STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF OSTEOPATHIC MEDICINE AND SURGERY
DISCIPLINARY SUBCOMMITTEE

In the Matter of

BENS JEAN-GERALD SANDAIRE, D.O.
License No. 51-01-011931

Complaint No. 51-18-149861
(Consolidated with No. 51-20-002315)

_____/

CONSENT ORDER AND STIPULATION

CONSENT ORDER

A first superseding administrative complaint was filed with the Disciplinary Subcommittee of the Board of Osteopathic Medicine and Surgery on February 23, 2021, charging Bens Jean-Gerald Sandaire, D.O. (Respondent) with having violated sections 16221(a), (b)(i), (c)(iv), and (w) of the Public Health Code, MCL 333.1101 *et seq*.

The parties have stipulated that the Disciplinary Subcommittee may enter this consent order. The Disciplinary Subcommittee has reviewed the stipulation contained in this document and agrees that the public interest is best served by resolution of the outstanding complaint. Therefore, the Disciplinary Subcommittee finds that the allegations of fact contained in the complaint are true and that Respondent has violated sections 16221(a), (b)(i), (c)(iv), and (w) of the Public Health Code.

Accordingly, for these violations, IT IS ORDERED:

Respondent is placed on PROBATION for a minimum period of one (1) year not to exceed three (3) years, commencing on the effective date of this order. Respondent shall be automatically discharged from probation upon the Department's receipt of satisfactory written evidence of Respondent's successful compliance with the terms and conditions as provided below, provided compliance occurs within three (3) years. Reduction of the period of probation shall occur only while Respondent is employed as an osteopathic physician. If Respondent fails to complete any term or condition of probation as set forth in this order within three (3) years of the effective date of this order, Respondent will be in violation of Mich Admin Code, R 338.1632 and section 16221(h) of the Public Health Code. The terms and conditions of the probation are as follows:

A. MEETING WITH DESIGNATED PHYSICIAN REVIEWER. Respondent shall meet quarterly with a physician assigned by Affiliated Monitors, Inc. or other board-approved monitoring entity, or a physician reviewer pre-approved by the Board Chairperson or the Chairperson's designee, to review Respondent's professional practice, including at least 25 of Respondent's patient records, with a particular focus on documentation.

Within 30 days of the effective date of the order, Respondent shall contact the Department to obtain the contact information for Affiliated Monitors, Inc., or other board-approved monitoring entity, or request approval of a proposed physician reviewer. When requesting approval of a proposed physician reviewer, Respondent shall provide a copy of the proposed reviewer's curriculum vitae to the Department. Respondent shall provide a copy of this order and the complaint dated February 23, 2021, to the proposed reviewer before submitting a request for approval to the Department. Respondent shall not work in any capacity for which an osteopathic medicine and surgery license is required until Respondent receives written confirmation from the Department that an Affiliated Monitors physician, or other

approved entity, has been designated or the proposed monitor was approved.

The initial meeting shall occur at the end of the third month of probation, and subsequent meetings shall occur every 3 months thereafter until the end of the probationary period. Respondent shall be responsible for scheduling the time and place of the meetings with the designated physician reviewer. Respondent shall submit all requests required by this subsection to the Department by email to BPL-Monitoring@michigan.gov.

B. DESIGNATED PHYSICIAN REVIEWER CHANGE. If at any time during the period of probation, Affiliated Monitors, Inc., or other board-approved monitoring entity is unable to designate a suitable physician to review, or other pre-approved physician is unable to review, Respondent's professional practice, Respondent shall report this information in writing to the Department within 15 days of such change and request approval of another physician reviewer. Respondent shall submit the request for approval of the proposed physician reviewer to the Department by email to BPL-Monitoring@michigan.gov.

C. DESIGNATED PHYSICIAN REVIEWER REPORTS. Respondent's designated physician reviewer shall file reports on the form prescribed by the Department, advising of Respondent's work performance. If, at any time, Respondent fails to comply with minimal standards of acceptable and prevailing practice or appears unable to practice with reasonable skill and safety, his designated physician reviewer shall immediately notify the Department.

D. COMPLIANCE WITH THE PUBLIC HEALTH CODE. Respondent shall comply with all applicable provisions of the Public Health Code and rules promulgated under the Public Health Code.

E. CONTINUING EDUCATION CREDITS. Within 90 days of the effective date of this Order, Respondent shall successfully complete 5 hours of continuing education credits in the area of recordkeeping. These credit hours shall not count toward the number of credit hours required for license renewal. Respondent must seek and obtain advance approval of the continuing education courses from the Chairperson of the Board or the Chairperson's designee. Respondent shall submit

requests for approval of a course and proof of successful completion of a course to the Department by email to BPL-Monitoring@michigan.gov.

F. REPORT OF NON-EMPLOYMENT. If, at any time during the period of probation, Respondent is not employed as an osteopathic physician, he shall file a report of non-employment with the Department. Respondent shall file this report within 15 days after becoming unemployed. Respondent shall continue to file reports of non-employment on a quarterly basis until he returns to practice as an osteopathic physician. If Respondent subsequently returns to practice as an osteopathic physician, he shall notify the Department of this fact within 15 days after returning to practice.

G. REPORTING PROCEDURE. Unless otherwise provided above, all reports required by the terms of probation shall be filed on a quarterly basis, the first report to be filed at the end of the third month of probation, and subsequent reports every three months until Respondent is discharged from probation. In addition to receiving reports as required above, the Department or its authorized representative may periodically contact the reporting individuals or agencies to inquire of Respondent's progress. By accepting the terms of this consent order and stipulation, Respondent has authorized the release of all necessary records and information.

Any violation of the Public Health Code by Respondent during the period of probation shall be deemed a violation of probation and constitute grounds for further disciplinary action.

Respondent is FINED Ten Thousand and 00/100 Dollars ($10,000.00) to be paid by check, money order, or cashier's check made payable to the State of Michigan (with complaint number 51-18-149861 clearly indicated on the check or money order), and shall be payable within ninety (90) days of the effective date of this order. The timely payment of the fine shall be Respondent's responsibility. Respondent shall mail the fine to: Department of Licensing and Regulatory Affairs,

Bureau of Professional Licensing, Enforcement Division, Compliance Section, P.O. Box 30189, Lansing, Michigan 48909.

If Respondent fails to timely meet the probationary physician-reviewer requirement or continuing education requirement, or fail to timely pay the fine, his license shall be suspended a minimum of 1 day until successful completion of the probationary requirements or payment of fine. If Respondent's license remains suspended for more than six months, reinstatement of the license shall not be automatic, and Respondent will have to petition for reinstatement of the license. If Respondent petitions for reinstatement of his license, the petition shall be in accordance with sections 16245 and 16247 of the Public Health Code and Mich Admin Code, R 792.10711. Under these provisions, Respondent must demonstrate the following by clear and convincing evidence: (1) good moral character; (2) the ability to practice the profession with reasonable skill and safety; (3) satisfaction of the guidelines on reinstatement adopted by the Department; and (4) that it is in the public interest for the license to be reinstated.

Respondent shall direct all communications, except fines, required by the terms of this Order to: BPL-Monitoring@michigan.gov.

Respondent shall be responsible for all costs and expenses incurred in complying with the terms and conditions of this consent order.

Respondent shall be responsible for the timely compliance with the terms of this consent order, including the timely filing of any documentation. Failure to comply within the time limitations provided will constitute a violation of this order.

If Respondent violates any term or condition set forth in this order, Respondent will be in violation of Mich Admin Code, R 338.1632, and section 16221(h) of the Public Health Code.

This order shall be effective 30 days from the date signed by the Chairperson of the Disciplinary Subcommittee or the Disciplinary Subcommittee's authorized representative, as set forth below.

Signed on April 7, 2022

MICHIGAN BOARD OF OSTEOPATHIC MEDICINE AND SURGERY

By _____ for
Chairperson, Disciplinary Subcommittee

STIPULATION

The parties stipulate as follows:

1. The facts alleged in the complaint are true and constitute a violation of the Public Health Code.

2. Respondent understands and intends that, by signing this stipulation, he is waiving the right under the Public Health Code, rules promulgated under the Public Health Code, and the Administrative Procedures Act of 1969, MCL 24.201 *et seq.*, to require the Department to prove the charges set forth in the complaint by presentation of evidence and legal authority, and to present a defense to the charges before the Disciplinary Subcommittee or its authorized representative. Should the Disciplinary Subcommittee reject the proposed consent order, the parties reserve the right to proceed to hearing.

3. The Disciplinary Subcommittee may enter the above consent order, supported by Board conferee Jesse Guasco, D.O. Dr. Guasco or an attorney from the Licensing and Regulation Division may discuss this matter with the Disciplinary Subcommittee in order to recommend acceptance of this resolution.

4. Dr. Guasco and the parties considered the following factors in reaching this agreement:

> A. Respondent represents that his documentation deficiencies stemmed in part from working multiple locations, including a significantly understaffed facility, in an effort to care for an underserved community in Detroit that had an inadequate medical records system. Since the time of filing of this licensing case, Respondent has left employment from the facility at issue but remains employed in the profession and represents working at a non-profit, community-based, out-patient mental health clinic.

B. In 2021, Respondent completed a 39-hour intensive review program in medical record keeping and controlled substance prescribing at the Case Western Reserve Medical School in Cleveland, Ohio.

C. Respondent has been a licensed Doctor of Osteopathic Medicine since 1995 and has not been the subject of a licensing sanction prior to the instant matter.

By signing this stipulation, the parties confirm that they have read, understand, and agree with the terms of the consent order.

AGREED TO BY:

/s/ Aleksandrs K. Bomis
Aleksandrs K. Bomis (P74311)
DeAnthony D. Shaw (P82292)
Assistant Attorneys General
Attorney for Complainant
Dated: March 8, 2022

AGREED TO BY:

Bens Jean-Gerald Sandaire, D.O.
Respondent

Dated: 3/7/2022

Alan T. Rogalski (P44550)
Attorney for Respondent
Dated: 3/7/2022

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF OSTEOPATHIC MEDICINE AND SURGERY
DISCIPLINARY SUBCOMMITTEE

In the Matter of

BENS JEAN-GERALD SANDAIRE, D.O.
License No. 51-01-011931, Complaint No. 51-18-149861
_____/ (Consolidated with No. 51-20-002315)

FIRST SUPERSEDING ADMINISTRATIVE COMPLAINT

Attorney General Dana Nessel, through Assistant Attorney General Bruce Charles Johnson, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this first superseding administrative complaint against Bens Jean-Gerald Sandaire, D.O. (Respondent), alleging upon information and belief as follows:

1. The Board of Osteopathic Medicine and Surgery, an administrative agency established by the Public Health Code, MCL 333.1101 *et seq.*, is authorized to find that a licensee has violated the Code and impose sanctions through its Disciplinary Subcommittee under the Code.

2. Respondent is currently licensed to practice osteopathic medicine and surgery in the state of Michigan. Respondent also holds an active controlled substance license pursuant to the Code.

3. At all relevant times, Respondent practiced from an office in Detroit, Michigan.

4. Amphetamine salts (e.g., Adderall) are schedule 2 controlled substances.

5. Alprazolam (e.g. Xanax), a schedule 4 controlled substance, is a benzodiazepine used to treat anxiety disorders and panic disorder. Alprazolam is a commonly abused and diverted drug, particularly in its 1 mg and 2 mg dosages.

6. Buprenorphine/naloxone (Suboxone) is an opioid schedule 3 controlled substance commonly used in opioid dependence treatment. It is commonly abuse and diverted. Subutex is buprenorphine without naloxone.

7. Clonazepam (e.g. Klonopin), a schedule 4 controlled substance, is a commonly abused and diverted benzodiazepine used to treat seizure, panic disorder, and akathisia.

8. Cocaine, a schedule 2 controlled substance, is an intense, euphoria-producing stimulant drug with strong addictive potential.

9. Diazepam (e.g. Valium) is a benzodiazepine schedule 4 controlled substance.

10. Gabapentin (e.g. Neurontin) is a schedule 5 controlled substance used to treat, among other things, neuropathic pain and seizures. Gabapentin is known to be abused and diverted.

11. Hydrocodone is an opioid. Hydrocodone combination products (e.g., Norco), are Schedule 2 controlled substances due to their high potential for abuse.

12. Marijuana is a schedule 1 controlled substance. Tetrahydrocannabinol (THC) is marijuana's principal psychoactive constituent.

13. Temazepam (e.g., Restoril) is a benzodiazepine schedule 4 controlled substance.

14. Zolpidem (e.g., Ambien), a schedule 4 controlled substance, is a non-benzodiazepine sedative used to treat sleep disorders and is commonly abused and diverted.

15. The federal Centers for Disease Control and Prevention (CDC) guidelines for opioid prescribing direct providers to avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

16. Section 16221(a) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for a violation of 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 that impairs, or may impair, the ability to safely and skillfully engage in the practice of the health profession.

17. Section 16221(b)(i) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for personal disqualifications, consisting of incompetence, which is defined in section 16106(1) of the Code to mean 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.

18. Section 16221(c)(iv) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for obtaining, possessing, or attempting to obtain or possess a controlled substance or a drug as defined in section 7105 without

lawful authority; or selling, prescribing, given away, or administering drugs for other than lawful diagnostic or therapeutic purposes

19. Section 16221(w) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for a violation of section 7303a(4) or (5).

20. Section 7303a(4) beginning June 1, 2018, before prescribing or dispensing to a patient a controlled substance in a quantity that exceeds a 3-day supply, a licensed prescriber shall obtain and review a report concerning that patient from the electronic system for monitoring schedule 2, 3, 4, and 5 controlled substances established under section 7333a. . .

21. Section 16226 of the Code authorizes the Disciplinary Subcommittee to impose sanctions against persons licensed by the Board if, after opportunity for a hearing, the Disciplinary Subcommittee determines that a licensee violated one or more of the subdivisions contained in section 16221 of the Code.

FACTUAL ALLEGATIONS

MAPS DATA

22. The Department reviewed data from the Michigan Automated prescription System (MAPS), the State of Michigan's prescription monitoring program, which gathers data regarding controlled substances dispensed in Michigan. MAPS data revealed that Respondent ranked among Michigan's highest-volume prescribers of commonly abused and diverted controlled substances in 2018 and 2019:

	2018 Q1	**2018 Q2**	**2018 Q3**	**2018 Q4**
All Controlled Substances	4	4	4	3
Adderall (all strengths)	2	1	1	1
Alprazolam 1 mg	1	1	1	1
Alprazolam 2 mg	13	13	10	9
Stimulants				
	2019 Q1	**2019 Q2**	**2019 Q3**	**2019 Q4**
All Controlled Substances	1	1	3	4
Adderall (all strengths)	1	1	1	1
Alprazolam 1 mg	1	1	1	1
Alprazolam 2 mg	7	8	16	15
Stimulants	1	1	5	3
Clonazepam (all strengths)				1

23. MAPS data from 2019 also revealed the following concerning circumstances:

a. In 2019, 75% of Respondent's controlled substance prescriptions were for Dextroamphetamine/amphetamine, clonazepam, and alprazolam, which are all commonly abused and diverted.

b. There were 150 instances of two or more patients with an address in common.

c. On March 13, 2019, Respondent issued a total of 139 controlled substance prescriptions to 89 individual patients.

d. For the whole of 2019, Respondent issued at least one controlled substance prescription to an average of 47 patients per day.

e. Looking at the top 20 patients that were receiving controlled substance prescriptions, Respondent failed to obtain and review MAPS data for 13 of these patients.

Expert Overview of Respondent's Practice

24. As part of an investigation of Respondent's prescribing practice, the Department received and analyzed medical records of fifteen (15) of Respondent's patients.

25. An expert reviewed the individual medical files and discovered the following deficiencies consistently across files:

(a) Respondent failed to document any detailed description of the patient's mental health history.

(b) Respondent failed to document the risks and benefits of controlled substance treatment.

(c) Respondent failed to document mental status exams.

(d) Respondent prescribed benzodiazepines with stimulants and failed to document any clinical necessity for this combination.

(e) Respondent failed to consistently order urine drug screens for patients who were prescribed controlled substances

(f) Respondent failed to document addressing anomalous urine drug screen results and continued to prescribe controlled substances to patients who were using illicit drugs and/or unprescribed benzodiazepines.

(g) Respondent failed to appropriately monitor or address aberrant drug use in patients with a known history of substance abuse disorders.

Jane Doe 1

26. Respondent treated Jane Doe 1 at TMH between May 1, 2013 and December 13, 2018. Jane Doe 1, who had a complex psychiatric history and a known history of opioid use disorder, saw several psychiatrists at TMH. The author of some of the progress notes is difficult to determine due to the signatures being illegible. However, it is clear that Respondent saw Jane Doe 1 on at least 19 occasions while she was being treated at TMH.

27. Respondent's patient progress notes for Jane Doe 1 are largely indecipherable. The notes fail to set out appreciable clinical content. Some of the notes consist only of check marks without any wording or clinical commentary.

None of the notes document Jane Doe 1's psychiatric diagnoses, and most fail to list her current medications.

28. Respondent's notes failed to document Jane Doe 1's status in recovery or her interim mental health history.

29. Respondent's treatment plans for Jane Doe 1 contained extremely limited content and were mostly limited to statements that her prescribed medication was or was not being changed.

30. Respondent failed to document the need for prescribing a benzodiazepine and Adderall for Jane Doe 1 while she was also being prescribed buprenorphine by an addiction medicine specialist.

Jane Doe 2

31. Jane Doe 2 was treated at TMP from August 23, 2013 until her death on April 23, 2014. TMP's initial psychosocial assessment for her noted that she had recently suffered a heroin overdose and had undergone both medical and psychiatric hospitalizations.

32. On September 7, 2013, Respondent conducted his initial psychiatric evaluation for Jane Doe 2. He noted that Jane Doe 2 suffered from anxiety, guilt, low energy, insomnia, and decreased appetite, and that she had a history of intravenous heroin use, and had been sober for one to two weeks. He diagnosed her as suffering from major depressive disorder, but he failed to discuss her heroin use in his diagnostic summary or in his treatment plan. He also failed to list her

current medications, provide a detailed psychiatric treatment plan, or make pharmacological recommendations for her.

33. In addition to this initial psychiatric evaluation, Respondent performed four follow-up assessments on Jane Doe 2, the last of which was on April 17, 2014, four days before her death. His progress notes for these sessions fail to provide crucial clinical data, including a clinical narrative of Jane Doe 2's current psychiatric state, a list of her prescribed medications, or psychiatric treatment plans for her. Documentation of having conducted mental status examinations is provided in notes for only two of the five assessments.

34. A case management note for November 18, 2013 and nursing notes for November 18, 2013 and January 2, 2014 express confusion regarding what medications had been prescribed for Jane Doe 2. Respondent failed to document current medications prescribed or comment on medication changes in his progress notes for Jane Doe 2, and thereby failed to resolve the confusion.

35. Respondent prescribed Klonopin and Valium, both of which are sedatives, for Jane Doe 2 without assessing her history of heroin use and her vulnerability to substance abuse disorder.

36. Respondent failed to document obtaining urine drug screens or Michigan Automated Prescription System (MAPS) reports for Respondent, despite her recent history of heroin use and her vulnerability to substance abuse disorder.

37. Jane Doe 2 died on April 21, 2014, four days after she was last seen by Respondent. While it is impossible to state definitively whether deficiencies in the

treatment Respondent provided to him may been a factor in her death, due to the fact that the medical records provided to Petitioner do not discuss the cause of death and that Petitioner is prevented from determining it on its own due to the fact that the court order under which the records were provided required the names of patients to be deleted, it seems reasonable to infer that the deficiencies in the treatment may have been, given the fact that Jane Doe 2 had suffered from repeated incidents of heroin overdose which Respondent failed to address.

Jane Doe 3

38. Jane Doe 3 was treated by Respondent and others at TMP from October 21, 2014 through May 9, 2018. Her initial assessment noted that she had a history of drug use during her teen years, and multiple progress notes indicated that she suffered from polysubstance dependence. She was diagnosed as suffering from ADHD, anxiety disorder, bipolar type 1 disorder, panic disorder, and major depressive disorder. Throughout her treatment, she was prescribed multiple psychiatric medications, including Adderall, Klonopin Depakote, Rexulti, Seroquel, and Vraylar.

39. Respondent assessed Jane Doe 3 on 34 occasions while she was treated at TMP, beginning on November 8, 2014. His documentation of these sessions failed to include detailed treatment plans or clinical recommendations for her.

40. Medication notes indicate that Respondent prescribed Klonopin for Jane Doe 3 on November 12, 2014 without documenting the need doing so. On November 8, 2014, Respondent documented in a progress note for Jane Doe 3,

"Patient wants Klonopin." Jane Doe 3's MAPS reports indicate that on November 3, 2014, just five days before, Jane Doe 3 was prescribed 30 2 mg tablets of Xanax by another provider. Respondent prescribed the Klonopin for Jane Doe 3 without documenting the medical necessity for doing so or review of her prescribing history.

41. Respondent prescribed Adderall for Jane Doe 3 without documenting a clinical need for doing so, despite her complex psychiatric condition and her documented history of substance abuse.

42. A number of Jane Doe 3's urine drug screen results indicated the presence of opioids, but Respondent never documented discussing these results with her.

43. Jane Doe 3's urine drug screen results for May 19, 2016, June 20, 2016, September 6, 2016, May 15, 2017 and February 12, 2018 indicated the absence of Klonopin, which Respondent prescribed for her, from her system, and urine drug screen results on January 9, 2016, May 15, 2017 and August 10, 2017 indicated the absence of Adderall, which Respondent also prescribed for her, from her system. Respondent only documented discussing these results, which were highly suggestive of the possible diversion of these drugs, with Jane Doe 2 on one occasion: June 28, 2016, when he documented telling her, "Patient was told if her urine test comes back with no Klonopin, it will be discontinued." Respondent nevertheless never did discontinue the Klonopin, despite the three subsequent urine screen results showing that it was not present in her system, and the similar subsequent urine drug screen results for Adderall.

44. Jane Doe 3's urine drug screen results for February 6, 2016, March 13, 2016, September 5, and November 30, 2017 indicate the presence of the benzodiazepines Valium or Xanax in Jane Doe 3's system. Respondent failed to document discussing these urine drug screen results with Jane Doe 3, despite the fact that he was also prescribing another benzodiazepine, Klonopin, for her.

45. Despite the multiple problems with Jane Doe 3's use of unprescribed controlled substances and her failure to take those which were prescribed, Respondent only documented discussing one of Jane Doe 3's MAPS reports, that for May 19, 2016, with her.

Jane Doe 5

46. Jane Doe 5 was treated by Respondent and others at TMP from June 26, 2015 through November 26, 2018. Her patient records, as created by Respondent and others, failed to provide a documented psychiatric diagnosis or mental health history, or to provide detailed clinical information.

47. Respondent's progress notes for Jane Doe 5 failed to list her prescription medications, failed to provide mental status assessments, or provided only exceptionally abbreviated ones, and failed to provide meaningful and detailed treatment plans.

48. Respondent simultaneously prescribed Adderall, Klonopin and Ambien for Jane Doe 5 without documenting a clinical rationale for doing so.

49. Jane Doe 5's MAPS reports indicated that she was acquiring opioid analgesics from multiple prescribers. Respondent documented reviewing her MAPS

reports, but did not document discussing these aberrant behaviors with her, in spite of the fact that he was also prescribing Adderall, Klonopin and Ambien for her.

Jane Doe 8

50. Jane Doe 8 was treated by multiple providers at TMP from October 28, 2014 through July 30, 2015. She died on August 5, 2015. She was documented as having a history of post traumatic stress disorder, mood disorder, and heroin addiction, and as being a resident of a substance abuse treatment facility.

51. Respondent met with Jane Doe 8 only on two occasions, April 23, 2015 and June 18, 2015.

52. Respondent violated sound prescription practices by prescribing Klonopin to a patient who was being actively treated for substance abuse disorder without reviewing her MAPS reports or urine drug screens.

53. Respondent failed to provide any clinical update on Jane Doe 8's drug use, failing to document whether she was currently actively using controlled substances improperly or whether she was active in a treatment program.

John Doe 1

54. John Doe 1 was treated by Respondent and others at TMP from February 20, 2014 through November 7, 2015. He died on November 22, 2015. He was documented as having a psychiatric history of ADHD, bipolar disorder, post-traumatic stress syndrome, borderline personality disorder, and substance abuse disorder, which included the frequent use of heroin and cocaine.

55. Respondent composed progress notes for fifteen sessions with John Doe 1. These notes failed to provide significant clinical information. They failed to address his current status in recovery, his active substance use, or his psychiatric symptoms. Almost none of them included documentation of a mental status examination having been conducted. Generally their only comment as to John Doe 1's condition was a reiteration of the conclusory statement that he was "doing well."

56. Respondent violated sound prescription practices by prescribing Adderall to John Doe 1, who had substantial substance abuse vulnerabilities and a documented history of drug abuse, without documenting that he had symptoms of ADHD or attention deficit disorder or that he met the criteria for being diagnosed with one of these conditions.

57. Moreover, on January 2, 2015, a clinician at TMH documented that John Doe 1 had relapsed and "abused his Adderall." When Respondent next saw John Doe 1 on February 7, 2015, he failed to address this finding, and continued John Doe 1's prescription for Adderall, noting only that he was "doing well."

58. Respondent violated sound prescribing practices by failing to document reviewing MAPS reports or obtaining urine drug screen for John Doe 1, who had marked substance abuse vulnerabilities. John Doe 1's medical records show that only two urine drug screens were obtained for him (on June 13, 2015 and August 1, 2015), and that Respondent did not review either.

59. Multiple clinical notes by various providers at TMH document ongoing substance abuse concerns regarding John Doe 3, as listed below. Respondent failed

to address any of them, and continued to prescribe Adderall to John Doe 3 in spite of them. The circumstances indicated in the notes are as follows:

- On June 23, 2014, July 2, 2014, and September 8, 2014, clinicians at TMH documented that John Doe 1 was "dropping dirty" in urine drug screens conducted by his criminal probation program. The September 8 note further stated that John Doe 1 "continues to use drugs." When Respondent saw John Doe 1 on September 24, 2014, he did not comment on any of these reports, and noted only that John Doe 1 was "doing well."
- A clinician's notes for March 23, 2015 indicated that John Doe 1 had then been sober from cocaine for only seven days.
- A clinician note for July 27, 2015 indicated that John Doe 1 had just been in jail for "dirty urine."
- On August 15, 2015, John Doe 1 completed a questionnaire in which he stated that he had used cocaine and marijuana daily for the past three months and that he had also used opioids and sedatives during the same time period. Despite this, Respondent, after seeing John Doe 1 on September 13, 2015, reported, "Patient is stable and doing well."

60. John Doe 1 died on November 22, 2015, a little over two months after he was last seen by Respondent. While it is impossible to state definitively whether deficiencies in the treatment Respondent provided to him may been a factor in his death, due to the fact that the medical records provided to Petitioner do not discuss the cause of death and that Petitioner is prevented from determining it on its own due to the fact that the court order under which the records were provided required the names of patients to be deleted, it seems reasonable to infer that the deficiencies in the treatment may have been, given the fact that John Doe 1 suffered from serious drug abuse issues which Respondent failed to address, despite being made aware that John Doe 1 was suffering from them.

John Doe 2

61. In an April 18, 2014 Case Management Progress Note, a staff member in TMH reported concerning John Doe 2, "Member reports that member has been down, having suicidal thought, and visited hospital." In his Medication Review Note for the same date, Respondent failed to discuss John Doe 2's depression or suicidal thoughts, and checked "NO" in the box on the report for "Suicidal Ideation."

62. On July 3, 2014, two staff members in TMH wrote Case Management Progress Notes reporting that John Doe 2 had been released from Detroit Receiving on June 28 after having been admitted following reporting that he "felt like killing himself. Respondent's next Medication Review Note for John Doe 2, on July 20, 2014, stated that John Doe 2 was "doing well," and checked "NO" in the box for "suicidal ideation" on the review note.

63. On August 22, September 8, and October 2 and 10 of 2014, patient notes by other staff in TMH discussed suicide attempts by John Doe 2, of which there had been a total of eight. Three of these notes discussed recent suicide attempts, and the fourth indicated that John Doe 2 might be actively contemplating suicide. When Respondent saw John Doe 2 on October 11, 2014, he did not discuss John Doe 2's suicidal tendencies, and his only comment about John Doe 2's condition was that John Doe 2 was "doing well."

64. In an October 10, 2014 Case Management Progress Note, a staff member stated that John Doe 2 reported being "stressed" and "depressed."

Respondent's October 11, 2014 Medication Review Note for John Doe 2 stated that he was "doing well."

65. A November 7, 2014 staff note for John Doe 2 and two staff notes on November 5, 2014 stated that he reported being "over the edge" and not having eaten for five days because, although hungry, he had "no will to eat." One of the November 5, 2014 staff notes also stated that John Doe 2 "would like to talk to the doctor about his medications but is unable because the doctor will not talk to him." Respondent's November 8, 2014 Medication Review Note for John Doe 2's only comments were "doing well" and "renew meds."

66. December 11, 2014 and December 15, 2014 staff notes for John Doe 2 reported that he reported being extremely depressed. Respondent's December 20, 2014 Medication Review Note for John Doe 2's only comments were "doing well" and "renew meds."

67. A January 8, 2015 staff Case Management Progress Note for John Doe 2 reported that he was severely depressed and stressed and that he cried frequently and was narcoleptic and having seizures. Respondent's February 14, 2015 Medication Review Note for John Doe 2 discussed none of these conditions; Respondent's only comment at that time about John Doe 2's mental state was "pt doing well."

68. On June 4, 2015, two staff members observed in their notes that Respondent was not in the office that day, and reported that John Doe 2 was upset about that because he felt that having to see a different therapist would result in

his not getting a prescription for Adderall; in fact, this therapist did decline to prescribe Adderall for John Doe 2. Notwithstanding this fact, Respondent nevertheless prepared an "Evaluation and Management Office/Outpatient Visit" report for a session with John Doe 2 that day, which includes a listing of a prescription for Adderall.

69. A June 23, 2015 LOCUS assessment of John Doe 2 by staff in TMH noted his current expression of suicidal or homicidal ideation. At his next meeting with John Doe 2 on July 3 and August 5, 2015, Respondent failed to discuss this note, and reported on both occasions that "[p]atient offers up no complaints at this time."

70. Most of the patient progress notes Respondent wrote up for John Doe 2 failed to indicate that mental status examinations were conducted.

71. Respondent's sessions with John Doe 2 typically lasted for only three to five minutes.

72. Most of the patient progress notes Respondent wrote up for John Doe 2 failed to include treatment plans. The treatment plans that were provided contained extremely limited content and failed to set out detailed descriptions of John Doe 1's symptoms or conditions, and failed to provide justifications for the planned treatment.

73. Respondent prescribed multiple controlled substances for John Doe 2, but never documented reviewing MAPS reports, in spite of the fact that John Doe 2 received 71 prescriptions from 11 prescribers, which were filled at eight pharmacies.

74. Respondent obtained only four urine drug screens for Respondent, and failed to document reviewing any of them. These reports indicated that Respondent took non-prescribed controlled substances, including morphine.

75. John Doe 2 died on November 5, 2015, three months after he was last seen by Respondent. While it is impossible to state definitively whether deficiencies in the treatment Respondent provided to him may been a factor in his death, due to the fact that the medical records provided to Petitioner do not discuss the cause of death and that Petitioner is prevented from determining it on its own due to the fact that the court order under which the records were provided required the names of patients to be deleted, it seems reasonable to infer that the deficiencies in the treatment may have been, given the fact that John Doe 2 suffered from suicidal ideation and Respondent gave only cursory attention to his symptoms and conditions, continually ignoring the documentation of suicidal tendencies and repeatedly writing in his patient notes, after spending only three to five minutes with a patient with severe psychiatric issues, that John Doe 2 was "doing well."

John Doe 3

76. Despite the fact that other staff in TMH noted repeatedly in patient notes that John Doe 3 was "struggling," Respondent's patient notes for John Doe 3 failed to provide significant clinical detail, and his only comment about John Doe 3's condition in most of these notes was that John Doe 3 was "doing well."

77. Staff patient notes for John Doe 3 for February 14, 2015 and March 8, 2015 indicated that John Doe 3 had serious problems with controlled substance

abuse and had recently received inpatient treatment for substance abuse at Sacred Heart. Respondent saw John Doe 3 on both February 14 and March 8, 2015, and failed to discuss his substance abuse problems on either occasion, commenting only that John Doe 3 was "doing well."

78. Respondent prescribed a relatively high dose (6 mg per day) of Xanax (alprazolam), a benzodiazepine with significant sedative and additive qualities, despite the fact that it was known that John Doe 3 was struggling with substance abuse disorder and that he had a propensity toward addiction, and failed to document a clinical need for the prescription.

79. Respondent failed to taper or discontinue the prescriptions of Xanax for John Doe 3 over time, despite the fact that it is clinically indicated that this be done with patients presenting with substance abuse disorder.

80. Respondent failed to document review of MAPS reports for John Doe 3, despite the fact that he received 70 prescriptions written by seven providers and filled at eight pharmacies during the time that he was treated by Respondent.

81. Respondent failed to arrange to have John Doe 3 monitored through regular urine drug screens, despite the fact that he was known to be suffering from substance abuse disorder.

82. Most of the patient progress notes that Respondent wrote up for John Doe 3 failed to indicate that he conducted mental status examinations.

83. Most of the patient progress notes that Respondent wrote up for John Doe 3 failed to include treatment plans. The treatment plans that were provided

contained extremely limited content and failed to set out detailed descriptions of John Doe 3's symptoms or conditions or to provide justifications for the planned treatment.

84. On October 13, 2013, in a Medication Review Note, Respondent stated regarding John Doe 3, "patient is doing well, no complaints," although another staff member at his clinic reported in a patient note made the same day that John Doe 3 had recently been released from jail after being arrested on drug charges.

85. John Doe 3 died from an opioid overdose on April 9, 2015, 18 days after last being seen by Respondent. It seems reasonable to infer that the deficiencies in Respondent's treatment of John Doe 3 may have may been a factor in his death, given that John Doe 3 suffered from substance abuse disorder and that Respondent failed to take note of or deal with this condition while treating John Doe 3.

86. On March 22, 2015, when Respondent had last conducted an evaluation and management session with John Doe 3 – for four minutes, and without performing a mental status examination or writing up a treatment plan – he had noted that "member is stable and doing well," despite the fact that clinic records indicate that John Doe 3 was then suffering from severe depression following the death of his girlfriend from a drug overdose two months before, and despite the fact that this note directly conflicted with his own observations contained in his own psychiatric evaluation of John Doe 3 on March 8, 2015, in which he noted John Doe 3's serious depression, bipolar disorder, substance abuse

disorder, long-term noncompliance with medications, and self-harm through "cutting."

John Doe 4

87. Respondent prescribed Xanax, Klonopin, Ambien, Risperdal, Lexapro, and Seroquel for John Doe 4, a patient with a history of opioid use disorder. This prescription pattern was presumptively in violation of the standard of care for the following reasons:

- Prescription of this combination of medications is generally counterindicated.
- Respondent failed to provide a justification for prescribing three sedatives with addictive potential to a patient with a history of opioid use disorder.
- Respondent failed to provide a justification for prescribing two benzodiazapines together with Ambien, a practice that is generally counterindicated.
- Respondent's patient notes for John Doe 4 indicate that John Doe 4 had previously attempted suicide by overdosing on Seroquel, without any discussion of whether it was safe to prescribe this medication for him.

88. Respondent, as indicated by John Doe 4's June 1, 2013 Medication Log, began prescribing Xanax for him on May 18, 2013, but Respondent failed to document initiation of this prescription in John Doe 4's patient note for this date.

89. On August 11, 2015, a clinician at TMH noted that John Doe 4 was obtaining Xanax off the street and was using 1 mg of the drug three times a day. On the same date, Respondent noted this fact in his psychiatric evaluation of John

Doe 4, but nevertheless prescribed 1 mg of Xanax three times a day for John Doe 4 without providing a rationale for doing so.

90. Respondent failed to document review of MAPS reports for John Doe 4, despite the fact that he received fifteen prescriptions written by five providers and filled at seven pharmacies while he was treated by Respondent, that he was known to have a history of opioid use disorder, and that he was known to be obtaining controlled substances illegally on the street while being treated by Respondent.

91. Respondent failed to arrange to have John Doe 4 monitored through regular urine drug screens, despite his known history of substance abuse disorder, and the fact that he was known to be obtaining a controlled substance illegally while being treated by Respondent.

92. Only three of the seven patient notes Respondent wrote for John Doe 4 indicated that he conducted a mental status examination.

93. None of the patient notes Respondent wrote up for John Doe 4 included treatment plans. Only one of the patient notes indicated the length of the session; the length of that session was four minutes.

94. John Doe 4 died from an opioid overdose on September 3, 2015, 23 days after he was last seen by Respondent. While it is impossible to state definitively whether deficiencies in the treatment Respondent provided to him caused or contributed to his death, due to the fact that the medical records provided to Petitioner do not discuss the cause of death and that Petitioner is prevented from determining it on its own due to the fact that the court order under which the

records were provided required the names of patients to be deleted, it seems reasonable to infer that the deficiencies in Respondent's treatment of John Doe 4 may have may been a factor in his death, given that John Doe 4 suffered from substance abuse disorder and that Respondent failed to take note of or deal with this condition while treating John Doe 4.

95. In his note for his last appointment with John Doe 4 23 days prior to John Doe 4's death, Respondent noted that John Doe 4 was obtaining drugs illegally on the street, and that John Doe 4 had attempted suicide three years before by overdosing on one of the six controlled substances Respondent was prescribing for him. Patient notes for John Doe 4 with respect to interaction on the same date indicate that he was having severe panic attacks, that he had attempted suicide several times in the last few years, that he was had been suffering for the last several weeks from severe chronic depression, that he "honestly [did not] want to talk about" the issues that were bothering him, that he thought that "everything [was] out the door" and that there was "really nothing for [him]," that he had no crisis plan and was unwilling to make one, and that he suffered from a "moderate" risk of harm due to the possibility of suicide. In his meeting with John Doe 4 that day for a psychiatric evaluation, Respondent failed to discuss any of these issues with him.

John Doe 6

96. Only of patient progress notes Respondent wrote up for John Doe 6 indicated that mental status examinations were conducted.

97. Respondent prescribed Klonopin, Depakote, Wellbutrin, and Seroquel for John Doe 6, a patient with a documented history of opioid use disorder. The prescription of Klonopin, a sedative with addictive potential, without a documented clinical justification for doing so or the psychiatric condition it was intended to treat, presumptively violated the standard of care.

98. Respondent conducted six "evaluation and management outpatient office visit sessions" with John Doe 6 between June 10, 2015 and November 11, 2015. The documentation of each session is virtually identical. Each session is documented as having lasted five minutes. No rationales for controlled substance prescriptions were provided, no review of urine drug screens or MAPS reports was documented, no detailed discussion with the patient was reported, and the treatment plans that were provided contained extremely limited content and failed to set out detailed descriptions of John Doe 1's symptoms or conditions, and failed to provide justifications for the planned treatment. The notes for each session state, "Patient put forth no complaints at this time," or words to that effect.

99. Respondent failed to document review of MAPS reports for John Doe 6. John Doe 6 received thirteen prescriptions written by five providers and filled at five pharmacies while he was treated by Respondent. John Doe 6 was known to have a history of opioid use disorder.

100. Respondent failed to arrange to have John Doe 6 monitored through regular urine drug screens, despite his known history of substance abuse disorder, and the fact that he was known to be obtaining a controlled substance illegally

while being treated by Respondent. Moreover, a urine drug screen performed on John Doe 6 on October 15, 2015 indicated that he had hydrocodone and cocaine metabolites in his system. Respondent failed to document discussing these urine drug screen results with John Doe 6 when he next saw him on November 11, 2015, ten days before he died from a suspected drug overdose.

101. John Doe 6 died from a suspected drug overdose on November 21, 2015, ten days after he was last seen by Respondent. It seems reasonable to infer that the deficiencies in Respondent's treatment of John Doe 6 may have may been a factor in his death, given that John Doe 6 suffered from substance abuse disorder and that Respondent failed to take note of or deal with this condition while treating John Doe 6.

102. Moreover, on November 11, 2011, a staff member at TMH who saw John Doe 6 that day noted that John Doe 6 reported to her that due to a combination of "stress" over a relationship and of "post acute withdrawal syndrome," he was not sure that he would be able to continue abstaining from drug abuse. A LOCUS health assessment staff had completed on John Doe 6 a week earlier also documented his serious and worsening conditions. Respondent failed to document discussing these concerns with John Doe 6 in the session he conducted with John Doe 6 that same day, just ten days before he died from a suspected drug overdose. Respondent stated, in his notes for that five-minute session, "Patient has no complaints at this time and remains stable in treatment."

John Doe 7

103. John Doe 7 received treatment between September 26, 2016 and May 4, 2018 from Respondent and other staff members at TMH, where he was diagnosed as having bipolar II disorder, generalized anxiety disorder, panic disorder, and attention deficit disorder. TMH did not diagnose John Doe 7 as having substance abuse disorder, but MAPS reports indicate that during the time of his treatment at TMH, John Doe 7 as being given oxycodone and hydrocodone prescriptions by several providers in other clinics.

104. John Doe 7 received prescriptions from Respondent and other providers at TMH for Xanax, Adderall, Abilify, trazadone and Zoloft.

105. Respondent saw John Doe 7 on 23 occasions at TMH. Respondent documented the length of 19 of the appointments, with 18 lasting five minutes and one lasting ten minutes. Respondent's notes for several of the appointments fail to include documentation of mental status examinations or treatment plans.

106. On October 10, 2016, Respondent first assessed John Doe 7. On this occasion, he prescribed the amphetamine Adderall for him at a dosage of 100 mg per day and the benzodiazepine Xanax at a dosage of 2 mg 3 times a day. These prescriptions presumptively violated the standard of care for the following reasons:

- The dosage prescribed for Adderall was significantly higher than the maximum recommended daily dose. The dosage for Xanax was also relatively high.
- Respondent failed to document a rationale for the high dosage or a clinical justification for the prescription of the drugs.
- Given the potential significant cardiovascular consequences of such a high dose of the amphetamine Adderall, responsible

prescription practices necessitated ensuring that the patient was physiologically acclimated to such a high dosage. Respondent failed to do so.

- Respondent failed to document obtaining MAPS reports or ordering and reviewing urine drug screens before writing the prescriptions.

- Responsible prescribing practices require that the initiation of a benzodiazepine like Xanax be accomplished through a gradual up-titration in which the prescriber begins by prescribing a low dose and then gradually works upward to a higher dose. Respondent failed to do so, thereby risking over-sedation of the patient and other potentially harmful physical and psychiatric consequences.

It should be noted that Respondent eventually decreased the dosage of both Xanax and Adderall prescribed for John Doe 7. However, in patient notes for two sessions conducted before he made the change, Respondent said dosages for the medications were excessively high, but nevertheless failed to lower them on those occasions.

107. Urine drug screens which TMH received for John Doe 7 indicated the presence of opioids, not prescribed by Respondent but prescribed by at least six other prescribers, in John Doe 7's system. A number of them also indicated the presence of opioids, THC, Valium and cyclobenzaprine, not prescribed by Respondent, in John Doe 7's system, and the absence of Abilify, Trazodone, and Zoloft, which Respondent had prescribed. Respondent failed to discuss these urine drug screens with John Doe 7.

108. A December 6, 2016 nursing note by a member of the staff at TMH indicated that a recent urine drug screen indicated the presence of metabolites of Valium, a benzodiazepine which Respondent was not prescribing for John Doe 7.

Simultaneously taking two benzodiazepines, one at a relatively high dose, while also taking opioids, puts a patient at risk of serious psychiatric and physical consequences, including over-sedation and even death. Respondent nevertheless failed to discuss the urine drug screen results with John Doe 7 and continued his prescription regimen without change.

109. Respondent failed to document review of MAPS reports for John Doe 7, although MAPS gave John Doe 7 an extremely high overdose risk score (790) and reported that, during the period he was treated by Respondent, he received 160 prescriptions, which were written by 15 prescribers, and filled at 27 pharmacies.

110. Respondent failed to document reviewing John Doe 7's urine drug screens, although TMH received them and other staff there reviewed them and summarized their results.

John Doe 8

111. John Doe 8 received treatment between March 23, 2015 and December 30, 2016 from Respondent and other staff members at TMH, where he was diagnosed as suffering from major depressive disorder and attention deficit disorder. TMH did not diagnose John Doe 8 as having substance abuse disorder, but MAPS reports indicate that during the time of his treatment at TMH, John Doe 8 was taking unprescribed benzodiazepines, and also was taking opioids prescribed by multiple practitioners.

112. Respondent saw John Doe 8 on 24 occasions while he was treated at TMH. For 16 of these appointments, Respondent failed to document conducting

mental status examinations; for 17, he failed to document a treatment plan; and for ten, he failed to assess risk factors for John Doe 8.

113. Respondent provided times for the length of his 24 appointments with John Doe 8. Of these, he documented 14 as lasting only five minutes, five as lasting four minutes, two as lasting ten minutes, and one as lasting two minutes.

114. On October 24, 2015, a TMH staff member who saw John Doe 8 reported that John Doe 8 refused to take a urinalysis test which he was required to do and was very upset upon reporting that he had recently been arrested and jailed for having a loaded gun and a bag of marijuana in his vehicle. Respondent's note for the 5-minute session he conducted for John Doe 8 on that date did not discuss these issues and stated, "Patient put forth no difficulties at this time."

115. Respondent documented the length of 19 of these appointments, with 18 lasting five minutes and one lasting ten minutes.

116. Respondent failed to document review of MAPS reports for John Doe 8, although MAPS gave John Doe 8 an extremely high overdose risk score (740) and reported that, during the period he was treated by Respondent, he received 209 prescriptions, which were written by 41 prescribers, and filled at 22 pharmacies.

117. During the course of his treatment of John Doe 8, Respondent at various times prescribed Adderall, Klonopin, Restoril, Valium, doxepin, Lamictal, Saphris, Baclopen, Fioricet, and Seroquel for him. Of these prescriptions, those for Klonopin and Adderall were consistent throughout the course of treatment.

118. Respondent failed to observe sound prescription practices by continuing to prescribe benzodiazapines for a patient receiving opioids from multiple prescribers, as consistently indicated by MAPS reports and urine drug screens, without documenting a rationale for doing so or making a referral to a substance abuse treatment center. In fact, on December 30, 2016, when John Doe 8 was testing positive for unprescribed Xanax, Respondent increased the dosage of Klonopin he prescribed for him without articulating a rationale for doing so.

119. This problem was all the more serious in light of the fact, as indicated by the urine drug screens discussed above, that for much of 2016, John Doe 8 appears to have been taking three benzodiazapines: Xanax, Valium, and Klonopin.

120. Nursing reports at TMH during 2016 consistently reported that unprescribed controlled substances, as indicated below, were indicated by John Doe 8's urine drug screens. Moreover, on at least one occasion, John Doe 8 refused to provide a urine sample for TMH, although he was told that he was required to do so. Respondent, however, only documented discussing urine sample test reports with John Doe 8 once, at the very end of the period during which he received treatment from Respondent, on December 30, 2016. Urine drug screen results showing unprescribed controlled substances were as follows:

- January 6, 2016: Xanax, plus a metabolite of Soma
- February 13, 2016: Xanax
- February 13, 2016: Xanax
- March 5, 2016: Xanax

- July 1, 2016: Xanax
- July 26, 2016: metabolite of Valium
- December 28, 2016: metabolite of Valium

121. Respondent made a number of changes in the medications he prescribed for John Doe 8 without explicitly documenting the changes in his progress notes or articulating a rationale for the changes. Specifically:

- On May 6, 2015, Respondent discontinued John Doe 8's prescription for Saphris and substituted a prescription for Lamictal. Respondent failed to document a rationale for the change and did not indicate that John Doe 8 was suffering from any psychiatric difficulties; on the contrary, his patient note for that date indicates that John Doe 8 was "stable and doing well." Respondent also failed to document conducting a mental status examination for John Doe 8 during the appointment at which he made this change in medication.
- On November 21, 2015, Respondent added Seroquel to John Doe 8's prescription regimen, but failed to provide a rationale for doing so.
- On February 13, 2016, Respondent added Valium, a sedative with addictive potential, to John Doe 8's prescription regimen, but failed to provide a rationale for doing so.
- On May 11, 2016, Respondent added Restoril, a sedative with addictive potential, to John Doe 8's prescription regimen, but failed to provide a rationale for doing so.
- On September 17, 2016, Respondent added Baclofen, a medication typically used to treat muscle spasticity and rarely used for psychiatric conditions, to John Doe 8's prescription regimen, but failed to provide a rationale for doing so.
- On November 10, 2016, Respondent added Fioricet, a medication typically used to treat headaches and rarely if ever used for psychiatric conditions, to John Doe 8's prescription regimen, but failed to provide a rationale for doing so.

- On December 30, 2016, Respondent increased the dosage for Klonopin, despite documenting that John Doe 8 was exceeding the prescribed dosage for it and that his labs showed that he was taking unprescribed Xanax, and discontinued the prescription for Lamictal, without providing a rationale for doing so.

122. In addition to the medical records of the fifteen patients referenced above, Petitioner also received a complaint regarding Respondent of a male patient whose initials are C.E., for whom Respondent prescribed Adderall.

123. On August 2, 2019, C.E.'s mother and sister met with Respondent and informed him that C.E. was misusing and diverting the Adderall and that it was causing him to behave violently. Respondent documented the receipt of this information, and did not document any doubts as to its credibility.

124. Prior to this time, on April 16, 2019, Respondent had documented Adderall abuse by C.E.

125. Respondent nevertheless did not discontinue his prescription of Adderall for C.E., and in fact at his next appointment with C.E., on August 27, 2019, he continued to provide Adderall for C.E., and did not document any discussion regarding concerns as to misuse, diversion, or violent behavior.

126. Respondent continued to prescribe Adderall for C.E. for over one year, until it was discontinued during an inpatient psychiatric hospital stay of C.E.'s sometime between August 26, 2020 and October 5, 2020.

127. Moreover, on December 17, 2019, C.E. tested positive for methamphetamine in a urine drug screen reported to Respondent, a further warning sign that C.E. had drug abuse issues.

128. Respondent's continued prescription of Adderall for C.E. in light of all the circumstances put C.E. at undue risk. Respondent failed to provide an adequate clinical justification for doing so.

129. Respondent thereby violated his general duty toward C.E., and failed to observe minimal and acceptable standards of practice.

COUNT I

130. Respondent's conduct as described above constitutes a violation of 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 that impairs, or may impair, the ability to safely and skillfully engage in the practice of the health profession, in violation of section 16221(a) of the Code.

COUNT II

131. Respondent's conduct as described above constitutes a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, in violation of section 16221(b)(i) of the Code.

COUNT III

132. Respondent's conduct as described above constitutes selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes, in violation of section 16221(c)(iv) of the Code.

COUNT IV

133. Respondent failed to obtain or review a MAPS report prior to prescribing a controlled substance, contrary to 7303a(4) and in violation of section 16221(w) of the Code.

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

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. Pursuant to section 16192(2) of the Code, Respondent is deemed to be in receipt of the complaint 3 days after the date of mailing listed in the attached proof of service. The written response shall be submitted by email to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing to LARA-BPL-RegulationSection@michigan.gov, with a copy mailed to the undersigned assistant attorney general. If unable to submit a response by email, Respondent may submit by regular mail to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909, with a copy mailed to the undersigned assistant attorney general.

Pursuant to section 16231(9) of the Code, failure to submit a written response within the 30 day-period 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.

FURTHER, the administrative complaint previously filed against Respondent on February 28, 2020 is hereby WITHDRAWN and replaced in full by this superseding complaint.

Respectfully submitted,

DANA NESSEL
Attorney General

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Dated: February 23, 2021

LF: 2020-0299334-A/Sandaire, Bens J., D.O., 149861/Complaint – First Superseding Administrative – 2021-02-22