prescribed controlled substances and/or other dangerous drugs in an inappropriate manner and otherwise failed to provide treatment in accordance with the minimal standards of care. Examples of such conduct include, but are not limited to, the following:

- (a) Dr. Griffin failed to refer or timely refer and/or document the referral or timely referral of Patients 1-4, 9(8), 11-13 (10-12), 16-21 (15-20), and 23(22) for psychological consultation. Dr. Chelimsky testified convincingly that, with chronic pain patients, the standard of care requires that a referral for a psychological consultation be made within three months of the patient presenting to the practice, and that the referral be documented in the medical record.

The evidence is insufficient to support this finding with regard to Patients 14(13), 15(14), and 24(23). A document in the medical record for Patient 14(13) shows a date for the timely referral of Patient 14(13) to behavioral medicine; a note in the medical record for Patient 15(14) indicates that he had had an appointment with a psychiatrist within three months following his first visit, which obviates the need for a referral; and, the discharge summary for Patient 24(23)'s first visit indicates that Patient 24(23) had been referred to a psychologist.

- (b) Dr. Griffin should have but failed to refer Patients 20(19) and 23(22) to an addiction medicine specialist and/or obtain toxicology screens despite signs of drug abuse and/or diversion.
- (c) Dr. Griffin performed unnecessary testing including somatosensory evoked potentials [SSEP], nerve conduction studies and/or “selective tissue conductance” [STC] studies [collectively, EDX studies] on Patients 1-2, 4-5, 10(9), 15-18 (14-17), and 23(22). Further, Dr. Griffin performed unnecessary testing including somatosensory evoked potentials and/or “selective tissue conductance” studies [again, collectively, EDX studies] on Patients 7-8 (6-7), 11(10), 14(13), and 21(20).

The evidence supports a finding that the EDX testing performed on the above patients was unnecessary.

- First, SSEP testing is no longer considered by most physicians to be useful for diagnosing radiculopathy, although some physicians continue to use it for that purpose based on old literature. Further, SSEP *cannot* be used to diagnose radiculopathy in the thoracic spine. Two of Dr. Griffin's patients had had SSEP studies of the thoracic spine.

The majority of the SSEP studies were performed, ordered, or interpreted by Dr. Leak, although Dr. Griffin performed SSEP studies of the thoracic spine on two occasions, and SSEP studies of the lumbar spine on three occasions. When Dr. Griffin performed SSEP studies of the thoracic spine, he performed it each time on the same nerve roots: T2, T4, T6, T8, and T12. Further, when Dr. Griffin performed SSEP studies of the lumbar spine, he performed it each time on the same nerve roots: L2-L5 and S1. There was no tailoring of the tests to the area relevant to the patient complaint. Further, Dr. Griffin performed SSEP studies on nerve roots for which no normative values have been established.

Dr. Griffin and Dr. Leak presented evidence that SSEPs (along with NCSs and STCs) were not used to diagnose patients but were instead used to confirm patients' subjective complaints of pain. That purpose was called into question by Dr. Chelimsky, who testified convincingly that some patients who exhibit no physical problems may truly suffer from pain, and others who exhibit many physical problems have no pain. Accordingly, the testing was unnecessary because it could not reliably demonstrate that a patient's complaint of pain was legitimate.

- The evidence supports a finding that the nerve conduction studies performed by Dr. Griffin were unnecessary. Dr. Griffin performed nerve conduction studies on three patients, Patients 1, 3, and 16, in conjunction with SSEP studies of the lumbar spine. On each patient, Dr. Griffin performed sensory nerve conduction studies of the sural nerves bilaterally and motor nerve conduction studies of the peroneal and tibial nerves bilaterally. Dr. Katirji testified convincingly that those patients suffered from joint pain or back pain and did not require nerve conduction studies.

In addition, Dr. Griffin always tested the same nerves, bilaterally. Further, nerve conduction studies were not restricted to the areas relevant to the patient's complaint, or to the side where the patient complained of pain. Dr. Katirji noted that the human body contains more nerves than the sural, peroneal, and tibial nerves, and questioned why other nerves were never tested. He concluded that no thought seemed to have been given to the tests that were ordered and performed; Dr. Leak and Dr. Griffin essentially were following the same diagnostic plan no matter the patient's presenting complaint.

- The evidence shows that STC studies had no value as they were used by Dr. Griffin. Dr. Jay testified that STCs are appropriate for monitoring the progress of diabetic neuropathy; however, none of the STCs performed by

Dr. Griffin on these patients appear to have been used for that purpose. Further, the evidence is clear that STCs are absolutely worthless for the pre- and post-injection tests Dr. Griffin was doing—Dr. Jay, an expert for the Respondents, testified that they are useful for that purpose *only for autonomic blocks*. None of the relevant injections were autonomic blocks. Moreover, the results of the pre- and post-injection blocks appeared to be random and there was no distinguishable pattern; some blocks seemed to “fix” some levels while other blocks seemed to cause further pathology. Dr. Chelimsky testified persuasively the results made no sense.

In addition, Dr. Chelimsky testified convincingly that STC testing is unproven technology and that the mere non-experimental use of STC studies is below the minimal standard of care. However, because there is evidence that Dr. Boswell, whose repute is not in question,³⁸ has used STC, this finding carries little weight. Nevertheless, the evidence supports a finding that STC studies as used by Dr. Griffin for the above-referenced patients were unnecessary.

Furthermore, the Respondents argued that Dr. Katirji and Dr. Chelimsky are not similar practitioners to Dr. Griffin because both Dr. Katirji and Dr. Chelimsky are neurologists whereas Dr. Griffin is not. However, as it concerns EDX testing, the specialty with the greatest level of expertise is neurology. If Dr. Griffin performs or interprets his own EDX studies, he is treading in the province of neurology and is held to the standard of a neurologist. Dr. Griffin cannot persuasively argue that that standard does not apply to him simply because he is not a neurologist. Accordingly, the Respondents’ argument is rejected.

Finally, the evidence clearly establishes that Dr. Griffin had been a fellow in Dr. Leak’s fellowship program from August 1999 through sometime in 2001. Further, uncontroverted testimony by Dr. Griffin and Dr. Hoogendoorn indicates that he had been a fellow for the entire period relevant to this matter. Moreover, evidence was presented that Dr. Leak had established standing orders concerning the ordering of EDX studies, including pre- and post-injection STC studies. Notably, Dr. Griffin testified that he has not utilized STC studies since leaving Dr. Leak’s practice.

³⁸ With regard to the weight that should be accorded Dr. Boswell’s testimony, counsel for both the State and Dr. Leak each spoke very highly of Dr. Boswell. During the course of arguing in favor of an objection, Mr. Clifford stated:

Are we using Dr. Boswell’s medical knowledge, which is vast and I don’t dispute that? * * * [Dr. Boswell was brought to discuss other matters], not his knowledge, which I don’t dispute as being vast, in pain medicine.

(Tr. at 50)

To which Mr. Graff, Dr. Leak’s counsel, responded:

We have available to us, thankfully from the State, one of the very top pain interventionists in the country, from one of the number one programs in the world. * * * (Tr. at 50-51)

The evidence is insufficient to support this finding with regard to Patients 12(11), 13(12), 19(18), and 20(19). No evidence was presented that Dr. Griffin had performed, ordered, or interpreted EDX studies on those patients.

- (d) Dr. Griffin failed to identify and/or document an appropriate indication for the use of the EDX studies on Patients 1-5, 7-11(6-10), 14-18(13-17), and 21-23(20-22).

The evidence is insufficient to support this finding with regard to Patient 19(18). No evidence was presented that Dr. Griffin had performed, ordered, or interpreted EDX studies on that patient.

- (e) Even if the EDX studies on Patients on Patients 1-5, 7-11(6-10), 14-18(13-17), and 21-23 (20-22) had been necessary, Dr. Griffin inappropriately failed to perform, recommend, and/or document the performance or recommendation of needle EMG examinations as was appropriate.

The evidence is insufficient to support this finding with regard to Patient 19(18). No evidence was presented that Dr. Griffin had performed, ordered, or interpreted EDX studies on that patient.

- (f) Dr. Griffin failed to properly document an appropriate comment on purported abnormal EDX study results for Patients 1, 3, 5, 7-9 (6-8), 11(10), 14(13), 17-18 (16-17), 21(20) and 22(21). Although the test reports always included an interpretation of the results, there was nothing in the medical records for those patients that integrated the abnormal results with the care of the patient. Dr. Leak and Dr. Griffin argued that the abnormal results simply confirmed the diagnosis. If that were the case, there should have been a statement to that effect in the medical record. As it is, a reasonable interpretation of the medical records as kept by Dr. Griffin would be that the abnormal results were ignored.

The evidence is insufficient to support this finding with regard to Patients 12(11), 13(12), and 19(18). No evidence was presented that Dr. Griffin had performed, ordered, or interpreted EDX studies on those patients.

- (g) Dr. Griffin failed to change and/or document a change in treatment or management of Patients 1, 3, 5, 7-9(6-8), 11-14(10-13), 17-19(16-18), 21(20) and 22(21) based on the abnormal results of EDX studies.
- (h) Dr. Griffin failed to follow up and/or document follow-up on a large mean corpuscular volume finding for Patient 20(19).
- (i) Dr. Griffin failed to form and/or document the formation of an overall clinical impression for Patients 1-5, 7-10(6-9), and 12-24(11-23). Nothing in these medical records cohesively connects patient complaints, histories, physical examinations, and test results with the physician's impressions, diagnoses, and plan for the care of the

patients. For example, each medical record contains a one or two page list of diagnoses; however, it is impossible to tell how Dr. Griffin determined the diagnoses without reviewing hundreds of pages of records of testing, nurses notes, discharge summaries, procedure notes, et cetera, that have little documented interconnection with each other.

- (j) Dr. Griffin inappropriately used and/or supervised a podiatrist to engage in the use of, destructive modalities of treatment such as chemolytic agents indiscriminately on nerves and muscles on Patients 1-5, 7(6), 11(10), 14(13), 17(16), 21(20). This allegation is interpreted to refer only to the appropriateness of the injections and not to Dr. Griffin's allowing Dr. Hoogendoorn to practice beyond the scope of podiatric medicine.

Dr. Leak testified that, Sarapin, the chemoneurolytic agent administered to Patients 7 and 17, is a nondestructive agent and similar to an anesthetic. However, Dr. Griffin testified that the purpose of Sarapin is to destroy nerve tissue. Dr. Bressi was not asked to address this issue. Accordingly, Dr. Leak's position that Sarapin is a nondestructive agent is rejected. Nevertheless, the evidence that Sarapin is a *mild* destructive agent is uncontroverted.

Dr. Chelimsky provided testimony that chemoneurolytic injections should be made to nerve tissue, not muscle tissue. Dr. Leak testified that Sarapin can be injected into muscle tissue with the hope that it will neutralize nerve fiber within the muscle. Dr. Chelimsky regarded that technique as unproven. Dr. Bressi was not asked to address the issue. Based on Dr. Chelimsky's testimony, as well as Dr. Griffin's testimony that Sarapin is a destructive agent, albeit a mild one, Dr. Leak's position is rejected. Therefore, the injections performed under Dr. Griffin's supervision were inappropriate. Furthermore, although several of the procedure notes identify the procedures as injections into the "dorsal cutaneous innervation" of the muscles involved, the descriptions of the procedures indicate that the injections were made into muscle tissue.

- (k) Dr. Griffin engaged in and/or supervised the excessive use of invasive techniques and blocks, including: chemoneurolytic and other injections into the splenius capitis, levator scapulae, trapezius, superior trapezius, cervical erector spinae, thoracic erector spinae, lumbar erector spinae, latissimus dorsi, paraspinal, and/or rhomboid muscles, and/or the interspinous ligament, and/or greater trochanter in Patients 1-5, 7-9 (6-8), 11(10), 14(13), 17(16), and 21-22 (20-21).

The evidence is insufficient to support this finding with regard to Patients 12(11), 15(14), 18(17), and 20(19). No evidence was presented that Dr. Griffin had performed, engaged in, or supervised invasive procedures on those patients.

The Respondents argued that Dr. Chelimsky should not be considered a similar practitioner to Dr. Griffin with regard to interventional pain medicine because Dr. Chelimsky is a neurologist and therefore not similar to Dr. Griffin, an emergency

medicine physician trained in pain medicine by Dr. Leak, an anesthesiologist. Further, the Respondents obtained testimony from Dr. Boswell that the fields of neurology and anesthesiology approach pain medicine with different philosophies. Therefore, the Respondents argue, Dr. Chelimsky cannot opine on the standard of care that applies to Dr. Griffin. However, although this argument initially seems to have merit, it is not persuasive for the reasons discussed below.

- First, regardless of the educational background of the physician, the three certifying boards that provide subspecialty certification in pain medicine use the same examination to certify pain medicine physicians. This signifies that the field of pain medicine has a single standard of care regardless of the educational background of the individual practitioner.
- In addition, it is evident from Dr. Griffin's situation that a physician need not have a background in any particular field—or in either neurology, anesthesiology, or physical medicine and rehabilitation—to obtain subspecialty certification in pain medicine. Dr. Griffin never completed a residency and spent the majority of his medical career practicing emergency medicine; however, he holds subspecialty certification in pain medicine through the American Board of Physical Medicine and Rehabilitation, an ABMS-member board, after having completed Dr. Leak's fellowship and passing the examination. If one were to accept the Respondents' argument that each specialty has its own standard with regard to pain medicine, then it would likely be impossible to determine what standard should apply to Dr. Griffin. From a public policy standpoint, that is unacceptable.
- Furthermore, Dr. Leak trained physicians in his fellowship whose educational backgrounds were diverse. As evidenced by Dr. Griffin's and Dr. Hoogendoorn's participation in the fellowship, he did not restrict his fellowship to physicians who, like him, were trained in anesthesiology. If one were to accept the Respondents' argument, it would mean that Dr. Leak could not opine on the standard of care that applied to his own fellows, which is nonsensical.

Accordingly, the evidence is sufficient to find that Dr. Chelimsky is competent to provide an opinion concerning the standard of care that applies to the pain medicine practice of Dr. Griffin.

Finally, the Respondents' defense of "fanning the needle" is not supported by the medical records and is therefore unconvincing. The majority of procedure notes that describe a large number of trigger point or chemoneurolytic injections being made—in some cases as many as 40 in one sitting—clearly indicate that each of the injections involved a separate needle entry.

- (1) The evidence is insufficient to support a finding that Dr. Griffin excessively prescribed morphine to Patient 3 and failed to consider and/or document the

consideration of the interaction of the combination of daily use of Topamax and opiates despite evidence of development of cognitive dysfunction in the patient.

The evidence shows that Patient 3 was intellectually challenged, but does not indicate that she developed cognitive impairment during treatment. Further, although the evidence indicates Patient 3 had been receiving very large doses of morphine, absent a showing that she did not suffer from a painful condition or that her condition did not warrant such a large dose, it is insufficient to support a finding that the amount had been excessive. Moreover, evidence that Patient 3 continued reporting a high pain level despite the morphine was adequately explained by documentation that her mental impairment prevented her from accurately reporting her pain.

- (m) The evidence is insufficient to support a finding that Dr. Griffin excessively prescribed OxyContin to Patient 11(10). A radiology report included in the medical records, along with a list of diagnoses, make it appear more likely than not that Patient 11(10) suffered from conditions more severe than simply mechanical back pain.
- (2) The evidence is insufficient to support a finding that, during the period in or about August 2000 through in or about November 2001, Dr. Griffin aided and abetted Dr. Hoogendoorn in the unlawful practice of medicine and surgery by permitting and/or supervising Dr. Hoogendoorn in:
- (a) administering chemoneurolytic and other injections into the splenius capitis, levator scapulae, trapezius, superior trapezius, cervical erector spinae, thoracic erector spinae, lumbar erector spinae, latissimus dorsi, paraspinal, and/or rhomboid muscles, and/or the intraspinous ligament, and/or greater trochanter, and/or gluteal area, and/or zygapophyseal joint of Patients 1-5, 7-9(6-8), 11(10), 14(13), 17(16), and 21-22(20-21).

Further, the evidence is insufficient to support this finding with regard to Patient 20(19) because no evidence was presented that Dr. Griffin permitted or supervised Dr. Hoogendoorn in administering injections to that patient.

- (b) prescribing controlled and noncontrolled medication, including, but not limited to, Nicotrol, Wellbutrin, Neurontin, Propranolol, Vioxx, Zyprexa, Ultram, Oxycontin, Clonazepam, Duragesic, Depakote, Senokot, Trazadone, hydrocodone, methadone, Transderm Scop, Celebrex, Zanaflex, Catapres, Zithromax, propoxyphene, oxazepam and/or methylphenidate to Patients 2, 7, 11(10), 12(11), 14(13), 23(22), and 24(23) for the treatment of non-podiatric conditions.

Further, the evidence is insufficient to support this finding with regard to Patients 13(12), 18(17), and 20(19), because no evidence was presented that Dr. Griffin permitted or supervised Dr. Hoogendoorn in prescribing medication to those patients.

2. The Respondents presented evidence that, during the period in question, Dr. Hoogendoorn had been engaged in a pain medicine fellowship run by Dr. Leak. In his written reports and

testimony, Dr. Chelimsky had expressed concern with regard to Dr. Hoogendoorn's activities in the fellowship, and opined that Dr. Hoogendoorn had practiced beyond the scope of podiatric medicine. However, Dr. Chelimsky later acknowledged during the hearing that he had had insufficient information upon which to render a fully accurate opinion with regard to the structure of the fellowship. Accordingly, Dr. Chelimsky's opinion with regard to the fellowship program is accorded less weight. Note that this applies only to his opinion concerning the scope of practice issue, and not to his opinion concerning minimal standard of care issues.

Although the wisdom of a podiatrist engaging in such a fellowship may be questionable, the evidence shows that it is more likely than not that the fellowship at PCC was a legitimate fellowship. Moreover, the Respondents presented convincing evidence that, in January 2002, Dr. Leak's fellowship program received approval as a podiatric fellowship by the Council for Podiatric Medical Education [CPME]. In addition, unrefuted testimony indicates that there was no change in the structure or content of the fellowship after CPME approval was granted. Furthermore, unrefuted testimony indicates that ten physicians, including Dr. Griffin, who completed the fellowship, obtained subspecialty certification in pain medicine through an ABMS-approved board. The evidence also shows that, during residency training, and under the supervision of allopathic or osteopathic physicians, podiatrists venture into areas that would be beyond their scope of practice outside of the training program. Testimony from one witness suggests that this may occur in podiatric fellowships as well. Finally, it is clear from the evidence that Dr. Leak, Dr. Griffin, and Dr. Hoogendoorn believed that the fellowship program was legitimate.

Accordingly, the evidence is insufficient to support a finding that Dr. Griffin aided and abetted Dr. Hoogendoorn in the unlawful practice of medicine and surgery.

CONCLUSIONS OF LAW

1. The conduct of Brian Frederic Griffin as set forth in Findings of Fact 1, except 1(l) and 1(m), constitutes "[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.
2. As set forth in Findings of Fact 2, the evidence is insufficient to support a conclusion that the conduct of Dr. Griffin constitutes "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate. Pursuant to Section 4731.99(A), Ohio Revised Code, violation of Section 4731.41, Ohio Revised Code, constitutes a felony offense. Nevertheless, because the unusual nature of Dr. Hoogendoorn's fellowship presented a case of first impression for the Board, the Board was substantially justified in pursuing this allegation.

* * * * *

The evidence clearly shows that Dr. Griffin's treatment of twenty-three patients violated the minimal standard of care. Specifically, his violations include subjecting patients to unnecessary tests—in some cases to an extraordinary number of unnecessary tests—without documenting the necessity for those tests and seemingly without heed to abnormal results when abnormal results were obtained. Further, Dr. Griffin subjected patients to an extraordinary number of invasive procedures, including chemoneurolytic injections into muscle tissue. Such conduct would ordinarily warrant removing Dr. Griffin from practice. Nevertheless, there is a very large mitigating factor present in Dr. Griffin's case: during the time period relevant to this matter, Dr. Griffin had been a fellow in Dr. Leak's fellowship. Dr. Leak's tutelage, influence, and standing orders undoubtedly played a significant role in Dr. Griffin's conduct. Accordingly, permanent revocation is not recommended in the Proposed Order.

The Proposed Order would impose a stayed permanent revocation of Dr. Griffin's certificate and place him on probation for a period of time during which he would be required to complete a course concerning the use of EDX studies and interventions in the practice of pain medicine, and his practice would be monitored by a pain medicine practitioner acceptable to the Board. Should the Board later discover that Dr. Griffin has continued to practice below acceptable standards, the Board would be warranted in issuing another notice of opportunity for hearing.

PROPOSED ORDER

It is hereby ORDERED that:

1. **PERMANENT REVOCATION, STAYED; PROBATION:** The certificate of Brian Frederic Griffin, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such permanent revocation is STAYED, subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years.
 - a. **Obey the Law:** Dr. Griffin shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
 - b. **Declarations of Compliance:** Dr. Griffin shall submit quarterly declarations under penalty of Board disciplinary action 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.
 - c. **Personal Appearances:** Dr. Griffin shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board.

Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested 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.

- d. **Clinical Education Program:** Before the end of the first year of probation, or as otherwise approved by the Board, Dr. Griffin shall provide acceptable documentation of satisfactory completion of a clinical education program, to be approved in advance by the Board or its designee, related to the concerning the use of EDX studies and interventions in the practice of pain medicine. The exact number of hours and the specific content of the program shall be determined by the Board or its designee, but shall total not less than 40 nor more than 80 hours per year. The Board may require Dr. Griffin to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

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

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

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

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

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Griffin must immediately so notify the Board in writing. In addition, Dr. Griffin shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the

Board. Furthermore, Dr. Griffin shall 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.

- f. **Absence from Ohio:** Dr. Griffin shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed.
 - g. **Noncompliance Will Not Reduce Probationary Period:** In the event Dr. Griffin is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.
2. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS:** Within thirty days of the effective date of this Board Order, Dr. Griffin shall provide a copy of this Board Order to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Griffin shall promptly provide a copy of this Board Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Griffin provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Board Order Dr. Griffin shall provide a copy of this Board Order to the Ohio Department of Public Safety, Division of Emergency Medical Services. Further, Dr. Griffin shall provide the Board with **one** of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was emailed.
 3. **REQUIRED REPORTING TO OTHER STATE LICENSING AUTHORITIES:** Within thirty days of the effective date of this Board Order, Dr. Griffin shall provide a copy of this Board 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, though which he currently holds any license or certificate. Dr. Griffin further agrees to provide a copy of this Board Order

at time of application to the proper licensing authority of any state in which he applies for any professional license or for reinstatement of any professional license. Further, Dr. Griffin shall provide the Board with **one** of the following documents as proof of each required notification within thirty days of the date of each such notification: (1) the return receipt of certified mail within thirty days of receiving that return receipt, (2) an acknowledgement of delivery bearing the original ink signature of the person to whom a copy of the Board Order was hand delivered, (3) the original facsimile-generated report confirming successful transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was faxed, or (4) an original computer-generated printout of electronic mail communication documenting the email transmission of a copy of the Board Order to the person or entity to whom a copy of the Board Order was emailed.

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

A handwritten signature in black ink, appearing to read 'R. Gregory Porter', written over a horizontal line.

R. Gregory Porter
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 AUGUST 13, 2008

REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Varyani announced that the Board would now consider the Proposed Findings and Proposed Orders appearing on its agenda. He asked whether each member of the Board had received, read and considered the hearing record; the findings of fact, conclusions and proposed orders; and any objections filed in the matters of: Shelly Bade, M.D.; Eugene Allan Brewer, M.D.; William David Leak, M.D.; Brian Frederic Griffin, M.D.; Kyle Elliott Hoogendoorn, D.P.M.; Parisa Khatibi, M.D.; and William W. Nucklos, M.D.; and the Proposed Findings and Proposed Orders in the matters of John A. Halpin, M.D.; and Frank Murray Strasek, D.P.M. A roll call was taken:

ROLL CALL:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Steinbergh	- aye
	Dr. Varyani	- aye

Dr. Varyani 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:	Mr. Albert	- aye
	Dr. Egner	- aye
	Dr. Talmage	- aye
	Dr. Suppan	- aye
	Dr. Madia	- aye
	Mr. Browning	- aye
	Mr. Hairston	- aye

Dr. Stephens - aye
Dr. Mahajan - aye
Dr. Steinbergh - aye
Dr. Varyani - aye

Dr. Varyani noted that, in accordance with the provision in Section 4731.22(F)(2), 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. They may, however, participate in the matter of Dr. Khatibi, as that case is not disciplinary in nature and concerns only the doctors' qualifications for licensure. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member.

The original Proposed Findings and Proposed Orders shall be maintained in the exhibits section of this Journal.

.....
BRIAN F. GRIFFIN, M.D.

Dr. Varyani directed the Board's attention to the matter of Brian F. Griffin, M.D. He advised that objections were filed to Hearing Examiner Porter's Report and Recommendation and were previously distributed to Board members.

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

Dr. Griffin was introduced to the Board by his attorney, Thomas W. Hess, Esq.

Dr. Griffin advised that he practices interventional pain medicine in Hilliard, Ohio. He thanked the Board for giving him the opportunity to make a statement.

Dr. Griffin stated that he is a licensed physician in the State of Ohio and has been practicing since 1979. He's board-certified in emergency medicine. He advised that he has a second board that is sanctioned by the ABMS through anesthesia. It's the anesthesia sub-specialty of pain treatment. He's also board certified in a lesser board in pain management, which is not ABMS sanctioned.

Dr. Griffin stated that he was practicing emergency medicine in Columbus, Ohio, in the late 1990s. In 1999 Dr. David Leak offered him a position in a fellowship program at Pain Control Consultants, located in Columbus. Dr. Griffin stated that he did perform due diligence prior to accepting the fellowship position. He learned that the program was established in 1984, that he would be the twelfth physician to participate

in this fellowship program, and that previous fellows had graduated and gone into pain management.

Dr. Griffin stated that the fellowship program had a 75-page syllabus that set forth what was expected of the fellows. The syllabus indicated that fellows would be exposed to both clinical and academic aspects of interventional pain medicine. In addition, the fellows were exposed to Pain Control Consultants' patients, and the patient encounters were used as a teaching experience. Finally, the syllabus indicated that fellows were guided by the standing requirements Dr. Leak had established for treating chronic pain patients.

Dr. Griffin advised that, in addition to the clinical learning experience in the fellowship program, Dr. Leak established an academic curriculum that included structured meetings, grand rounds and a drill club. This academic curriculum provided fellows the opportunity to participate in publication or lecturing in the field of interventional pain medicine and greatly contributed to the knowledge gleaned from the fellowship program. Dr. Griffin stated that the fellows had structured meetings with Dr. Leak at 8:00 a.m. each morning. These meetings were used to discuss clinic and patient problems and to allow the fellows to present issues regarding various pain control patients. He stated that Dr. Leak ran each of these morning conferences and critiqued the care that was being provided by the fellows. Grand rounds were also held every Thursday night. Dr. Griffin stated that grand rounds provided fellows and Dr. Leak the opportunity to present a single problem or single patient to the group with some discussion on the patient's disease and the treatment necessary to treat the disease.

Dr. Griffin stated that he participated in the fellowship program for two years. The first year, 1999, was devoted to clinical pain management. The second year, 2000, involved the surgical procedures of pain management. In all, the fellowship provided him the opportunity to truly learn the interventional side of pain management. Dr. Griffin stated that he completed the fellowship program in 2001. Therefore, he was still in training during the time period in question, 1999 and 2000. Dr. Griffin pointed out that all of this occurred nine years ago.

Dr. Griffin continued that in 2000 Dr. Kyle Hoogendoorn, a licensed podiatrist, participated in the fellowship program. He stated that Dr. Leak informed him that he, as a senior fellow, would assist Dr. Leak in the fellowship program and monitor Dr. Hoogendoorn's participation during his first year of fellowship. Dr. Griffin stated that it was his experience that the fellowship program, like any other educational program in the medical field, was operating using a hierarchy. This meant that Dr. Leak, the director, would teach him, the second year fellow; and he, in turn, would teach Dr. Hoogendoorn, the first year fellow. They would all teach whoever else might be in the clinic for an educational endeavor.

Dr. Griffin stated that the fellowship program was accredited by the Accreditation Council for Continuing Medical Education, which, at the time, was the only accreditation available to this training program. The fellowship program was not accredited by the Accreditation Council for Graduate Medical Education (ACGME) because the Council was not accrediting pain management fellowships during the time period in question. Dr. Griffin advised that, despite the fact that the fellowship was not accredited by ACGME, the ABMS recognized his training and allowed him to sit for subspecialty certification in pain medicine, the

only ABMS-backed exam for pain management. Dr. Griffin stated that he passed the examination on his first attempt. He stated that he thinks that that indicates that he was, by that time, knowledgeable, and it shows the validity of the fellowship.

Dr. Griffin stated that, in terms of medical specialties, interventional pain medicine is a relatively new field. He stated that he feels that, at times, his field of interest is misunderstood. Some of the public think that he is nothing more than a pill pusher who has no concern for patient care or safety. This impression is not true. More often than not, his patients have suffered with pain and its associated consequences for many, many years. On average, about eleven physicians have been seen by this patient prior to their referral to his practice.

Dr. Griffin stated that he is privileged to treat patients from all walks of life and from a wide geographic area. He even has a D.E.A. agent as one of his patients.

Dr. Varyani advised Dr. Griffin to conclude his statement.

Dr. Griffin stated that the fellowship program was a real event. He had to do grand rounds, speak, write a chapter in a medical text, and took call. He commented that it would seem to him that when you're in the training program, by fact, you don't know as much as you would like to know and intend to know down the road. Therefore, you're not completely up on all aspects of the care of the patient in pain management. That is why the attending is in place – so that they can teach you the proper way and you know what you're doing down the road. The fellowship is another layer of education for physicians interested in pain management.

Dr. Steinbergh stated that she thinks that this is in the hearing record, but asked whether there has ever been an attempt to get this fellowship accredited. Dr. Steinbergh stated that she didn't see any indication that the program was ever accredited by the ACGME.

Dr. Griffin stated that he doesn't believe it was.

Dr. Varyani asked whether the Assistant Attorney General wished to respond.

Mr. Wilcox stated that the State's comments regarding Dr. Griffin will be focused on just a few points. First, the State agrees with the Conclusion of the Hearing Examiner that the evidence in this case clearly shows that Dr. Griffin's treatment of the 23 patients in question was below the minimal standard of care. Dr. Griffin subjected these patients to an extraordinary number of invasive procedures, including injections into muscle and nerve tissue. He also subjected these patients to a barrage of unnecessary and worthless tests, under the guise of confirming that these patients had legitimate nerve damage and the resulting pain.

Mr. Wilcox stated that the State disagrees with the Hearing Examiner's Finding that the evidence was insufficient to support a conclusion that Dr. Griffin aided and abetted Dr. Hoogendoorn in the unlawful

practice of medicine and surgery. Mr. Wilcox stated that the Board should make written findings that detail that, from the period of August 2000 through November 2001, Dr. Griffin committed the equivalent of conspiracy, in violation of Ohio Revised Code (ORC) 2923.03 by aiding and abetting Dr. Hoogendoorn in the unlawful practice of medicine in violation of ORC Section 4731.41, which is a felony offense as defined in ORC 4731.99(A). Mr. Wilcox stated that the State respectfully requests that these written findings be incorporated into the final order issued by the Board.

Mr. Wilcox continued that the State disagrees with the Report and Recommendation, regarding the mitigation factor that seems to lessen the culpability of Dr. Griffin from the substandard practice because he was under the direction and influence of Dr. Leak. Mr. Wilcox stated that Dr. Griffin is responsible for his own actions, regardless of whether they were under the so-called fellowship program of Dr. Leak. Dr. Griffin knew what he was doing, and he should have recognized that the practice at Pain Control Consultants was far below the standard of care. It was his responsibility as a licensee to extricate himself from a bad situation. His failure to do so, coupled with his willing participation in this fraudulent practice, warrant a more serious penalty than the Hearing Examiner's proposed stayed revocation.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER IN THE MATTER OF BRIAN F. GRIFFIN, M.D. DR. EGNER SECONDED THE MOTION.

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

Dr. Egner stated that she would like to address some of the very specific allegations and some conclusions about them. She stated that, as far as the STC tests, Dr. Griffin testified that STC tests influenced their treatment, but he also testified that they were not very reliable. Dr. Egner stated that you can tell by the patient record and from the tables in the Report and Recommendation who the ordering physician was, and Dr. Griffin ordered the STC test on 16 of 23 patients. He performed an average of nine of these tests per patient. Two of the patients had twenty STC tests ordered by Dr. Griffin. Dr. Egner stated that there is no doubt that those tests were ordered in an excessive manner. Dr. Egner commented that, ironically, Dr. Griffin defends ordering these tests and the appropriateness of these tests, but then says that he has not ordered or performed one STC test since leaving Dr. Leak's practice. Dr. Egner stated that that makes no sense at all, unless he knew at the time that these were not worthwhile tests.

Dr. Egner continued that in the record Dr. Griffin defends everything that he did while at Pain Control Consultants. Concerning his failure to recommend or do EMGs, Dr. Griffin testified that SSEP is the benchmark test; yet, no expert, not even their own, agreed with this. Concerning failure to have indication for the tests, tests were done on a routine standing order basis.

Dr. Egner stated that Dr. Griffin didn't come to this unaccredited fellowship program right out of a residency. He had one year of postgraduate training, and then he had quite a few emergency room physician jobs, where he matured, became more responsible. He also had a position where he was the

liaison between physician staff and administration, which was also a position of responsibility. Dr. Egner stated that it's hard for her to understand how Dr. Griffin would couch everything as "I was just following standard orders."

Concerning Dr. Griffin's failure to document, Dr. Egner stated that Dr. Griffin's answers always justify the lack of documentation. Dr. Griffin says that if there's no note in the chart regarding the results of tests, it wasn't necessary as there was a result on the test. Dr. Egner stated that all practicing physicians know that every test result comes with an impression at the end; but to just put that into the chart someplace, where it's not easy to find, and not follow it through the patient record, really almost nullifies having done the test. It's difficult to refer back to. It's difficult to consider this, especially during such long-term, ongoing treatment.

Dr. Egner stated that, when asked about the failure to make psychiatric referrals, Dr. Griffin said that every patient had a referral. When asked whether the information was in the chart, Dr. Griffin referred to it as drivel. Dr. Griffin said, ". . . it's hard to remember to put every single drivel of information into the chart." Dr. Egner stated that that's how much importance Dr. Griffin placed on psychiatric and psychiatry referrals for chronic pain management care.

Dr. Egner noted other areas of concern, including failure to refer patients to addictionologists and failure to do tox screens. She noted that Patient 20 lost his OxyContin prescription, and still got more prescriptions. Patient 20 had also increased his methadone on his own. Dr. Griffin gave this patient a verbal reprimand. Dr. Egner stated that part of Dr. Griffin's past includes his being a deputy sheriff. He was a member of a SWAT team. Dr. Egner stated that she would think that Dr. Griffin is familiar with law enforcement and with laws. Yet, he didn't see that red flag of either over-use and addiction or diversion and selling drugs. Dr. Egner stated that she doesn't believe Dr. Griffin. She does believe that he was well aware of what was going on.

Dr. Egner noted Dr. Griffin's excessive use of invasive techniques: giving injections for trigger points versus tender points. Dr. Egner stated that she thinks that was brought out very well in this case, and the experts addressed that issue. Trigger point injections are indicated, not tender points. Dr. Griffin would give chemoneurolysis injections around lots of nerve fibers, instead of the main one. Dr. Chelimsky states that this is an unproven approach. Dr. Egner stated that Patient 17 had 21 invasive procedures in an eight-month period of time. Patient 14 had 11 procedures in four months. Dr. Egner stated that, in and of itself, this might be indicated, but putting all of the facts of the case together, there is a record and a pattern of excessive invasive techniques.

Dr. Egner stated that, looking over the record, she sees that Dr. Griffin has a false entry in his CV. He claims that he is board certified through the Board of Anesthesia, when he's board certified through the Board of Physical Medicine and Rehabilitation. She stated that she doesn't understand that; she doesn't know how anyone doesn't know through what board they're boarded. She again noted Dr. Griffin's history: he was a deputy sheriff, a member of a SWAT team; he worked in multiple emergency rooms; he

acted as a liaison between physicians and medical staff. Yet, he justifies everything he did today and in his objections because he was a fellow, as if he didn't have the ability to think on his own. He doesn't even say that he knew then or knows now that there may have been a better way. There may have been better documentation, to give more comprehensive care. Dr. Griffin justifies all of it. Dr. Egner stated that, for this, she believes that he should be held responsible. He had full licensure in Ohio and had the ability to at least tell the Board that he's learned something from this fellowship that he might do differently. As far as the Board knows, he doesn't do anything differently except for not ordering that one test.

Dr. Egner stated that she is in favor of the Hearing Examiner's Proposed Order, except for the timing of it. She indicated that her proposal would restrict Dr. Griffin's license until such time as he completes the proposed clinical education program portion of the Order. Dr. Egner advised that she would like Dr. Griffin to devote himself to some education and relearning before going back into his private practice and being monitored.

DR. EGNER MOVED TO AMEND THE PROPOSED ORDER IN THE MATTER OF BRIAN FREDERIC GRIFFIN, M.D., BY SUBSTITUTING THE FOLLOWING:

It is hereby ORDERED that:

1. **PERMANENT REVOCATION, STAYED; PROBATION:** The certificate of Brian Frederic Griffin, M.D., to practice medicine and surgery in the State of Ohio shall be PERMANENTLY REVOKED. Such permanent revocation is STAYED, subject to the following PROBATIONARY terms, conditions, and limitations for a period of at least three years.
 - a. **Obey the Law:** Dr. Griffin shall obey all federal, state, and local laws, and all rules governing the practice of medicine and surgery in Ohio.
 - b. **Limitation/Restriction:** The certificate of Dr. Griffin to practice medicine and surgery in the State of Ohio shall be LIMITED and RESTRICTED as follows:

Clinical Education Program: Dr. Griffin's certificate shall be LIMITED and RESTRICTED to participation in a clinical education program, to be approved in advance by the Board or its designee, related to or concerning the use of EDX studies and interventions in the practice of pain medicine. The exact number of hours and the specific content of the program shall be determined by the Board or its designee, but shall total not less than 40 nor more than 80 hours. The Board may require Dr. Griffin to pass an examination related to the content of the program. This program shall be in addition to the Continuing Medical Education requirements for relicensure for the Continuing Medical Education period(s) in which they are completed.

Prior to the termination of the limitation, Dr. Griffin shall submit to the Board documentation of successful completion of the clinical education program and a written report describing the program, setting forth what he learned from the program, and identifying with specificity how he will apply what he has learned to his practice of medicine in the future. Upon acceptance of the documentation of successful completion of the clinical education program and the written report, the Board shall provide Dr. Griffin with written notification that this condition has been fulfilled and that the LIMITATION and RESTRICTION has been terminated.

- c. **Declarations of Compliance:** Dr. Griffin shall submit quarterly declarations under penalty of Board disciplinary action 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.
- d. **Personal Appearances:** Dr. Griffin shall appear in person for an interview before the full Board or its designated representative during the third month following the month in which this Order becomes effective, or as otherwise directed by the Board. Subsequent personal appearances must occur every three months thereafter, and/or as otherwise requested 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.
- e. **Monitoring Physician:** Within thirty days of the effective date of this Order, or as otherwise determined by the Board, Dr. Griffin shall submit the name and curriculum vitae of a monitoring physician for prior written approval by the Secretary or Supervising Member of the Board. In approving an individual to serve in this capacity, the Secretary and Supervising Member will give preference to a physician who practices in the same locale as Dr. Griffin and who is engaged in the same or similar practice specialty.

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

Further, the monitoring physician shall provide the Board with reports on the

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

In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, Dr. Griffin must immediately so notify the Board in writing. In addition, Dr. Griffin shall make arrangements acceptable to the Board for another monitoring physician within thirty days after the previously designated monitoring physician becomes unable or unwilling to serve, unless otherwise determined by the Board. Furthermore, Dr. Griffin shall 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.

- f. **Absence from Ohio**: Dr. Griffin shall obtain permission from the Board for departures or absences from Ohio. Such periods of absence shall not reduce the probationary term, unless otherwise determined by motion of the Board for absences of three months or longer, or by the Secretary or the Supervising Member of the Board for absences of less than three months, in instances where the Board can be assured that probationary monitoring is otherwise being performed.
 - g. **Noncompliance Will Not Reduce Probationary Period**: In the event Dr. Griffin is found by the Secretary of the Board to have failed to comply with any provision of this Order, and is so notified of that deficiency in writing, such period(s) of noncompliance will not apply to the reduction of the probationary period under this Order.
2. **REQUIRED REPORTING TO EMPLOYERS AND HOSPITALS**: Within thirty days of the effective date of this Board Order, Dr. Griffin shall provide a copy of this Board Order to all employers or entities with which he is under contract to provide health care services (including but not limited to third party payors) or is receiving training, and the Chief of Staff at each hospital where he has privileges or appointments. Further, Dr. Griffin shall promptly provide a copy of this Board Order to all employers or entities with which he contracts to provide health care services, or applies for or receives training, and the Chief of Staff at each hospital where he applies for or obtains privileges or appointments. In the event that Dr. Griffin provides any health care services or health care direction or medical oversight to any emergency medical services organization or emergency medical services provider, within thirty days of the effective date of this Board Order Dr. Griffin shall provide a copy of this Board Order to the Ohio Department of Public Safety, Division of

Dr. Egner	- aye
Dr. Talmage	- abstain
Dr. Suppan	- aye
Dr. Madia	- abstain
Mr. Browning	- aye
Mr. Hairston	- aye
Dr. Amato	- aye
Dr. Stephens	- nay
Dr. Mahajan	- aye
Dr. Steinbergh	- aye
Dr. Varyani	- aye

The motion carried.

DR. STEINBERGH MOVED TO APPROVE AND CONFIRM MR. PORTER'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND PROPOSED ORDER, AS AMENDED, IN THE MATTER OF BRIAN FREDERIC GRIFFIN, M.D. DR. VARYANI SECONDED THE MOTION. A vote was taken:

ROLL CALL:

Mr. Albert	- abstain
Dr. Egner	- aye
Dr. Talmage	- abstain
Dr. Suppan	- aye
Dr. Madia	- abstain
Mr. Browning	- aye
Mr. Hairston	- aye
Dr. Amato	- aye
Dr. Stephens	- nay
Dr. Mahajan	- aye
Dr. Steinbergh	- aye
Dr. Varyani	- aye

The motion carried.

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

*

*

BRIAN F. GRIFFIN, M.D.

*

ORDER AND ENTRY

On August 9, 2007, the State Medical Board of Ohio issued a Notice of Opportunity for Hearing to Brian F. Griffin, M.D., based on allegations that Dr. Griffin engaged in acts that constitute felonies and on his alleged impairment of ability to practice medicine according to acceptable and prevailing standards of care due to habitual or excessive use or abuse of drugs or alcohol. The foregoing would constitute grounds for disciplinary action pursuant to Sections 4731.22(B)(10) and 4731.22(B)(26), Ohio Revised Code.

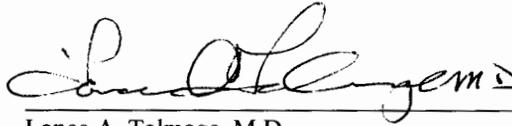
Subsequently, the Board determined that it would be administratively inefficient to pursue this matter at this time.

It is hereby ORDERED that the Notice of Opportunity for Hearing issued on August 9, 2007, pursuant to Sections 4731.22(B)(10) and 4731.22(B)(26), Ohio Revised Code, be and is hereby DISMISSED WITHOUT PREJUDICE.

This Order is entered by the State Medical Board of Ohio and on its behalf.

So ORDERED this 9th day of January 2008.

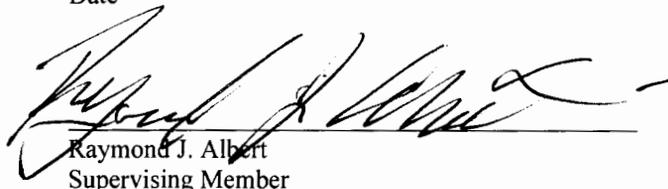
(SEAL)



Lance A. Talmage, M.D.
Secretary

1-9-08

Date



Raymond J. Albert
Supervising Member

1/9/08

Date

CERTIFIED MAIL NO. 91 7108 2133 3933 2407 0990
RETURN RECEIPT REQUESTED

Thomas Hess, Esq.
CERTIFIED MAIL NO. 91 7108 2133 3933 2407 0983
RETURN RECEIPT REQUESTED

State Medical Board of Ohio

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



Richard A. Whitehouse, Esq.
Executive Director

(614) 466-3934
med.ohio.gov

August 9, 2007

Brian Frederic Griffin, M.D.
3655 Ridge Mill Drive
Hilliard, OH 43026

Dear Doctor Griffin:

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 medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1)(a) On or about July 14, 1993, the Board immediately suspended [Immediate Suspension] your certificate to practice medicine and surgery [certificate] in Ohio based on your pleas of guilty in the Hamilton County Court of Common Pleas, located in Cincinnati, Ohio, and in the Franklin County Court of Common Pleas, located in Columbus, Ohio, to felony drug abuse offenses (deception to obtain a dangerous drug), for which you were granted treatment in lieu of conviction.

On or about July 16, 1993, you entered into a Consent Agreement the Board [July 1993 Consent Agreement] staying that immediate suspension and imposing probationary terms, conditions and limitations on your certificate including limiting your ability to prescribe controlled substance medications to hospital use based upon your violations of Sections 4731.22(B)(10) and (B)(26), Ohio Revised Code.

On or about August 12, 1993, the Board entered into a Consent Agreement [August 1993 Consent Agreement] with you terminating the stayed immediate suspension and imposing probationary terms, conditions and limitations on your certificate including restrictions on your ability to prescribe, dispense or administer controlled substance medications based upon your violations of Sections 4731.22(B)(10) and (B)(26), Ohio Revised Code. On or about August 15, 1996, the Board released you from the terms of the August 1993 Consent Agreement.

Mailed 8.9.07

- (b) On or about August 9, 2006, the Board issued to you a Notice of Opportunity for Hearing alleging that you violated Section 4731.22(B)(6), Ohio Revised Code, and Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate. Thereafter, you timely requested a hearing, which currently remains pending.
- (2) Prior to and continuing after May 31, 2007, in the course of your practice, you undertook the care of Patients 1 and 2, as identified on the attached Patient Key (Patient Key confidential and to be withheld from public disclosure).

On or about May 31, 2007, without Patient 1's consent, you palmed and hid on your person at least one tablet containing oxycodone, a schedule II controlled substance, from Patient 1 during the course of a patient visit. Further, on or about June 5, 2007, without Patient 2's consent, you palmed and hid on your person at least one tablet containing oxycodone, a schedule II controlled substance, from Patient 2 during the course of a patient visit.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.11, Ohio Revised Code, Possession of Controlled Substances.

Further, your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Sections 2913.02(A) and (B)(6), Ohio Revised Code, Theft of drugs.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "[i]mpairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice," as that clause is used in Section 4731.22(B)(26), 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 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/DPK/flb
Enclosures

CERTIFIED MAIL #91 7108 2133 3931 8317 7014
RETURN RECEIPT REQUESTED

cc: Thomas Hess, Esq.
191 West Nationwide Boulevard
PO Box 151120
Columbus, OH 43215-8120

CERTIFIED MAIL #91 7108 2133 3931 8317 7021
RETURN RECEIPT REQUESTED



State Medical Board of Ohio

77 S. High St., 17th Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

August 9, 2006

Brian Frederic Griffin, M.D.
712 Weston Park Drive
Powell, OH 43065

Dear Doctor Griffin:

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 medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) From in or about 1999 to in or about 2001, in the routine course of your practice, you undertook the treatment of Patients 1-23 as identified on the attached Patient Key (key confidential to be withheld from public disclosure). In treating Patients 1 - 23, you failed to form and/or document the formation of an overall clinical impression, and/or prescribed controlled substances and/or other dangerous drugs in an inappropriate manner and otherwise failed to provide treatment in accordance with the minimal standards of care. Examples of such conduct include, but are not limited to, the following:
 - (a) You failed to refer or timely refer and/or document the referral or timely referral of Patients 1-4, 8-20, 22 and 23 for psychological consultation.
 - (b) You failed to refer Patients 19 and 22 to an addiction medicine specialist and/or obtain toxicology screens despite signs of drug abuse and/or diversion.
 - (c) You performed unnecessary testing including somatosensory evoked potentials, nerve conduction studies and/or "selective tissue conductance" studies [collectively, EDX studies] on Patients 1-5, 9, 14-17, and 22. Further, you performed unnecessary testing including somatosensory evoked potentials and/or "selective tissue conductance" studies on Patients 6-8, 10-13 and 18-20.
 - (d) You failed to identify and/or document an appropriate indication for the use of the EDX studies on Patients 1-10, 13-18, and 20-22.
 - (e) Assuming, *arguendo*, that EDX studies on Patients 1-10, 13-18, and 20-22 were necessary, you failed to perform or recommend and/or document the performance or recommendation of a needle EMG examination.

Mailed 8-10-06

- (f) You failed to properly document an appropriate comment on purported abnormal EDX study results for Patients 1, 3, 5-8, 10-13, 16-18, 20 and 21.
 - (g) You failed to change and/or document a change in treatment or management of Patients 1, 3, 5-8, 10-13, 16-18, 20 and 21 based on the abnormal results of EDX studies.
 - (h) You failed to follow up and/or document follow up on a large mean corpuscular volume finding for Patient 19.
 - (i) You failed to form and/or document the formation of an overall clinical impression for Patients 1-9 and 11-23.
 - (j) You inappropriately used and/or supervised a podiatrist to engage in the use of, destructive modalities of treatment such as chemolytic agents indiscriminately on nerves and muscles on Patients 1-6, 10, 13, 16 and 20.
 - (k) You engaged in and/or supervised the excessive use of invasive techniques and blocks, including: chemoneurolytic and other injections into the splenius capitis, levator scapulae, trapezius, superior trapezius, cervical erector spinae, thoracic erector spinae, lumbar erector spinae, latissimus dorsi, paraspinal, and/or rhomboid muscles, and/or the interspinous ligament, and/or greater trochanter in Patients 1-8, 10, 11, 13, 14, 16, 17, 19, 20 and 21.
 - (l) You excessively prescribed morphine to Patient 3 and failed to consider and/or document the consideration of the interaction of the combination of daily use of Topamax and opiates despite evidence of development of cognitive dysfunction in the patient.
 - (m) You excessively prescribed Oxycontin to Patient 10.
- (2) During the period in or about August 2000 through in or about November 2001, you aided and abetted Kyle Elliott Hoogendoorn, D.P.M., in the unlawful practice of medicine and surgery by permitting and/or supervising Dr. Hoogendoorn in:
- (a) administering chemoneurolytic and other injections into the splenius capitis, levator scapulae, trapezius, superior trapezius, cervical erector spinae, thoracic erector spinae, lumbar erector spinae, latissimus dorsi, paraspinal, and/or rhomboid muscles, and/or the interspinous ligament, and/or greater trochanter, and/or gluteal area, and/or zygapophyseal joint of Patients 1-8, 10, 13, 16, 19, 20 and 21;
 - (b) prescribing controlled and noncontrolled medications, including, but not limited to, Nicotrol, Wellbutrin, Neurontin, Propranolol, Vioxx, Zyprexa,

Ultram, Oxycontin, Clonazepam, Duragesic, Depakote, Senokot, Trazadone, hydrocodone, methadone, Transderm Scop, Celebrex, Zanaflex, Catapres, Zithromax, propoxyphene, oxazepam and/or methylphenidate to Patients 2, 6, 10-13, 17, 19, 22 and 23 for the treatment of non-podiatric conditions.

Your acts, conduct, and/or omissions as alleged in paragraph (1) 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.

Your acts, conduct, and/or omissions as alleged in paragraph (2) above, individually and/or collectively, constitute “[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed,” as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2923.03, Ohio Revised Code, Complicity, to wit: Section 4731.41, Ohio Revised Code, Practice of medicine or surgery without certificate. Pursuant to Section 4731.99(A), Ohio Revised Code, violation of Section 4731.41, Ohio Revised Code, constitutes a felony offense.

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.

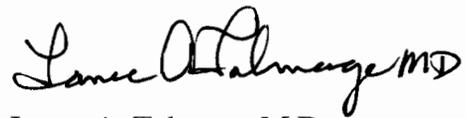
In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate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

Brian F. Griffin, M.D.
Page 4

Copies of the applicable sections are enclosed for your information.

Very truly yours,

A handwritten signature in black ink that reads "Lance A. Talmage MD". The signature is written in a cursive style with a large, stylized initial "L".

Lance A. Talmage, M.D.
Secretary

LAT/blt
Enclosures

CERTIFIED MAIL # 7004 2510 0006 9801 7510
RETURN RECEIPT REQUESTED

**CONSENT AGREEMENT
BETWEEN
BRIAN F. GRIFFIN, M.D.
AND
THE STATE MEDICAL BOARD OF OHIO**

This CONSENT AGREEMENT is entered into by and between BRIAN F. GRIFFIN, M.D. and THE STATE MEDICAL BOARD OF OHIO, a state agency charged with enforcing Chapter 4731., Ohio Revised Code.

BRIAN F. GRIFFIN, M.D. enters into this Agreement being fully informed of his rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

This CONSENT AGREEMENT is entered into on the basis of the following stipulations, admissions and understandings:

- A. THE STATE MEDICAL BOARD OF OHIO is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for violations of Sections 4731.22(B)(10) and (B)(26) of the Ohio Revised Code.
- B. THE STATE MEDICAL BOARD OF OHIO enters into this CONSENT AGREEMENT in lieu of formal proceedings based upon the Notice of Immediate Suspension and Opportunity for Hearing dated July 14, 1993, a copy of which is attached hereto and incorporated herein, and expressly reserves the right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Agreement.
- C. BRIAN F. GRIFFIN, M.D. is licensed to practice medicine and surgery in the State of Ohio.

- D. DOCTOR GRIFFIN ADMITS that on February 3, 1992, he was admitted to Harding Hospital for in-patient treatment due to "inappropriate use of controlled substances in the context of a chronic pain syndrome." DOCTOR GRIFFIN was discharged on February 14, 1992, with a discharge diagnosis of opiate and benzodiazepine dependence.

DOCTOR GRIFFIN further ADMITS that from May 11, 1992, through September 23, 1992, he self-prescribed Soma and Lortab, specific instances of which led to his being subsequently arrested in Franklin and Hamilton County and charged with Deception to Obtain Dangerous Drugs.

On October 2, 1992, DOCTOR GRIFFIN was admitted to Saint Vincent Charity Hospital for further inpatient treatment. DOCTOR GRIFFIN was discharged on October 15, 1992, with a diagnosis of narcotic dependence and benzodiazepine abuse in remission.

- E. DOCTOR GRIFFIN knowingly and voluntarily ADMITS that on or about January 29, 1993, he pleaded guilty by way of information to Deception to Obtain a Dangerous Drug in violation of Section 2925.22 of the Ohio Revised Code, in the Hamilton County Court of Common Pleas in Case Number B-929224, and was granted Treatment in Lieu of Conviction pursuant to Section 2951.041 of the Ohio Revised Code.
- F. DOCTOR GRIFFIN knowingly and voluntarily ADMITS that on or about March 17, 1993, he pleaded guilty to one count of Deception to Obtain a Dangerous Drug in violation of Section 2925.22 of the Ohio Revised Code, in the Franklin County Court of Common Pleas in Case Number 92CR-12-6517, and was granted Treatment in Lieu of Conviction pursuant to Section 2951.041 of the Ohio Revised Code.
- G. DOCTOR GRIFFIN further ADMITS that the acts, conduct, and/or omissions underlying the judicial findings of eligibility for Treatment in Lieu of Conviction of violations of Section 2925.22 of the Ohio Revised Code as mentioned in paragraphs (E.) and (F.) above constitute commission of acts that constitute a felony in this State as set forth in Section 4731.22(B)(10) of the Ohio Revised Code.

Consent Agreement Between
Brian F. Griffin, M.D. and
The State Medical Board of Ohio
Page 3

- H. DOCTOR GRIFFIN further ADMITS that the judicial findings of eligibility for Treatment in Lieu of Conviction of violations of Section 2925.22 of the Ohio Revised Code as mentioned in paragraphs (D.), (E.) and (F.) above, and the acts, conduct, and/or admissions underlying the above-mentioned judicial findings, constitute "impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice," as that clause is used in Section 4731.22(B)(26) of the Ohio Revised Code.
- I. DOCTOR GRIFFIN has been in compliance with his court ordered period of rehabilitation including aftercare.
- J. DOCTOR GRIFFIN'S certificate to practice medicine and surgery in the State of Ohio was immediately suspended pursuant to Section 3719.121(C) of the Ohio Revised Code on July 14, 1993.
- K. DOCTOR GRIFFIN entered into an interim CONSENT AGREEMENT with THE STATE MEDICAL BOARD OF OHIO on July 16, 1993, pursuant to the authority granted by the BOARD at its July 15, 1993, meeting. The interim CONSENT AGREEMENT stayed the immediate suspension with probationary requirements.

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, BRIAN F. GRIFFIN, M.D. knowingly and voluntarily agrees with THE STATE MEDICAL BOARD OF OHIO, (hereinafter BOARD), to the following:

1. The suspension of DOCTOR GRIFFIN'S certificate to practice medicine and surgery in the State of Ohio pursuant to Section 3719.121 of the Ohio Revised Code is terminated effective upon ratification of this CONSENT AGREEMENT by the BOARD;
2. The CONSENT AGREEMENT entered into between DOCTOR GRIFFIN and the BOARD on July 16, 1993, is terminated effective upon the ratification of this CONSENT AGREEMENT by the BOARD. Records of compliance with the terms of the above-mentioned CONSENT AGREEMENT shall be retained by DOCTOR GRIFFIN and be made available to the BOARD at his first personal appearance for a quarterly interview before the BOARD;

3. DOCTOR GRIFFIN'S certificate to practice medicine and surgery in the State of Ohio shall be subject to the following PROBATIONARY terms, conditions and limitations for a period of at least three (3) years:
 - a. DOCTOR GRIFFIN shall obey all federal, state and local laws, and all rules governing the practice of medicine in Ohio, and all terms of probation imposed by the Court in criminal case numbers B-929224 and 92CR-12-6517;
 - b. DOCTOR GRIFFIN shall submit quarterly declarations under penalty of Falsification stating whether there has been compliance with all the conditions of this CONSENT AGREEMENT;
 - c. DOCTOR GRIFFIN shall appear in person for quarterly interviews before the BOARD or its designated representative, or as otherwise directed by the BOARD;
 - d. In the event that DOCTOR GRIFFIN should leave Ohio for three (3) continuous months, or reside or practice outside the State, DOCTOR GRIFFIN must notify the BOARD in writing of the dates of departure and return. Periods of time spent outside Ohio will not apply to the reduction of the probationary period under this CONSENT AGREEMENT;
 - e. In the event DOCTOR GRIFFIN is found by the Secretary of the Board to have failed to comply with any provision of this agreement, 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 CONSENT AGREEMENT;
 - f. DOCTOR GRIFFIN is permitted to retain his United States Drug Enforcement Administration Certificate. However, use of this Certificate shall be expressly limited to use in the hospital for duly registered Emergency Department patients or hospitalized inpatients. Further, DOCTOR GRIFFIN shall not be permitted to personally dispense or administer any controlled substances without prior BOARD approval;

- g. DOCTOR GRIFFIN shall abstain completely from the personal use or possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of DOCTOR GRIFFIN's history of chemical dependency;
- h. DOCTOR GRIFFIN shall abstain completely from the use of alcohol;
- i. DOCTOR GRIFFIN shall submit to random urine screenings for drugs and alcohol on a weekly basis or as otherwise directed by the BOARD. DOCTOR GRIFFIN shall ensure that all screening reports are forwarded directly to the BOARD on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board;

Within thirty (30) days of the effective date of this Agreement, DOCTOR GRIFFIN shall submit to the BOARD for its prior approval the name of a supervising physician to whom DOCTOR GRIFFIN shall submit the required urine specimens. The supervising physician shall ensure that the urine specimens are obtained on a random basis, that the giving of the specimen is witnessed by a reliable person, and that appropriate control over the specimen is maintained. In addition, the supervising physician shall immediately inform the BOARD of any positive screening results;

In the event that the designated supervising physician becomes unable or unwilling to so serve, DOCTOR GRIFFIN must immediately notify the BOARD in writing, and make arrangements acceptable to the BOARD for another supervising physician as soon as practicable;

- j. The BOARD retains the right to require, and DOCTOR GRIFFIN agrees to submit, blood or urine specimens for analysis upon request and without prior notice;

- k. Within thirty (30) days of the effective date of this CONSENT AGREEMENT, DOCTOR GRIFFIN shall undertake and maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., or Caduceus, approved in advance by the BOARD specifically for DOCTOR GRIFFIN, no less than three (3) times per week. Substitution of any specific program must receive prior BOARD approval. At his appearances before the BOARD or its designated representative, DOCTOR GRIFFIN shall submit acceptable documentary evidence of continuing compliance with this program;
- l. Within thirty (30) days of the effective date of this CONSENT AGREEMENT, DOCTOR GRIFFIN shall submit for the BOARD's prior approval the name of a monitoring physician, who shall monitor DOCTOR GRIFFIN and provide the BOARD with quarterly reports on the doctor's progress and status. DOCTOR GRIFFIN shall ensure that such reports are forwarded to the BOARD on a quarterly basis. In the event that the designated monitoring physician becomes unable or unwilling to serve in this capacity, DOCTOR GRIFFIN must immediately so notify the BOARD in writing, and make arrangements acceptable to the BOARD for another monitoring physician as soon as practicable;
- m. DOCTOR GRIFFIN shall maintain continued compliance with the terms of the aftercare contract entered into with his treatment provider, provided, that where terms of the aftercare contract conflict with terms of this Agreement, the terms of this Agreement shall control;
- n. DOCTOR GRIFFIN shall provide continuing authorization, through appropriate written consent forms, for disclosure by his treatment provider to the BOARD, to treating and monitoring physicians, and to others involved in the monitoring process, of information necessary for them to fulfill their respective duties and obligations; and

Consent Agreement Between
Brian F. Griffin, M.D. and
The State Medical Board of Ohio
Page 7

- o. Within thirty (30) days of the effective date of this Agreement, DOCTOR GRIFFIN shall provide a copy of this CONSENT AGREEMENT to all employers or entities with which he contracts to provide physician services or receive training; and the Chief of Staff at each hospital where he has, applies for, or obtains privileges or appointments.

The above described terms, conditions, and limitations may be amended or terminated in writing at any time upon the agreement of both parties. However, this Agreement shall remain in force for a minimum of three (3) years prior to any request for termination of said Agreement.

If, in the discretion of the Secretary and Supervising Member of THE STATE MEDICAL BOARD OF OHIO, DOCTOR GRIFFIN appears to have violated or breached any terms or conditions of this Agreement, THE STATE MEDICAL BOARD OF OHIO reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Agreement.

DOCTOR GRIFFIN acknowledges that he has had an opportunity to ask questions concerning the terms of this Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the BOARD based on alleged violations of this CONSENT AGREEMENT shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

DOCTOR GRIFFIN hereby releases THE STATE MEDICAL BOARD OF OHIO, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

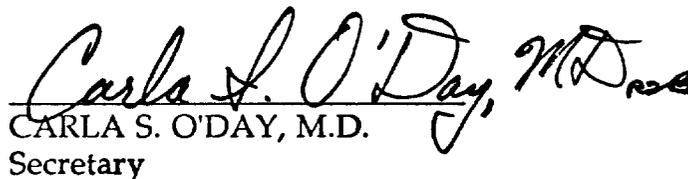
Consent Agreement Between
Brian F. Griffin, M.D. and
The State Medical Board of Ohio
Page 8

This CONSENT AGREEMENT shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code. It is expressly understood that this CONSENT AGREEMENT is subject to ratification by the BOARD prior to signature by the Secretary and Supervising Member and shall become effective upon the last date of signature below.

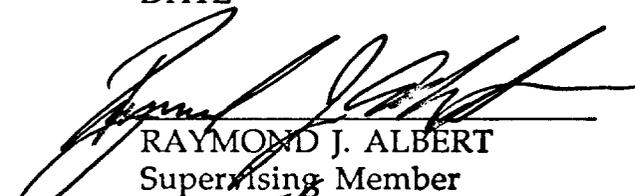
Further, this information may be reported to appropriate organizations, data banks and governmental bodies.


BRIAN F. GRIFFIN, M.D.

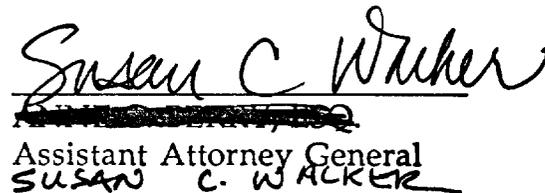
8/9/93
DATE


CARLA S. O'DAY, M.D.
Secretary

8/12/93
DATE


RAYMOND J. ALBERT
Supervising Member

8/12/93
DATE


~~XXXXXXXXXXXX~~
Assistant Attorney General
SUSAN C. WALKER

8/12/93
DATE

**CONSENT AGREEMENT
BETWEEN
BRIAN F. GRIFFIN, M.D.
AND
THE STATE MEDICAL BOARD OF OHIO**

This CONSENT AGREEMENT is entered into by and between BRIAN F. GRIFFIN, M.D. and THE STATE MEDICAL BOARD OF OHIO, a state agency charged with enforcing Chapter 4731., Ohio Revised Code.

BRIAN F. GRIFFIN, M.D. enters into this Agreement being fully informed of his rights under Chapter 119., Ohio Revised Code, including the right to representation by counsel and the right to a formal adjudicative hearing on the issues considered herein.

This CONSENT AGREEMENT is entered into on the basis of the following stipulations, admissions and understandings:

- A. THE STATE MEDICAL BOARD OF OHIO is empowered by Section 4731.22(B), Ohio Revised Code, to limit, revoke, suspend a certificate, refuse to register or reinstate an applicant, or reprimand or place on probation the holder of a certificate for violations of Sections 4731.22(B)(10) and (B)(26) of the Ohio Revised Code.
- B. THE STATE MEDICAL BOARD OF OHIO enters into this CONSENT AGREEMENT in lieu of formal proceedings based upon the violations of Sections 4731.22(B)(10) and (B)(26) of the Ohio Revised Code, and expressly reserves the right to institute formal proceedings based upon any other violations of Chapter 4731. of the Revised Code, whether occurring before or after the effective date of this Agreement.
- C. BRIAN F. GRIFFIN, M.D. is licensed to practice medicine and surgery in the State of Ohio.
- D. DOCTOR GRIFFIN ADMITS that on February 3, 1992, he was admitted to Harding Hospital for in-patient treatment due to "inappropriate use of controlled substances in the context of a chronic pain syndrome." DOCTOR GRIFFIN was discharged on February 14, 1992, with a discharge diagnosis of opiate and benzodiazepine dependence.

DOCTOR GRIFFIN further ADMITS that from May 11, 1992, through September 23, 1992, he self-prescribed Soma and Lortab, specific instances of which led to your being subsequently arrested in Franklin and Hamilton County and charged with Deception to Obtain Dangerous Drugs.

On October 2, 1992, DOCTOR GRIFFIN was admitted to Saint Vincent Charity Hospital for further inpatient treatment. DOCTOR GRIFFIN was discharged on October 15, 1992, with a diagnosis of narcotic dependence and benzodiazepine abuse in remission.

- E. DOCTOR GRIFFIN knowingly and voluntarily ADMITS that on or about January 29, 1993, he pleaded guilty by way of information to Deception to Obtain a Dangerous Drug in violation of Section 2925.22 of the Ohio Revised Code, in the Hamilton County Court of Common Pleas in Case Number B-929224, and was granted Treatment in Lieu of Conviction pursuant to Section 2951.041 of the Ohio Revised Code.
- F. DOCTOR GRIFFIN knowingly and voluntarily ADMITS that on or about March 17, 1993, he pleaded guilty to ~~five~~ ^{one} count of Deception to Obtain a Dangerous Drug in violation of Section 2925.22 of the Ohio Revised Code, in the Franklin County Court of Common Pleas in Case Number 92CR-12-6517, and was granted Treatment in Lieu of Conviction pursuant to Section 2951.041 of the Ohio Revised Code.
- G. DOCTOR GRIFFIN further ADMITS that the judicial findings of eligibility for Treatment in Lieu of Conviction of violations of Section 2925.22 of the Ohio Revised Code as mentioned in paragraphs (D.), (E.) and (F.) above, and the acts, conduct, and/or omissions underlying the above-mentioned judicial findings, constitute commission of acts that constitute a felony in this State, as set forth in Section 4731.22(B)(10) of the Ohio Revised Code.
- H. DOCTOR GRIFFIN further ADMITS that the judicial findings of eligibility for Treatment in Lieu of Conviction of violations of Section 2925.22 of the Ohio Revised Code as mentioned in paragraphs (D.), (E.) and (F.) above, and the acts, conduct, and/or admissions underlying the above-mentioned judicial findings,

constitute "impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice," as that clause is used in Section 4731.22(B)(26) of the Ohio Revised Code.

- I. DOCTOR GRIFFIN has been in compliance with his court ordered period of rehabilitation including aftercare.
- J. DOCTOR GRIFFIN'S certificate to practice medicine and surgery in the State of Ohio was immediately suspended pursuant to Section 3719.121(C) of the Ohio Revised Code on July 14, 1993.
- K. DOCTOR GRIFFIN UNDERSTANDS that the STATE MEDICAL BOARD expressly reserves the right to institute formal proceedings based upon any violations of Chapter 4731. of the Ohio Revised Code, whether occurring before or after the effective date of this CONSENT AGREEMENT.

Wherefore, in consideration of the foregoing and mutual promises hereinafter set forth, and in lieu of any formal proceedings at this time, BRIAN F. GRIFFIN, M.D. knowingly and voluntarily agrees with THE STATE MEDICAL BOARD OF OHIO, (hereinafter BOARD), to the following:

- 1. Pursuant to the authority granted by the BOARD at its July 15, 1993, meeting, the suspension of DOCTOR GRIFFIN'S certificate to practice medicine and surgery in the State of Ohio pursuant to Section 3719.121 of the Ohio Revised Code is stayed effective upon the last date of signature below through August 12, 1993;
- 2. DOCTOR GRIFFIN'S certificate to practice medicine and surgery in the State of Ohio shall be subject to the following PROBATIONARY terms, conditions and limitations:
 - a. DOCTOR GRIFFIN shall obey all federal, state and local laws, and all rules governing the practice of medicine in Ohio, and all terms of probation imposed by the Court in criminal case numbers B-929224 and 92CR-12-6517;
 - b. DOCTOR GRIFFIN is permitted to retain his United States Drug Enforcement Administration Certificate. However, use of this Certificate shall be expressly limited to

inpatient hospitalization use. For purposes of this CONSENT AGREEMENT, inpatient hospitalization use will apply to patients entering the Emergency Room setting prior to hospital admittance. Further, DOCTOR GRIFFIN shall not be permitted to personally dispense or administer any controlled substances;

- c. DOCTOR GRIFFIN shall keep a log of all controlled substances prescribed for inpatient hospitalization use or legally authorized by DOCTOR GRIFFIN to be dispensed or administered by another for inpatient hospitalization use. Such log shall be submitted in the format approved by the BOARD thirty (30) days prior to DOCTOR GRIFFIN'S personal appearance before the BOARD or its designated representative, or as otherwise directed by the BOARD;
- d. DOCTOR GRIFFIN shall abstain completely from the personal use or possession of drugs, except those prescribed, dispensed or administered to him by another so authorized by law who has full knowledge of DOCTOR GRIFFIN's history of chemical dependency;
- e. DOCTOR GRIFFIN shall abstain completely from the use of alcohol;
- f. DOCTOR GRIFFIN shall submit to random urine screenings for drugs and alcohol on a weekly basis or as otherwise directed by the BOARD. DOCTOR GRIFFIN shall ensure that all screening reports are forwarded directly to the BOARD on a quarterly basis. The drug testing panel utilized must be acceptable to the Secretary of the Board;
- g. The BOARD retains the right to require, and DOCTOR GRIFFIN agrees to submit, blood or urine specimens for analysis upon request and without prior notice;
- h. DOCTOR GRIFFIN shall undertake and maintain participation in an alcohol and drug rehabilitation program, such as A.A., N.A., or Caduceus, approved in advance by the BOARD specifically for DOCTOR GRIFFIN, no less than three (3) times per week. Substitution of any

specific program must receive prior BOARD approval. At his appearances before the BOARD or its designated representative, DOCTOR GRIFFIN shall submit acceptable documentary evidence of continuing compliance with this program;

- i. DOCTOR GRIFFIN shall maintain continued compliance with the terms of the aftercare contract entered into with his treatment provider, provided, that where terms of the aftercare contract conflict with terms of this Agreement, the terms of this Agreement shall control;
- j. DOCTOR GRIFFIN shall provide continuing authorization, through appropriate written consent forms, for disclosure by his treatment provider to the BOARD, to treating and monitoring physicians, and to others involved in the monitoring process, of information necessary for them to fulfill their respective duties and obligations; and
- k. DOCTOR GRIFFIN shall provide a copy of this CONSENT AGREEMENT to all employers or entities with which he contracts to provide physician services or receive training; and the Chief of Staff at each hospital where he has, applies for, or obtains privileges or appointments.

The above described terms, limitations and conditions may be amended or terminated in writing at any time upon the agreement of both parties. However, this Agreement shall remain in force through the August 12, 1993 meeting of the STATE MEDICAL BOARD OF OHIO.

If, in the discretion of the Secretary and Supervising Member of THE STATE MEDICAL BOARD OF OHIO, DOCTOR GRIFFIN appears to have violated or breached any terms or conditions of this Agreement, THE STATE MEDICAL BOARD OF OHIO reserves the right to institute formal disciplinary proceedings for any and all possible violations or breaches, including but not limited to, alleged violations of the laws of Ohio occurring before the effective date of this Agreement.

Consent Agreement Between
Brian F. Griffin, M.D. and
The State Medical Board of Ohio
Page 6

DOCTOR GRIFFIN acknowledges that he has had an opportunity to ask questions concerning the terms of this Agreement and that all questions asked have been answered in a satisfactory manner.

Any action initiated by the BOARD based on alleged violations of this CONSENT AGREEMENT shall comply with the Administrative Procedure Act, Chapter 119., Ohio Revised Code.

DOCTOR GRIFFIN hereby releases THE STATE MEDICAL BOARD OF OHIO, its members, employees, agents, officers and representatives jointly and severally from any and all liability arising from the within matter.

This CONSENT AGREEMENT shall be considered a public record as that term is used in Section 149.43, Ohio Revised Code.

Further, this information may be reported to appropriate organizations, data banks and governmental bodies.


BRIAN F. GRIFFIN, M.D.
7/16/93
DATE


CARLA S. O'DAY, M.D. *TAD per phone authorization*
Secretary
7/16/93
DATE


RAYMOND J. ALBERT *TAD per phone authorization*
Supervising Member
7/16/93
DATE


SUSAN C. WALKER, ESQ. *TAD per phone authorization*
Assistant Attorney General
7/16/93
DATE



STATE MEDICAL BOARD OF OHIO

77 South High Street, 17th Floor • Columbus, Ohio 43266-0315 • (614) 466-3934

NOTICE OF IMMEDIATE SUSPENSION AND OPPORTUNITY FOR HEARING

July 14, 1993

Brian F. Griffin, M.D.
712 Weston Park Drive
Powell, OH 43065

Dear Doctor Griffin:

In accordance with Sections 2929.17 and 4731.223(B), Ohio Revised Code, the Office of the Prosecuting Attorney of Hamilton County, Ohio reported that on or about January 29, 1993, the Hamilton County Court of Common Pleas found you Eligible for Treatment in Lieu of Conviction for violations of Section 2925.22, Deception to Obtain a Dangerous Drug, pursuant to Section 2951.041 of the Ohio Revised Code.

Further, in accordance with Sections 2929.17 and 4731.223(B), Ohio Revised Code, the Office of the Prosecuting Attorney of Franklin County, Ohio, reported that on or about March 17, 1993, the Franklin County Court of Common Pleas found you Eligible for Treatment in Lieu of Conviction for violations of Section 2925.22, Deception to Obtain a Dangerous Drug, pursuant to Section 2951.041 of the Ohio Revised Code.

Therefore, pursuant to Section 3719.121(C), Ohio Revised Code, you are hereby notified that your license to practice medicine and surgery in the State of Ohio is immediately suspended. Continued practice after this suspension shall be considered practicing medicine without a certificate in violation of Section 4731.41, Ohio Revised Code.

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

- (1) On or about January 29, 1993, in the Hamilton County Court of Common Pleas, you pleaded guilty to Deception to Obtain a Dangerous Drug in violation of Section 2925.22 of the Ohio Revised Code, and were granted Treatment in Lieu of Conviction pursuant to Section 2951.041, Ohio Revised Code.

Mailed 7/15/93

July 14, 1993

Moreover, in order to grant your request for Treatment in Lieu of Conviction, the Court was required by statute to find that your "drug dependence was a factor leading to the criminal activity with which (you were) charged, and rehabilitation through treatment would substantially reduce the likelihood of additional criminal activity."

- (2) On or about March 17, 1993, you pleaded guilty to one (1) count of Deception to Obtain a Dangerous Drug in violation of Section 2925.22 of the Ohio Revised Code, in the Franklin County Court of Common Pleas, and were granted Treatment in Lieu of Conviction pursuant to Section 2951.041 of the Ohio Revised Code.

Moreover, in order to grant your request for Treatment in Lieu of Conviction, the Court was required by statute to find that your "drug dependence was a factor leading to the criminal activity with which he is charged, and rehabilitation through treatment would substantially reduce the likelihood of additional criminal activity."

This judicial finding of Eligibility for Treatment in Lieu of Conviction of a violation of Deception to Obtain a Dangerous Drug pursuant to Section 2925.22 of the Ohio Revised Code, and the acts, conduct, and/or omissions underlying this finding as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "commission of an act that constitutes a felony in this state regardless of the jurisdiction in which the act was committed," as that clause is used in Section 4731.22(B)(10), Ohio Revised Code, to wit: Section 2925.22, Ohio Revised Code.

The judicial finding of Eligibility for Treatment in Lieu of Conviction of a violation of Deception to Obtain a Dangerous Drug in violation of Section 2925.22 of the Ohio Revised Code, and the acts, conduct, and/or omissions underlying this finding as alleged in paragraphs (1) and (2) above, individually and/or collectively, constitute "impairment of ability to practice according to acceptable and prevailing standards of care because of habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability to practice," as that clause is used in Section 4731.22(B)(26), 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 (30) days of the time of mailing of this notice.

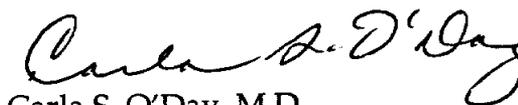
You are further advised that you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence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

July 14, 1993

In the event that there is no request for such hearing received within thirty (30) 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, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand or place you on probation.

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Carla S. O'Day, M.D.
Secretary

CSO;jmb

Enclosures:

CERTIFIED MAIL # 348 885 323
RETURN RECEIPT REQUESTED