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

In the Matter of

DAWN D. FOSTER, M.D.
License No. 43-01-067981,

File No. 43-17-149249

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: 6/11, 2018

By: Cheryl Wykoff Pezon, Director
Bureau of Professional Licensing

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

In the Matter of

DAWN D. FOSTER, M.D.
License No. 43-01-067981,

File No. 43-17-149249

Respondent.

ADMINISTRATIVE COMPLAINT

The Michigan Department of Licensing and Regulatory Affairs by Cheryl Wykoff Pezon, Director, Bureau of Professional Licensing, complains against Respondent Dawn D. Foster, 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.

3. At times relevant to this Complaint, Respondent practiced from offices in Detroit, Michigan and Southfield, 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. Hydrocodone is an opioid. Hydrocodone combination products (e.g., Norco), are Schedule 2 controlled substances due to their high potential for abuse.

6. 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.

7. 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.

8. Oxymorphone, a schedule 2 controlled substance, is an opioid used to treat pain, and is a commonly abused and diverted drug. Oxymorphone 40 mg is the most commonly abused and diverted strength of oxymorphone.

9. Pregabalin (e.g., Lyrica) is a schedule 5 controlled substance, used to treat, among other things, diabetic neuropathy, fibromyalgia, and to control seizures. It is known to be abused and diverted.

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

11. 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.

12. Gabapentin (e.g., Neurontin) is a prescription medication used to treat, among other things, neuropathic pain and seizures. Gabapentin is known to be abused and diverted.

13. Amitriptyline is a tricyclic antidepressant that is sometimes used to treat pain. It has strong sedative properties and requires a prescription.

14. Morphine is a frequently diverted and abused schedule 2 controlled substance.

15. Temazepam (e.g. Restoril), a schedule 4 controlled substance, is a benzodiazepine used to treat insomnia.

16. 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.

17. 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.

18. When used in combination, opioids, carisoprodol, and benzodiazepines can produce a feeling of euphoria. These combinations are highly desired for diversion and abuse and have the street name "Holy Trinity."

19. 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.

20. The Department looked at MAPS data from 2016 through the first quarter of 2018 and found that Respondent was consistently among the top 100 prescribers in the state of Michigan for Alprazolam and Oxymorphone.

Investigative interview

21. On or about April 19, 2018, Respondent was interviewed by a Department investigator. Respondent stated she is not board certified in any specialty, including pain management.

22. Respondent stated that she conducts a full examination of patients prior to prescribing controlled substances. This includes ordering the necessary tests and obtaining medical records from previous providers.

23. Respondent believes that approximately 30-40% of her patients receive narcotic pain medications.

24. Respondent stated that she only sporadically used MAPS and urine drug screens to monitor compliance with medication regimens and admitted that she should be doing these things more frequently.

Expert overview of Respondent's practice

25. As part of an investigation of Respondent's prescribing practices, the Department requested the medical records of nine (9) of Respondent's patients. Respondent was only able to provide six (6) of the requested records and did not know where the other three (3) were located.

26. The expert noted that, despite Respondent's assertion in paragraph 21, there is no evidence in the medical records that she is conducting adequate exams and evaluations, nor is she requesting diagnostic studies and tests.

27. The expert also noted that while the Respondent made specialty referrals, there are no reports of the referrals themselves, which bring into question whether they occurred. Regardless, there is no evidence that Respondent followed up on the results of the referrals.

28. The expert questioned the use of high doses of opioids. In most of the reviewed charts, patients were prescribed opioids at twice the level the CDC recommends, and in some cases, they were receiving five (5) times the level that is recommended.

29. The expert also noted that the Respondent was a high-volume prescriber of oxymorphone and alprazolam 2mg relative to his peers, which was unusual, given that she does not have a pain management focus or background. In the case of the alprazolam, the expert added that there was no evident reason why a primary care physician without a psychiatric specialty would be a high-volume prescriber.

30. The expert also questioned the frequent prescribing of opioids with benzodiazepines, a practice that is discouraged by the CDC because it places patients at great risk of injury or death, due to overdose. The expert also stated that the Respondent prescribed other drugs (Soma, barbiturates, and Zolpidem) along with opioids that carry similar risks to benzodiazepines.

31. As part of the review, the expert reviewed MAPS data regarding Respondent's prescribing patterns with other patients. In a random sampling of 21 patients, eight (8) were taking a combination of opioids and benzodiazepines or opioids and carisoprodol, a practice that leads to higher risk of overdose. Another random sample of eighteen (18) patients found that eight (8) were prescribed similar combinations.

32. The expert questioned the frequent use of carisoprodol by the Respondent, including prescribing it along with an opioid and a benzodiazepine (the Holy Trinity). The expert further stated that carisoprodol is only approved for short-term use and questioned why some of Respondent's patients were taking it for years.

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

(a) Respondent's patient notes lack pain histories and exams.

(b) Respondent fails to obtain prior treatment records or evaluations.

(c) There is no evidence that Respondent pursued tests or studies for the causes of pain.

(d) There is no evidence that Respondent assessed her patients for risk related to substance abuse.

(e) Respondent did not appear to try a non-opioid treatment for pain.

(f) Respondent failed to provide any justification for deviating from accepted guidelines as to opioid dosages.

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

(h) Respondent's patient files consistently lack any kind of risk versus benefit analysis of prescribed medications.

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

(j) Respondent failed to order urine drug screens and address abnormal test results and continued to prescribe when there were strong indications that patients were diverting their medications.

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

Individual patient examples

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

Patient JG[1]

(a) Respondent failed to document any history of this patient's back pain, nor is there any evidence that a physical exam was done until one year after treatment started.

(b) Respondent referenced some other physicians regarding this patient, but there are no notes that state what they thought or what they recommended.

(c) Patient was placed on an opioid regimen and there is no discussion as to why. In addition, the dosages ranged from four (4) to six (6) times the recommended amount by the CDC.

(d) At one point, this patient was prescribed two (2) opioids and three (3) benzodiazepines. The expert noted that this placed the patient at very high risk on injury doe to respiratory depression.

(e) This patient also reported frequent nausea and vomiting, which may have been a side effect of the opioids that were prescribed by Respondent. There is no evidence that Respondent considered this as a cause.

(f) Respondent also failed to adequately address possible diversion by this patient by checking MAPS or ordering urine drug screens. A MAPS check would have revealed that this patient was prescribed controlled substances by several other providers.

Patient DM

(g) As with the previous patient, there is no comprehensive history of the causes of this patient's pain, nor is there any stated diagnosis beyond a vague "chronic low back pain."

(h) As with the previous patient, Respondent placed DM on an opioid regimen with dosages that ranged from four (4) to six (6) times the recommended amount by the CDC.

[1]Patient initials used to protect confidentiality.

(i) This patient was prescribed Soma, an opioid, and a benzodiazepine (the Holy Trinity).

(j) The Respondent prescribed, at various times, oxymorphone, oxycodone, alprazolam, zolpidem, carisoprodol, gabapentin, amitriptyline, and several anti-psychotics. The expert noted that this combination would likely impair this patient's cognition and there does not appear to be any evidence that this was considered.

(k) Respondent ordered several urine drug screens that showed DM was not taking the medications prescribed at that time. The expert noted that Respondent failed to address this evidence of diversion.

(l) As with the previous patient, there is evidence that DM was experiencing side-effects related to his medications that required trips to the hospital and Respondent failed to address this.

(m) The expert also noted that DM had several other serious health conditions that Respondent failed to adequately address.

Patient WV

(n) As with the previous patient, there is no comprehensive history of the causes of this patient's pain.

(o) As with the previous patient, Respondent placed WV on an opioid regimen with dosages that were four (4) times the recommended amount by the CDC. In addition, there were sharp escalations of these dosages without any kind of explanation.

(p) This patient was prescribed Soma, an opioid, and a benzodiazepine (the Holy Trinity).

(q) Respondent failed to check MAPS or conduct any urine drug screens.

(r) Patient WV died of a drug overdose on June 11, 2015. This was two (2) days after she filled a prescription from Respondent for morphine, Norco, alprazolam, and Soma. The expert stated that her overdose was unsurprising, considering these medications.

Patient LH

(s) Again, there are no prior records for this patient, nor is there any kind of comprehensive examination or evaluation of functional status. There also does not appear to be any kind of follow up related to referrals.

(t) As with previous patients, LH was prescribed opioids well over the recommended dosages without any kind of justification. In addition, these dosages were changed sharply with the patient reporting they

were still experiencing high levels of pain. Respondent failed to consider if opioids were even working and if other therapies should be tried.

(u) Respondent failed to check MAPS or conduct any urine drug screens.

(v) As with previous patients, Respondent failed to address patient's reported side-effects related to opioids.

Patient LC

(w) 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.

(x) As with previous patients, LC was prescribed opioids well over the recommended dosages without any kind of justification. In addition, these dosages were increased greatly with the patient reporting they were still experiencing high levels of pain. Again, Respondent failed to consider if opioids were even working and if other therapies should be tried.

(y) As with previous patients, Respondent failed to address patient's reported side-effects related to opioids. Most notably were this patient's increased seizures, which may have been the result of the tramadol that was prescribed by Respondent.

(z) Respondent failed to address evidence of diversion or abuse. This includes numerous instances where patient asked for early refills and tested negative for controlled substances she was prescribed.

Patient TH

(aa) As with previous patients, there was a lack of any kind of history, referral to specialists, and testing.

(bb) Despite TH stating he had a history of alcohol and IV drug abuse, Respondent never ordered a drug screen or a MAPS report before prescribing several opioids.

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

(dd) Respondent failed to address evidence of diversion or abuse. This includes "losing" medication and receiving medications from other providers.

(ee) As with previous patients, TH was prescribed opioids well over the recommended dosages without any kind of justification. In addition, these dosages were increased or decreased greatly at levels that may cause severe withdrawal symptoms.

(ff) As with previous patients, Respondent failed to address patient's reported side-effects related to opioids.

Patient MW

(gg) Respondent did not provide the record for this patient. The expert noted that if the Respondent did not maintain a record for this patient, that would be a violation of the standard of care.

(hh) The expert was able to review a MAPS report of this patient that listed the drugs that were prescribed by Respondent. This includes Norco and temazepam. Respondent prescribed an opioid and a benzodiazepine, contrary to CDC guidelines.

(ii) Patient MW died of a drug overdose on February 11, 2015. The expert noted that while it is unclear whether MW was taking the above-prescribed medications, if he was, that is a combination that is known to be associated with increased risk of death.

Patient DH

(jj) Respondent did not provide the record for this patient. The expert noted that if the Respondent did not maintain a record for this patient, that would be a violation of the standard of care.

Patient BH

(kk) Respondent did not provide the record for this patient. The expert noted that if the Respondent did not maintain a record for this patient, that would be a violation of the standard of care.

(ll) The expert was able to review a MAPS report of this patient that listed the drugs that were prescribed by Respondent. This includes Norco, Opana, Soma, and alprazolam. Respondent prescribed an opioid and a benzodiazepine, contrary to CDC guidelines. In addition, DH was prescribed some of these drugs at levels that are higher than recommended by the CDC.

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).

COUNT V

Respondent's conduct, as set forth above, constitutes a failure to comply with a subpoena, in violation of MCL 333.16221(i).

COUNT VI

Respondent's conduct constitutes a failure to keep and maintain records for each patient, as required by MCL 333.16213, which is a violation of MCL 333.16221(h).

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: 6/11/, 2018

By: Cheryl Wykoff Pezon, Director
Bureau of Professional Licensing