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

In the Matter of

FREDERICK W. GROVE, M.D.
License No. 43-01-033991,

File No. 43-17-148074

Respondent.

ORDER OF SUMMARY SUSPENSION

The Department filed an *Administrative Complaint* against Respondent as provided by the Public Health Code, MCL 333.1101 *et seq*, the rules promulgated under the Code, and the Administrative Procedures Act, MCL 24.201 *et seq.*

After careful consideration and after consultation with the Chairperson of the Board of Medicine pursuant to MCL 333.16233(5), the Department finds that the public health, safety, and welfare requires emergency action.

Therefore, IT IS ORDERED that Respondent's license to practice medicine in the state of Michigan is SUMMARILY SUSPENDED, commencing the date this *Order* is served.

MCL 333.7311(6) provides that a controlled substance license is automatically void if a licensee's license to practice is suspended or revoked under Article 15 of the Code.

Under Mich Admin Code, R 792.10702, Respondent may petition for the dissolution of this *Order* by filing a document clearly titled **Petition for Dissolution of Summary Suspension** with the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909.

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATORY AFFAIRS

Dated: 4/20, 2018

By: Cheryl Wykoff Pezon, Acting Director
Bureau of Professional Licensing

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ADMINISTRATIVE COMPLAINT

The Michigan Department of Licensing and Regulatory Affairs by Cheryl Wykoff Pezon, Acting Director, Bureau of Professional Licensing, complains against Respondent Frederick W. Grove, M.D. as follows:

1. The Michigan Board of Medicine is an administrative agency established by the Public Health Code, MCL 333.1101 *et seq.* Pursuant to MCL 333.16226, the Board's Disciplinary Subcommittee (DSC) is empowered to discipline licensees for Code violations.

2. Respondent holds a Michigan license to practice medicine. Respondent also holds an active controlled substance license and active drug control-location licenses.

3. At times relevant to this Complaint, Respondent practiced from offices in Jackson, Michigan and his home in Albion, Michigan.

4. After consultation with the Board Chairperson, the Department found that the public health, safety, and welfare requires emergency action. Therefore, the Department summarily suspended Respondent's license to practice medicine in the state of Michigan pursuant to MCL 333.16233(5), effective on the date the accompanying Order of Summary Suspension was served.

5. Buprenorphine/naloxone (Suboxone) is an opioid schedule 3 controlled substance commonly used in opioid dependence treatment. Suboxone is known as "prison heroin," and is commonly abused and diverted. Subutex is buprenorphine without naloxone.

6. Fentanyl is an extremely potent opioid schedule 2 controlled substance. Subsys is fentanyl in sublingual spray form. Its manufacturer is Insys Therapeutics, Inc. (Insys). Subsys is an extremely dangerous drug, due to its high addiction potential and capacity for abuse. It is indicated only for treatment of breakthrough pain in cancer patients.

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

8. Methadone is a commonly abused and diverted opioid schedule 2 controlled substance used to treat pain and to aid in detoxification in people with opioid dependence.

9. 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.

10. 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.

11. Carisoprodol (Soma) is a muscle relaxant and a schedule 4 controlled substance. Carisoprodol has significant potential for abuse, dependence, overdose, and withdrawal, particularly when used in conjunction with opioids and benzodiazepines.

12. Codeine preparations (e.g., codeine/promethazine syrup) are schedule 5 controlled substances prescribed for treating cough and related upper respiratory symptoms. Codeine/promethazine syrup is a highly sought-after drug of abuse, and is known by the street names "lean," "purple drank," and "sizzurp."

13. Oxycodone (e.g., Percocet), a schedule 2 controlled substance, is an opioid used to treat pain, and is commonly abused and diverted.

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

15. Testosterone is a schedule 3 controlled substance.

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

17. On December 12, 2006, the Disciplinary Subcommittee of the Board of Medicine suspended the Respondent's license to practice medicine for a period of at least 6 months and 1 day. This was the result of Respondent's non-compliance with treatment following his referral to HPRP because he was self-prescribing and abusing controlled substances.

18. The federal Centers for Disease Control and Prevention guidelines for opioid prescribing direct providers to use "extra precautions" when prescribing opioids with a daily morphine milligram equivalent (MME) of 50 or more. Those guidelines also direct providers to "avoid or carefully justify" increasing dosage to a daily MME of 90 or more.

19. 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.

MAPS Data

20. 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.

21. The Department looked at Respondent's MAPS data from October 1, 2016, through August 15, 2017, and discovered that over 60% of the prescriptions, totaling 1,612, were for the following, commonly abused and diverted controlled substances:

a. Hydrocodone/acetaminophen 10-325 mg, 491 prescriptions, (18.6%)

b. Buprenorphine 8 mg, 446 prescriptions, (16.9%)

c. Methadone 10 mg, 349 prescriptions, (13.12%)

d. Hydrocodone/acetaminophen 7.5-325 mg, 184 prescriptions, (7%)

e. Alprazolam 1 mg, 142 prescriptions, (5.4%)

22. From October 1, 2016, through August 15, 2017, the percentage of patients that paid with cash was above 21.5. The state average for cash payment is less than ten percent (10%). The high proportion of patients paying cash for controlled substance medications is indicative of prescriptions filled for the purpose of drug diversion.

23. Respondent has authorized prescriptions for high doses of methadone (10 mg), averaging over 300 MME per day. Respondent has also authorized prescriptions for other opioids averaging 200 to 300 MME per day.

Investigative interview

24. On or about March 8, 2018, Respondent was interviewed by a Department investigator, officers from the Albion Police Department, and Agents from the United States Drug Enforcement Agency (DEA). Respondent was questioned about overprescribing controlled substances and other risky practices.

25. Respondent indicated he has never been Board Certified in any kind of specialty, nor has he received any kind of specialized continuing education in pain management or opioid prescribing. Respondent was not familiar with the Michigan Guidelines on Prescribing of Controlled Substances, nor was he initially familiar with morphine equivalent dosing, though he later claimed in the interview that he was.

26. Respondent stated that he had prescribed Ambien to himself for a period and was currently taking Norco that he had prescribed for his ex-wife.

27. When Respondent was asked if he would voluntarily give up his DEA registration that allows him to prescribe controlled substances, he stated:

> "You know I think I want to hold off on this. Is there any way I can drag this out for a while, if I get a lawyer and drag it out, uh, even a few months of money coming in will help me, um cause you know a lot of my business is all controlled substance..."

Expert overview of Respondent's practice

28. As part of an investigation of Respondent's prescribing practices, the Department received and analyzed medical records of eleven (11) of Respondent's patients.

29. The expert noted that most of the reviewed patients were prescribed methadone. Nearly all of them were receiving dosages well in excess of the CDC recommended upper limit, with the highest being an MME of 960. In 2016, only one patient was within the recommended limit, and in 2017, only two were within the recommended limit. The expert also noted that Respondent never commented on why he felt the high doses were warranted, nor did he document doing any of the required cardiac monitoring that should accompany the use of this medication.

30. The expert also commented on the Respondent's choice of Subutex over Suboxone for his patients that were prescribed buprenorphine. Suboxone is much more difficult to abuse and is preferred for patients that may have addiction problems. The expert noted that two of Respondent's patients had obvious issues with addiction and should have been prescribed Suboxone but were instead prescribed Subutex. In addition, many were prescribed over the maximum recommended dose without any kind of documented explanation.

31. The expert questioned the use of benzodiazepines by Respondent to treat patients' "anxiety." Due to their addictive potential, benzodiazepines are not recommended for long-term treatment. The CDC also recommends that they not be paired with opioids, which Respondent did for several patients. The expert also noted that Respondent did not appear to consider any other treatment options and that his default treatment was the use of controlled substances.

32. An expert reviewed the individual medical files Respondent produced and discovered the following deficiencies consistently across files:

(a) Respondent's patient notes are largely illegible and generally contain little or no information regarding patients' complaints, Respondent's clinical reasoning, and treatment decisions.

(b) All lack critical information regarding patients' history, pain, functional status, medication efficacy, medication side effects, or psychiatric status.

(c) For many of the reviewed patients, it is difficult to even determine what painful condition is being treated. In addition, none have adequate histories regarding prior treatment or the rationales for their treatment regimens.

(d) Respondent's records clearly do not meet the standard for supporting controlled substance prescribing. Specifically, Respondent's records lack medication lists and critical information about the patients' status and treatment. Respondent's files do not contain any evidence that he ordered diagnostics tests or exams related to patient conditions. Most also did not contain any records from previous treatment providers.

(e) There is no evidence that Respondent assessed his patients for risk related to substance abuse. In the few that he did document addiction, he did not make any referral for treatment.

(f) Respondent's files do not contain narcotic agreements with the patient.

(g) Respondent's patient files consistently lack treatment goals, assessment of medications, and any kind of risk versus benefit analysis of prescribed medications.

(h) Respondent failed to document responses to evidence of abuse or diversion of controlled substances.

(i) Respondent failed to address abnormal test results and continued to prescribe when there were strong indications that patients were diverting their medications.

(j) Respondent routinely prescribed high opioid dosages and unsafe combinations of medications.

Individual patient examples

33. The expert discovered the following deficiencies in the individual medical files Respondent produced, in addition to those noted above:

Patient John Doe[1]

(a) Respondent failed to document any history of this patient's care, despite a note that he suffered a severe trauma in 1986. Additionally, there are no records from outside Respondent's practice.

(b) Respondent prescribed this patient methadone that was more than 4 times the dosage recommended by the CDC. There is nothing to indicate that Respondent evaluated this patient for pain, including imaging studies or any other kind of tests. Respondent also failed to monitor this patient for potentially fatal side effects.

(c) Patient had a positive screen for cocaine. Respondent did not comment on this at all, nor did he appear to follow up or refer Patient JH for substance abuse services.

Patient John Doe 2

(d) As with the previous patient, there is no comprehensive history of the causes of this patient's pain nor is there any kind of treatment history, specialty consultations, or testing.

(e) Patient had multiple instances where his urine toxicology indicated active substance abuse of heroin and cocaine. Despite this, there are no comments by the Respondent, nor is there any indication that he followed up on this in any way.

[1]Patients names withheld to protect confidentiality.

(f) Respondent prescribed methadone for this patient at a dosage that was 3 times the amount recommended by the CDC and failed to document why this was justified.

Patient Jane Doe

(g) As with the previous patient, there is no comprehensive history of the causes of this patient's pain, nor is there any kind of treatment history, specialty consultations, or testing.

(h) As with many of the other patients, this patient was prescribed methadone at substantially higher than maximums recommended in the CDC guidelines. Again, Respondent failed to document his rationale, and did not indicate that he recognized the risk to the patient.

(i) Contrary to CDC guidelines, Respondent prescribed high doses of opioids with sedatives, in this case, zolpidem, which was also prescribed at a dosage that was higher than recommended by the US Food and Drug Administration (FDA). As in other cases, Respondent failed to document the rationale for this or indicate understanding of the risk.

(j) Despite some indication that this patient had previously tested positive for medications she was not prescribed, Respondent did not order any kind of further testing.

(k) Respondent's treatment of this patient's diabetes was substandard in that he did not appear to manage it properly, in terms of monitoring, testing, and treatment.

Patient John Doe 3

(l) Again, Respondent did not obtain prior records for this patient, nor did he perform a comprehensive examination or evaluation of functional status. There also does not appear to be any kind of monitoring of whether the medication is influencing the patient's functional status.

(m) Patient was prescribed two controlled substances, Subutex and testosterone, that require careful monitoring. There is no evidence that this was done.

(n) Despite the risks associated with long-term opioid therapy, it does not appear that Respondent considered or attempted less dangerous therapies.

Patient John Doe 4

(o) As with previous patients, there is no comprehensive history of the causes of this patient's pain, nor is there any kind of treatment history, specialty consultations, or testing. Even more notable is a 3-year gap in the records with no explanation.

(p) Respondent prescribed several controlled substances and did not appear to have checked MAPS or perform any kind of testing.

(q) Respondent prescribed Subutex for "chronic pain" and failed to conduct any kind of evaluation or document any clinical reason for doing so. Respondent changed this in a subsequent visit to methadone and failed to document the reason for switching medication.

(r) Respondent prescribed methadone with an MME that was 3 times the recommended CDC limit and failed to document any justification.

(s) Respondent prescribed Adderall and failed to document anything in the record that would indicate this patient needed this drug.

Patient John Doe 5

(t) This patient had multiple drug screens for illegal drugs and controlled substances that he was not prescribed, including cocaine and fentanyl.

(u) Despite clear indicators of substance abuse, Respondent failed to refer this patient to addiction treatment.

(v) Respondent co-prescribed opioids and benzodiazepines, contrary to CDC guidelines and failed to consider less dangerous alternatives.

Patient John Doe 6

(w) Again, Respondent failed to adequately document this patient's history. In addition, there are only superficial references to pain and nothing that would indicate any kind of diagnostics or imaging was done or any referral was made to a specialist.

(x) Respondent failed to document any kind of basic measures to prevent misuse or diversion of controlled substances, such as MAPS review, regular urine screens, controlled substance agreements, or pill counts.

(y) Respondent prescribed methadone at 4 times the CDC recommended dose. As with other patients, there is no documentation of the risk versus benefits or reasons for such a high dosage. Though Respondent did document that the dosage was "too high", there is no indication he attempted to reduce it.

(z) Respondent co-prescribed an opioid and a benzodiazepine, contrary to CDC guidelines.

(aa) This patient was receiving testosterone therapy. Respondent failed to provide the required testing and follow up for this drug. Respondent also failed to consider this patient's cardiac history in prescribing this treatment, despite well-known risks associated with this drug.

(bb) Patient reported a history of hepatitis C. Respondent failed to treat this condition or provide an appropriate referral.

Patient John Doe 7

(cc) Again, Respondent failed to document a patient history or conduct any kind of meaningful evaluation. Despite reported back pain, Respondent failed to document examining the patient's back.

(dd) This patient reported "anxiety," but Respondent failed to document any kind of psychiatric exam or indicate any kind of need for a referral.

(ee) Respondent prescribed testosterone for this patient and failed to document any kind of test or indicator that this patient needed the medication.

(ff) Respondent prescribed opioids at almost 3 times above the limit that the CDC recommends and failed to document any reasoning.

(gg) Respondent co-prescribed an opioid and a benzodiazepine, contrary to CDC guidelines.

(hh) This patient's urine toxicology failed to show the opioids he was prescribed. Additionally, the patient requested large quantities of oxycodone and alprazolam, which are commonly abused drugs. Respondent failed to address these red flags for drug diversion.

Patient Jane Doe 2

(ii) As with other patients, this chart contains scant documentation of prior treatments, prior evaluations, or any kind of risk/benefit associated with her treatment for chronic pain. The expert also noted it was unclear why Respondent prescribed her controlled substances, as some notes referred to "addiction" and others referred to "chronic pain."

(jj) Respondent noted that this patient is a narcotic addict and has problems with marijuana addiction. Despite this, there is nothing to suggest that this patient received any kind of non-medication treatment or referral.

(kk) Respondent failed to adequately monitor the patient for substance abuse. There was only one urine screen (that was ordered by another facility), no controlled substance agreement, and one reference to MAPS.

(ll) This patient had chronic issues with nausea and vomiting, in addition to uncontrolled diabetes. Respondent failed to document any effective treatment or make a referral to a specialist, despite clear indicators that this needed to be done.

(mm) Respondent prescribed a high concurrent dose of an opioid and a benzodiazepine, which was dangerous, without supporting documentation.

Patient Jane Doe 3

(nn) Again, Respondent failed to document a patient history, conduct any kind of meaningful evaluation, or develop a controlled substance agreement.

(oo) Respondent prescribed this patient benzodiazepines for "anxiety" without conducting any kind of psychiatric assessment or referring her for some outside care.

(pp) Respondent prescribed high amounts of hydrocodone, alprazolam, and Lyrica, despite the obvious risk of death related to overdose. Respondent even increased the dosage for alprazolam over time.

(qq) This patient had a drug screen for several drugs that she was not prescribed, including morphine, fentanyl, and hydromorphone. Despite the serious risk, Respondent failed to document addressing this or making any changes to her prescribed medications.

(rr) Respondent noted that this patient filled two prescriptions for Norco from another provider while under his care but failed to address this adequately.

(ss) Respondent's notes indicate that this patient showed him bruises that were reported to be from the patient's son. There is no documentation that Respondent attempted to find out why or contact law enforcement regarding possible domestic abuse.

(tt) It was reported that several of this patient's family members contacted Respondent to say that she was abusing medication. There is no indication that he addressed these concerns.

(uu) Respondent treated this patient in his private home. The expert noted that this was unusual.

(vv) This patient died as a result of a drug overdose. The expert noted that her death was, "at least indirectly, a result of [Respondent's] departures from the standard of care."

COUNT I

Respondent's conduct constitutes a violation of a general duty, consisting of negligence or failure to exercise due care, in violation of MCL 333.16221(a).

COUNT II

Respondent's conduct fails to conform to minimal standards of acceptable, prevailing practice for the health profession in violation of MCL 333.16221(b)(i).

COUNT III

Respondent's conduct demonstrates Respondent's lack of a "propensity . . . to serve the public in the licensed area in a fair, honest, and open manner," MCL 338.41(1), and accordingly a lack of "good moral character," in violation of MCL 333.16221(b)(vi).

COUNT IV

Respondent's conduct, as set forth above, constitutes selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes, in violation of MCL 333.16221(c)(iv).

RESPONDENT IS NOTIFIED that, pursuant to MCL 333.16231(8), Respondent has 30 days from the date of receipt of this Complaint to answer it in writing and to show compliance with all lawful requirements for retention of the license.

Respondent shall submit the written answer to the Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, MI 48909.

Respondent's failure to submit an answer within 30 days is an admission of the allegations in this complaint. If Respondent fails to answer, the Department shall transmit this complaint directly to the Board's Disciplinary Subcommittee to impose a sanction pursuant to MCL 333.16231(9).

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATORY AFFAIRS

Dated: 4/20/, 2018

By: Cheryl Wykoff Pezon, Acting Director
Bureau of Professional Licensing