STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF MEDICINE
DISCIPLINARY SUBCOMITTEE

In the Matter of

MAMOUN DABBAGH, M.D.
License No. 43-01-045473
_____/

Complaint No. 43-14-133183
(Consolidated with File Nos.
43-14-132958 and 43-14-132961

ADMINISTRATIVE COMPLAINT

Attorney General Bill Schuette, through Assistant Attorney General Bruce C. Johnson, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this complaint against Mamoun Dabbagh, M.D. (Respondent), alleging upon information and belief:

1. The Board of Medicine, an administrative agency established by the Public Health Code, 1978 PA 368 as amended, MCL 333.1101 *et seq.*, is empowered to discipline licensees under the Code through its Disciplinary Subcommittee (DSC).

2. Respondent is licensed to practice medicine under Article 15 of the Code. At all times relevant to this Administrative Complaint, Respondent practiced psychiatry in Warren, Michigan, although he is not board-certified as a psychiatrist.

3. Respondent has surrendered his federal Drug Enforcement Administration registration, making his controlled substance license invalid, but he nevertheless appears not to have stopped prescribing controlled substances.

4. Respondent has forfeited thousands of dollars' worth of personal property to the United States Government because of his illegal controlled substance prescription practices.

5. As detailed below, Respondent has prescribed large quantities of controlled substances to patients whom he has not properly examined or diagnosed before writing the prescriptions.

6. Sections 3(a), 3(m), and 4(f) of the Michigan Medical Marihuana Act, 2008 IL 1 as amended, MCL 333.26421 *et seq.*, authorize a physician to issue a certification for the medical use of marihuana to a bona fide patient of the physician if after a review of the patient's relevant medical records, a full assessment of the patient's medical history and current medical condition, and an examination of the patient, the physician determines that the patient determines that in the physician's professional opinion, it is likely that the patient will receive therapeutic or palliative benefits from using marihuana medically to treat or alleviate a debilitating medical condition or symptoms associated with it.

7. Section 16221(a) of the Code authorizes the DSC to discipline licensees for "violation of a general duty, consisting of negligence or failure to exercise due care, including negligent delegation to, or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice the health profession."

8. Respondent was previously sanctioned for violating section 16221(a) of the Code psychotropic medications prescription practices, in a consent order and stipulation entered by the DSC in Case No. 43-05-098712 on May 26, 2010.

9. Section 16221(b)(i) of the Code authorizes the DSC to discipline licensees for incompetence, defined in section 16106 of the Code as "a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs."

10. Section 16221(b)(vi) of the Code authorizes the DSC to discipline licensees for lack of good moral character, defined as "the propensity on the part of the person to serve the public in the licensed area in a fair, honest, and open manner."

11. Section 16221(c)(iv) of the Code authorizes the DSC to discipline licensees for obtaining, possessing or attempting to obtain or possess a controlled substance as defined in section 7104 of the Code, or a drug as defined in section 7105 of the Code, or selling, prescribing, giving away or administering drugs for other than lawful diagnostic or therapeutic purposes.

12. Section 16221(e)(iii) of the Code authorizes the DSC to discipline licensees for promoting an unnecessary drug, device, treatment, procedure or service for personal gain.

13. Section 16226 of the Code authorizes the DSC to impose sanctions against a person's license by the Board, if after opportunity for a hearing, the DSC

determines that a licensee violated one or more of the subdivisions contained in Section 16221 of the Code.

14. Section 16233(5) of the Code provides for the summary suspension of a license, reading in pertinent part, as follows:

> After consultation with the chair of the appropriate board or task force or his or her designee, the department may summarily suspend a license or registration if the public health, safety, or welfare requires emergency action in accordance with section 92 of the administrative procedures act of 1969, being section 24.292 of the Michigan Compiled Laws.

FACTUAL ALLEGATIONS

Medications

15. Adderall is a Schedule II controlled substance used to treat attention deficit hyperactivity disorder. It has at least some potential for leading to addiction.

16. Latuda (lurasidone) is an atypical antipsychotic medication used to treat schizophrenia and, since July 2013, bipolar 1 disorder.

17. Lamictal (lamotrigine) is an anticonvulsant medication used to treat epilepsy and bipolar disorder.

18. Zanaflex (tizanidine) is an antispasmodic medication used as a muscle relaxant and as a sleep aid.

19. Dextroamphetamine is a central nervous system stimulant used to treat attention deficit hyperactivity disorder and narcolepsy. It is contraindicated for people with a history of drug abuse, severe agitation or anxiety, or heart disease.

20. Concerta (methylphenidate) is a Schedule II controlled substance used to treat attention deficit hyperactivity disorder.

21. Ritalin (methylphenidate) is a central nervous system stimulant used to treat attention deficit hyperactivity disorder and narcolepsy. It is a Schedule II controlled substance.

22. Dexedrine (dextroamphetamine) is a central nervous system stimulant used to treat attention deficit hyperactivity disorder and narcolepsy. It is a Schedule II controlled substance.

23. Klonopin (clonazepam) is a benzodiazepine tranquilizer used to treat seizures, panic disorder, and akathisia. Its side effects can include agitation, increased risk of suicide, and tolerance and dependence.

24. Seroquel (quetiapine) is an atypical antipsychotic medication used to treat schizophrenia, bipolar disorder and, in combination with other medications, major depressive disorder.

25. Remeron (mirtazapine) is a medication used to treat depression.

26. Medrol (methylprednisolone) is a corticosteroid drug used as an anti-inflammatory medication.

27. Naprosine (naproxen) is a nonsteroidal anti-inflammatory drug used for relief of pain, fever, swelling, and stiffness.

28. Baclofen (lioresal) is a central nervous system depressant used as a skeletal muscle relaxant.

29. Soma (carisoprodol) is a Schedule IV controlled substance used as a muscle relaxant. It has a high potential for causing dependence and is subject to widespread recreational misuse. Because of its euphoric and sedative effects, which

are increased when it is taken together with opiates, users frequently take overdoses of it.

30. Catapres (clonidine) is a medication used to treat, among other conditions, attention deficit hyperactivity disorder and anxiety disorders.

31. Neurontin (gabapentin) is a medication used for a variety of purposes, including treatment of anxiety disorders, insomnia, and bipolar disorder.

32. Xanax (alprazolam) is a Schedule IV controlled substance used to treat anxiety disorders and panic disorder. It is a benzodiazepine.

33. Valium (diazepam) is a Schedule IV controlled substance used to treat anxiety, among other conditions. It is a Schedule IV controlled substance.

34. Vyvanse (lisdexafetamine) is a Schedule II controlled substance used to treat attention deficit hyperactivity disorder, among other conditions.

35. Promethazine with codeine is an opioid Schedule V controlled substance used to treat cold symptoms and to suppress coughs. It has weak antipsychotic and strong sedative effects.

36. Methadone is an opioid used to treat pain and to assist in detoxification of patients who are opioid dependent. It is a Schedule II controlled substance.

37. Vicodin (Hydrocodone/APAP) is an opioid analgesic which is a Schedule II controlled substance used to treat moderate to severe pain.

M.W.

38. Respondent provided psychiatric treatment for M.W. (initials used to protect patient confidentiality), a male, born in 1979 and now deceased, from January 25, 2010 until December 3, 2012. On December 6, 2012, M.W. died from acute intoxication from the combined effects of multiple prescription medications that Respondent prescribed for him.

39. M.W. had a history of substance abuse before he first saw Respondent. He had had brain surgery and was subject to frequent seizures, placing him at increased risk from any negligent prescription practices.

40. Respondent performed an initial psychiatric diagnostic assessment of M.W. on March 8, 2010. He diagnosed M.W. as suffering from (1) generalized anxiety disorder; (2) attention deficit hyperactivity disorder, combined type; (3) bipolar disorder 1, most recent episode mixed, unspecified; and (4) psychotic disorder, not otherwise specified.

41. The initial psychiatric assessment Respondent performed for M.W. lacks a comprehensive assessment of M.W.'s past and current symptoms and signs, of his substance abuse history and his treatment for it, of his family's health and mental health history, or of a comprehensive mental status examination.

42. Respondent failed to provide data to document his diagnosis that M.W. suffered from attention deficit hyperactivity disorder.

43. During the course of his treatment of M.W., Respondent prescribed Adderall, Methadone, Neurontin, Naprasine, Lamictal, Xanax, Klonopin, Latuda, Baclofen, Dextroamphetamine and Cantapres for him.

44. While being treated by Respondent, M.W. was receiving prescriptions for Hydrocodone/APAP from another practitioner.

45. Despite M.W.'s history of substance abuse, Respondent failed to perform drug screens or order laboratory tests to determine how M.W.'s liver and kidney were functioning, and what other drugs, if any, were in his system. Respondent did not at any time obtain MAPS reports on M.W.

46. Respondent failed to order subsequent random drug screens while M.W. was taking the prescribed medications to verify that he was taking and not diverting them, and that he was not taking other illicit or non-prescribed controlled substances.

47. Respondent failed to prepare a comprehensive treatment plan for M.W.'s pain management with goals to target, or document progress resulting from the treatment.

48. Respondent prescribed Klonopin, Xanax, Adderall, Dextroamphetamine and Methadone, all contraindicated for someone with M.W.'s history of substance abuse, without adequately documenting the rationale for the prescriptions, or of discussing the risks posed by the prescriptions with M.W.

49. Despite prescribing medication to treat M.W.'s pain, Respondent failed to perform or order a physical examination for him or referr him to a pain specialist.

50. Respondent, by combining prescription of benzodiazepines – Xanax and Klonopin – with a prescription for Methadone, an opioid narcotic, placed M.W. at increased risk of respiratory suppression and death. The risk posed by this combination of medications was further increased by the fact that M.W. was simultaneously receiving prescriptions for Hydrocodone/APAP, which is also an opioid narcotic, from another practitioner.

51. On December 3, 2012, three days before M.W. died from acute intoxication from the combined effects of multiple prescription medications, Respondent documented prescribing the following medications for M.W.:

- Adderall 20 mg tablets twice a day (prescription for 60 tablets);
- Methadone Concentrate 10 mg tablets four times a day (120 tablets);
- Neurontin 400 mg tablets three times a day (90 tablets);
- Xanax 1 mg tablets four times a day (120 tablets);
- Latuda 80 mg tablets in the morning and before bed (60 tablets);
- Baclofen 10 mg tablets three times a day (90 tablets); and
- Catapres .1 mg tablet twice a day (60 tablets).

M.S.

52. Respondent provided psychiatric treatment for M.S., a male, born in 1995, from at least November 7, 2013 through at least July 16, 2014.

53. Respondent diagnosed M.S. as having generalized anxiety disorder, attention deficit disorder, and attention deficit hyperactivity disorder.

54. In diagnosing M.S. as having attention deficit disorder, Respondent did not document having made the type of assessment required to support this diagnosis. Specifically, Respondent did not document any of the following:

- An assessment of M.S.'s school performance as a child;
- A detailed review of issues with attention and concentration in M.S.'s present life;
- Collateral information such as a parent's input regarding school and home performance and behavior;
- Use of a standard assessment form, such as the ADHD Self-Report Scale (ASRS) Symptom Checklist; or
- Referral to a psychologist for specific testing for ADD.

55. Respondent failed to document preparing a treatment plan for M.S.'s ADD, or provide targets for changes in his behavior resulting from his treatment.

56. Respondent prescribed the following medications for M.S.: Adderall, Xanax, Zanaflex, Seroquel, Medrol, Lamictal, and Promethazine with codeine.

57. Respondent failed to order baseline lab work before prescribing these medications, so as to determine how M.S.'s liver and kidney were functioning, and what other drugs, if any, were in his system.

58. Respondent failed to order subsequent random drug screens while M.S. was taking the prescribed medications to verify that he was taking and not diverting them, and that he was not taking other illicit or non-prescribed controlled substances.

59. Given that there is no documentation of M.S. being diagnosed as suffering from seizures or from bipolar disorder, Respondent failed to document a justification for prescribing Lamictal for him.

60. Given that there is no documentation of M.S. having been diagnosed as psychotic, and that he was taking other prescribed medications to treat anxiety and sleep disorders, Respondent failed to document a justification for prescribing Seroquel for him.

61. Respondent failed to perform or order a physical examination for M.S.

62. Given the lack of a physical examination to diagnose M.S. as suffering from a cold or a cough, Respondent failed to document a justification for prescribing Promethazine with codeine for him.

63. Given the lack of a physical examination to diagnose M.S. as having an inflammatory condition, Respondent failed to document a justification for prescribing Medrol for him.

J.H.

64. Respondent provided psychiatric treatment for J.H., a female, born in 1963 and now deceased, from August 24, 2009 through December 3, 2012. A few days after her last appointment with Respondent, J.H. died from acute intoxication by combined effects of multiple prescription medications prescribed for her by Respondent.

65. Respondent performed an initial evaluation of J.H. on August 24, 2009. His notes for this evaluation are scanty and difficult to read. They appear to

include diagnoses of bipolar disorder, attention deficit disorder, kidney problems, and two other conditions, the notes for which are completely indiscernible.

66. Respondent failed to perform an evaluation of J.H. sufficient for correct diagnosis of her symptoms. The initial evaluation lacks information regarding:

- current and past symptoms and signs;
- family history;
- prior physical and psychiatric history;
- substance use history;
- current medical problems;
- current medications;
- medication allergies; or
- performance of a mental status exam.

67. Respondent failed to perform or refer J.H. for physical examinations indicated by her condition. For example, although he noted that she suffered from renal failure, he never ordered or obtained labs assessing her renal function.

68. Respondent's documentation of his therapy sessions with J.H. is unsatisfactory or, in some cases, virtually non-existent. For example, Respondent documented monthly medication reviews for J.H. for most months from April 19, 2010 through December 3, 2012. For each medication review, he completed a medication review form. The form has spaces for noting diagnoses; signs and symptoms; prescribed medications; the patient's general condition; how soon the patient should return; and general notes. Respondent failed to complete the forms

for August 23, 2010, April 27, 2011, and October 7, 2011 except for providing his signature, the date, and a circled billing code. He also failed to complete the forms for September 22, 2010 and October 20, 2010 medication reviews, except for providing his signature and the date and a circled billing code, and indicating the time of the next appointment.

69. The progress notes that Respondent provided for J.H. are lengthy and detailed, but they are self-contradictory and fail to make coherent sense. They are from boilerplate forms, rather than an individualized description of J.H., suggesting that Respondent did not actually prepare progress notes based upon actual examination of J.H. Specifically, the progress note for J.H. for November 7, 2011 has a lengthy description of her mental status identical, almost word-for-word, to that in progress notes for M.W. for September 21, 2011, October 19, 2011, and November 16, 2011. The November 7 progress note for J.H. uses the masculine pronouns "he" and "his" ten times to refer to J.H.

70. The November 7, 2011 progress note for J.H. begins by indicating she "continues to be inattentive" and provides details as to her inattention. Most of this progress note is identical word-for-word with the November 16, 2011 progress note he wrote for a different patient, M.W.

71. After stating that J.H. is "inattentive," the November 7, 2011 progress note contradicts this diagnoses by stating, in the section on her mental status, that she is "calm," "attentive," and "relaxed." It states "there are no signs of anxiety" and "there are no signs of hyperactive or attentional difficulties," but also states

that "he [sic] is excited." It describes her affect as "appropriate." And after denying that J.H. suffers from anxiety, hyperactivity, or problems with affect, the report then diagnoses J.H. as suffering from active generalized anxiety disorder, attention deficit hyperactive disorder, inattentive type, and major depressive disorder.

72. In addition, the April 18, 2012 progress note for J.H. states that there are "no signs of depression," but then indicates a diagnosis of active major depressive disorder. Both it and the March 20, 2012 progress note use masculine pronouns to refer to J.H.

73. During the course of treatment, Respondent prescribed the following medications for J.H.: Xanax, Adderall, Vicodin, Methadone, Klonopin, Seroquel, Vyvanse, Remeron, Valium, and Soma. During the course of her treatment by Respondent, J.H. was also receiving prescriptions for controlled substances from other practitioners.

74. Respondent failed to perform drug screens or order laboratory tests to determine how J.H.'s liver or kidneys or thyroid were functioning, or what other drugs, if any, were in her system. The failure to assess her kidney functions are particularly troubling, given the diagnosis of her as suffering from kidney problems.

75. Respondent failed to order subsequent random drug screens while J.H. was taking the prescribed medications to verify that she was taking and not diverting them, and that she was not taking other illicit or non-prescribed controlled substances.

76. Respondent failed to prepare a comprehensive treatment plan for J.H.'s pain management with goals to target, nor did he document progress resulting from the treatment.

77. Respondent failed to obtain informed consent from J.H. for her treatment or enter an agreement with her regarding it.

78. Despite prescribing medication to treat J.H.'s pain, Respondent failed to perform or order a physical examination for her or refer her to a pain specialist.

79. Respondent, by combining prescription of benzodiazepines – Xanax and Klonopin – with a prescription for Vicodin and Methadone, which are opioid narcotics, placed J.H. at increased risk of respiratory suppression and death.

80. Respondent violated the standard of care by simultaneously prescribing more than one medication from a single class – for example, Xanax and Valium and Klonopin, as well as Vicodin and Methadone – for J.H. The prescription of these medications for a person suffering from major depression or bipolar disorder, both of which Respondent diagnosed J.H. as suffering from, also violated the standard of care.

81. J.H. died sometime between December 5 and December 8, 2012; the precise time and date of her death is unknown. Her amended death certificate attributes the cause of her death (pending further studies) to acute intoxication from the combined effects of cocaine and multiple prescription medications. On December 3, 2012, a few days before her death, Respondent documented prescribing the following medications for J.H.:

- Vicodin four times a day (120 tablets);
- Soma 350 mg tablets four times a day (120 tablets);
- Valium 10 mg tablets four times a day (120 tablets);
- 2 Methadone Concentrate 10 mg tablets twice a day (120 tablets; and
- Adderall 30 mg tablets three times a day.

Fraudulent Medical Marijuana Certification

82. At a medical marijuana clinic conducted in Rosewater, Michigan on February 4, 2016, Respondent examined an undercover police agent. The only symptom that the undercover agent reported to Respondent was a sore shoulder. Respondent nevertheless noted that the agent suffered from a "sore shoulder consistent with M.S.," although the agent gave Respondent no indication that the agent suffered from multiple sclerosis. In exchange for a payment of one hundred and fifty dollars, Respondent issued the agent a medical marijuana certification card.

Respondent's Controlled Substance and Stimulant Prescription Practices and Respondent's Prescriptions Following Surrender of His DEA Registration

83. Three of the five most diverted and abused controlled substances are Hydrocodone/APAP; Carisoprodol; and Alprazolam.

84. A study of MAPS report for Respondent from the period between January 1, 2014 and February 10, 2016 compared the number of times he prescribed the five most commonly diverted and abused controlled substances listed above with the number of times these medications were prescribed during the same

period by four other psychiatrists who also practice in Warren, Michigan, as indicated by MAPS reports for these psychiatrists. It also compared the number of times Respondent prescribed stimulant medications such as the Schedule II controlled substances Adderall, Adderall XR, Vyvanse, Concerta, Ritalin, Dexedrine and their generic equivalents with the number of times they were prescribed by the other psychiatrists during the same period.

85. The MAPS reports indicate that Respondent wrote a total of 31,085 prescriptions during the relevant period. The number written by the other four psychiatrists were, respectively 16,258; 12,318; 2,267; and 959.

86. The MAPS reports indicate that Respondent wrote 6,835 prescriptions for Alprazolam during the relevant period. The number of times it was prescribed by the other four psychiatrists were, respectively, 1,866; 1,305; 133; and 11. The prescriptions for this medication comprised 22% of the total number of prescriptions written by Respondent during the relevant period, compared with, respectively, 11%, 10%, 6%, and 1% for the other four psychiatrists.

87. Respondent wrote 175 prescriptions for Hydrocodone/APAP during the relevant period, compared with, respectively, 37, 36, 35 and 2 prescriptions written by the other four psychiatrists.

88. Respondent wrote 44 prescriptions for Carisoprodol during the relevant period, compared with 2, 2, 0, and 0, respectively, by the other four psychiatrists.

89. Respondent wrote 11,966 prescriptions for the stimulants referenced above during the relevant period, comprising 38% of his total prescriptions. The number of times they were prescribed by the other four psychiatrists were 1,998; 757; 75; and 68 – respectively, 12%, 8%, 6%, and 3% of their respective prescriptions.

90. These totals indicate a significant disparity between the prescription practices for the most commonly diverted and abused medications and for stimulants with the four other psychiatrists in Warren, Michigan with whom his prescription practices were compared. This disparity is particularly significant given the much shorter period during the relevant period during which Respondent was legally authorized to prescribe them, and suggest that Respondent significantly overprescribed the most commonly abused and diverted medications and stimulants during the relevant period.

91. Respondent's MAPS report includes his having written 114 prescriptions after the surrender of his DEA registration on April 6, 2015.

COUNT I

92. Respondent's conduct as described above constitutes negligence, in violation of section 16221(a) of the Code.

COUNT II

93. Respondent's conduct as described above constitutes incompetence, in violation of section 16221(b)(i) of the Code.

COUNT III

94. Respondent's conduct as described above constitutes lack of good moral character, in violation of section 16221(b)(vi) of the Code.

COUNT IV

95. Respondent's conduct as described above constitutes possessing drugs for other than lawful diagnostic or therapeutic purposes, in violation of section 16221(c)(iv) of the Code.

COUNT V

96. Respondent's conduct as described above constitutes promoting an unnecessary drug, device, treatment, procedure or service for personal gain, in violation of section 16221(e)(iii) of the Code.

THEREFORE, Complainant requests that this complaint be served upon Respondent and that he be offered an opportunity to show compliance with all lawful requirements for retention of aforesaid license. If compliance is not shown, Complainant further requests that formal proceedings be commenced pursuant to the Public Health Code, rules promulgated pursuant to it, and the Administrative Procedures Act of 1969, 1969 PA 306, as amended; MCL 24.201 *et seq.*

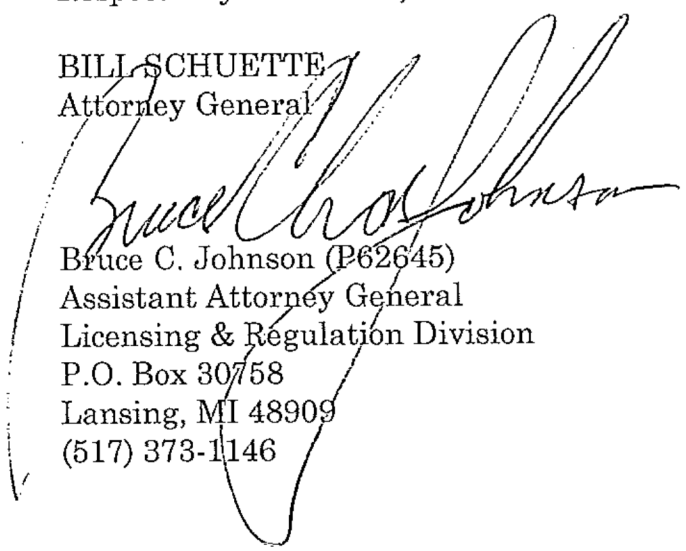
FURTHER, Complainant requests that pending the hearing and final determination, Respondent's license to practice as a physician in the State of Michigan continue to be summarily suspended pursuant to section 92 of the Administrative Procedures Act and section 16233(5) of the Public Health Code for the reason that, based upon the allegations set forth herein, to permit Respondent

to continue to practice the profession constitutes a danger to the public health, safety and welfare requiring emergency action.

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(8) of the Public Health Code, Respondent has 30 days from receipt of this complaint to submit a written response to the allegations contained in it. The written response shall be submitted to the Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, Michigan 48909, with a copy to the undersigned assistant attorney general. Further, pursuant to section 16231(9), failure to submit a written response within 30 days shall be treated as an admission of the allegations contained in the complaint and shall result in transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

Respectfully Submitted,

BILL SCHUETTE
Attorney General



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