STATE OF MICHIGAN

COURT OF APPEALS

In re RICHARD PAUL PAYEA, M.D.

DEPARTMENT OF COMMUNITY HEALTH, BUREAU OF HEALTH PROFESSIONS,

Petitioner-Appellee,

v

RICHARD PAUL PAYEA, M.D.,

Respondent-Appellant.

UNPUBLISHED
September 29, 2011

No. 293727
Board of Medicine
LC No. 2006-000250

Before: SHAPIRO, P.J., and WILDER and MURRAY, JJ.

PER CURIAM.

Respondent Richard Paul Payea, M.D., appeals as of right from an order of the Board of Medicine Disciplinary Subcommittee, an entity within the Department of Community Health (DCH)'s Bureau of Health Professions, suspending his license to practice medicine "for a minimum period of six months and one day" for violating four sections of the Public Health Code, specifically, MCL 333.16221(a), (b)(i), (b)(vi), and (c)(iv). We affirm.

The DCH filed an administrative complaint against respondent in August 2005. In four counts, the complaint alleged violations of the aforementioned statutes with respect to each of four different patients (KBF, VF, DR, and LH). The complaint detailed for each patient respondent's similar conduct in prescribing controlled substances without any documented medical basis in the patient's chart. Following a hearing conducted between June 2006 and January 2008, a hearing referee issued a proposal for decision in which he concluded that petitioner failed to establish by a preponderance of the evidence that respondent violated MCL 333.16221(a), (b)(i), (b)(vi), or (c)(iv) with regard to his treatment of any of the four patients.

Petitioner filed exceptions with the Disciplinary Subcommittee, which issued its findings of fact and conclusions of law in July 2009. The Disciplinary Subcommittee detailed 18 of the hearing referee's findings of fact that the subcommittee rejected partially or in total. The Disciplinary Subcommittee then concluded that respondent's treatment of KBF, VF, DR, and LH violated the standards in MCL 333.16221(a), (b)(i), (b)(vi), and (c)(iv).

I. THE DISCIPLINARY SUBCOMMITTEE'S FINDINGS AND CONCLUSIONS

Respondent contests the adequacy of proof supporting the Disciplinary Subcommittee's findings and conclusions, arguing that (1) the Disciplinary Subcommittee improperly "focused its attention on the [medical] records . . . [despite] the clear evidence that patient records were incomplete"; (2) the "incomplete records cast doubt on petitioner's expert's standard of care opinions"; and (3) petitioner erroneously compared the prescription information in respondent's medical records to prescription quantities derived from "local pharmacies and the state-run" Michigan Automated Prescription System (MAPS), where totals had been inflated due to forgery and prescription fraud.

Judicial review of a disciplinary subcommittee's order under Article 15 of the Public Health Code, MCL 333.16101 *et seq*., is limited to ascertaining whether "'competent, material and substantial evidence on the whole record'" supports the order. *Dep't of Community Health v Risch*, 274 Mich App 365, 370-371; 733 NW2d 403 (2007), quoting Const 1963, art 6, § 28. "When reviewing whether an agency's decision was supported by competent, material, and substantial evidence on the whole record, a court must review the entire record and not just the portions supporting the agency's findings." *Risch*, 274 Mich App at 372. "Substantial evidence" signifies a quantum of proof "that a reasonable mind would accept as sufficient to support" the agency's factual findings; substantial evidence "consists of more than a scintilla of evidence, [but] it may be substantially less than a preponderance." *In re Payne*, 444 Mich 679, 692 (lead opinion by BOYLE, J.), 698 (opinion by RILEY, J., concurring in part and dissenting in part); 514 NW2d 121 (1994); see also *Risch*, 274 Mich App at 372. "A court . . . [may] not set aside findings merely because alternative findings also could have been supported by substantial evidence on the record." *In re Payne*, 444 Mich at 692. Importantly, in making our review we must keep in mind the deference we owe to the expertise of the Disciplinary Subcommittee. *Risch*, 274 Mich App at 374-375.

The Disciplinary Subcommittee found that respondent violated the following four subsections of MCL 333.16221, which provide:

> [t]he department may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order relevant testimony to be taken and shall report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee shall proceed under section 16226 if it finds that 1 or more of the following grounds exist:
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> (a) 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 practice the health profession.
>
> (b) Personal disqualifications, consisting of 1 or more of the following:

(i) Incompetence.

* * *

(vi) Lack of good moral character.

* * *

(c) Prohibited acts, consisting of 1 or more of the following:

* * *

(iv) Obtaining, possessing, or attempting to obtain or possess a controlled substance as defined in section 7104 or a drug as defined in section 7105 without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes.

"Good moral character" has a statutory definition. MCL 333.16104(5); MCL 338.41(1). "Good moral character" means "the propensity on the part of the person to serve the public in the licensed area in a fair, honest, and open manner." MCL 338.41(1). The Legislature has defined "incompetence" as "a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury occurs." MCL 333.16106(1).

The Disciplinary Subcommittee commenced the conclusions of law portion of its decision by addressing general matters pertinent to its analysis of respondent's treatment of all four patients. One significant matter involves the extent to which the Disciplinary Subcommittee credited the parties' respective expert witnesses, Dr. Elizabeth Alexander, petitioner's expert, and Dr. George Sawabini, respondent's expert. In this regard, the Disciplinary Subcommittee concluded:

> [t]he Disciplinary Subcommittee is not persuaded by the testimony of Respondent's expert, George Sawabini, D.O., who opined that the documentation contained in the medical records reviewed was acceptable. For reasons set forth below, the Disciplinary Subcommittee finds the testimony of Petitioner's expert, Beth Alexander, M.D., more persuasive and has, therefore, given her testimony the greater weight in reviewing this matter.
>
> Dr. Alexander is a consummate professional and well-respected by her peers and this Disciplinary Subcommittee. Her opinions are based on many years of practice and teaching at Michigan State University College of Human Medicine. Of significant note is the fact that Dr. Alexander has years of experience in establishing standards of care for family practice physicians by authoring questions for the final licensing exam for the National Board of Medical Examiners. This Disciplinary Subcommittee finds her testimony more persuasive and has given that testimony the greater weight in review of this matter.

As we discuss further in section II, Dr. Alexander's testimony regarding her medical experience and the information in Dr. Alexander's curriculum vitae amount to competent, material, and substantial evidence of her qualifications adequate to support the Disciplinary Committee's findings regarding her experience. Therefore, we decline to revisit the Disciplinary Subcommittee's credibility assessment of Dr. Alexander. *Hitchingham v Washtenaw Co Drain Comm'r*, 179 Mich App 154, 159; 445 NW2d 487 (1989) (citations omitted) ("credibility of witnesses and the weight to be given evidence is for the determination of the administrative agency and not for the court").

Regarding purportedly incomplete patient records, respondent voiced a concern on the second day of the disciplinary hearing about the completeness of the copies of the patient records in evidence. The hearing referee repeatedly offered respondent and his counsel the opportunity to submit any additional patient documentation missing from the charts entered into evidence at the disciplinary hearing. At no point over the course of the next seven days of the hearing, which spanned a period of 18 months, did respondent present any documentation missing from the medical charts of KBF, VF, DR, or LH. And neither respondent nor his counsel ever pointed to any particular, relevant medical tests or other information allegedly missing from the medical charts of KBF, VF, DR, or LH. On appeal, respondent again criticizes the reliability of the copies of his patient records scrutinized during the disciplinary hearing, but again fails to identify any documentation or records absent from the patients' medical charts, or any specific information respondent believes should have been contained in the patient files of KBF, VF, DR, and LH. Thus, the record does not support respondent's unsubstantiated complaints of medical record incompleteness.

Concerning prescription forgeries that allegedly inflated MAPS records of respondent-authorized controlled substance prescriptions to DR and LH, the record tends to directly establish that CG, LH's daughter, may have forged one prescription in LH's name, and one in DR's name, and that she made one unsuccessful attempt to forge a second prescription in DR's name. But even assuming the presence of some limited misinformation in the patient records of DR and LH attributable to prescription fraud by CG, our review of the record in this case reveals no misinformation in the MAPS records that affected the Disciplinary Subcommittee's findings and conclusions with respect to respondent's statutory violations. The Disciplinary Subcommittee cited at length in its findings and conclusions the testimony and a written report by Dr. Alexander, and a reading of her testimony and report demonstrates that she primarily premised her standard of care opinions on respondent's medical records. And respondent's medical records, which he has not shown as being incomplete in any relevant manner, amply support the findings and opinions of Dr. Alexander that the Disciplinary Subcommittee ultimately adopted.

We have reviewed the administrative record, and in particular that part of the record pointed out by the parties, and conclude that the Subcommittee's findings and conclusions are supported by competent, material and substantive evidence. Specifically, all four patient records showed that respondent repeatedly prescribed controlled substances absent much, if any, documentation of a medical basis for the treatment. A review of Dr. Alexander's hearing testimony reveals that her opinions concerning respondent's improper treatment of all four patients accurately portrayed his patient files. The MAPS records of prescriptions to KBF, VF, DR, and LH lent additional support to Dr. Alexander's opinions, but were not essential to her findings and conclusions. Deferring to the Disciplinary Subcommittee's assignment of

credibility to Dr. Alexander's testimony, we conclude that abundant material and competent evidence on the whole record supports the Disciplinary Subcommittee's conclusions that respondent violated MCL 333.16221(a), (b)(i), (b)(vi), and (c)(iv) with respect to KBF, VF, DR, and LH.

II. DR. ALEXANDER'S TESTIMONY

Respondent challenges the hearing referee's admission of, and the Disciplinary Subcommittee's reliance on, the testimony of petitioner's expert witness, Dr. Alexander. In respondent's view, while the allegations of misconduct depended on complaints about respondent's prescription of controlled substances, Dr. Alexander "has no experience in pain management," "was not offered as an expert in that area," and, although Dr. Alexander "had read state guidelines on pain management, . . . [she] did not apply them to this case." Respondent adds that Dr. Alexander's opinions did not rest on sufficient facts or data, or reliable principles or methods, given that she "based her analysis on incomplete medical records" and inaccurate pharmacy reports containing hearsay.

We "review[] a trial court's rulings concerning the qualifications of proposed expert witnesses to testify for an abuse of discretion." *Woodard v Custer*, 476 Mich 545, 557; 719 NW2d 842 (2006). An abuse of discretion occurs when a trial court selects an outcome falling outside the range of reasonable and principled outcomes. *Maldonado v Ford Motor Co*, 476 Mich 372, 388; 719 NW2d 809 (2006). To the extent that our review of an evidentiary issue "requires interpretation of the Michigan Rules of Evidence, an issue of law is presented, which this Court reviews de novo." *People v Dobek*, 274 Mich App 58, 93; 732 NW2d 546 (2007).

Respondent disputes Dr. Alexander's qualifications under MRE 702, which provides:

> [i]f the court determines that scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise if (1) the testimony is based on sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.

Respondent does not contest that "scientific, technical, or specialized knowledge" lent assistance to the Disciplinary Subcommittee's comprehension of facts in dispute in this case pertaining to the appropriate family physician standard of care. He does challenge Dr. Alexander's "knowledge, skill, experience, training, or education," the sufficiency of the data on which Dr. Alexander premised her opinions, MRE 702(1), and the reliability of Dr. Alexander's "principles and methods." MRE 702(2).

The record confirms that respondent's treatment of KBF, VF, DR, and LH occurred in the context of a family practice, and that Dr. Alexander possessed board certification in family practice since 1980. Since 1989, Dr. Alexander had both practiced family medicine at the Clinical Center at Michigan State University and worked as a faculty member of MSU's College of Human Medicine. Dr. Alexander averred that she was familiar with the standard of care for

family practice physicians since 1993 in light of her decades of practice as a primary care physician and her eight or nine years of work in setting standards nationally for physicians, specifically authoring questions for "the final licensure exam for M.D. physicians with the National Board of Medical Examiners."[1]

Dr. Alexander testified that her practice included treatment of patients with chronic pain, affirmatively replying to an inquiry whether she had "always treated chronic pain patients in your practice[.]" She repeated on cross-examination that she was "a family physician who treats people with pain and who works in a setting in which I do that all the time." Dr. Alexander's testimony and curriculum vitae detail her extensive "knowledge, skill, experience, training, . . . [and] education" in the realm of family practice, a field that encompassed the treatment of chronic pain patients. MRE 702. Consequently, the hearing referee acted within his discretion when he certified Dr. Alexander as an expert in family practice.

With regard to the requirement in MRE 702(1) that an expert's opinion must rest "on sufficient facts or data," respondent repeats his assertion that the patient records introduced at the disciplinary hearing were incomplete and unreliable. Dr. Alexander relied primarily on KBF's, VF's, DR's, and LH's patient records in forming her findings and conclusions, and, as we discussed in section I, respondent has not demonstrated the incompleteness of these records in any pertinent respect. Over the course of Dr. Alexander's extended testimony, she scrupulously applied family practice standards of care to the information, or lack of documentation, contained in KBF's, VF's, DR's, and LH's medical records. Dr. Alexander applied controlled substance standard of care principles contained in model guidelines. As will be further discussed in section III, the model guidelines for controlled substance treatment of pain are essentially identical to Michigan standards of care, which respondent urges should govern his treatment of KBF, VF, DR, and LH. In conclusion, the hearing referee properly admitted the expert testimony by Dr. Alexander.

III. DUE PROCESS

Respondent lastly maintains that, in a manner that offends constitutional due process principles, "the Board of Medicine . . . turn[ed] its back on its own policies" that were designed to "assur[e] . . . practitioners that they will [be] afforded some leeway in their treatment of chronic pain." Respondent asserts that the Disciplinary Subcommittee "did not address these guidelines in any fashion," and thus "failed to give due weight to the policies of the Department, as well as the representations upon which practitioners rely."

To the extent that respondent argues that the Subcommittee's purported failure to adhere to its own policies on treating chronic pain patients, such a failure would not offend due process. The Due Process clause protects individuals from government decisions that deprive one of life,

[1] According to Dr. Alexander, the family practitioner standard of care varied between urban and rural settings only if "the problems presented require technically more sophisticated facilities, equipment or expertise in terms of specialists . . . in a way that's immediate crisis-oriented. Otherwise, the standard of care doesn't vary."

liberty or property without due process of law. *By Lo Oil Co v Dep't of Treasury*, 267 Mich App 19, 28-29; 703 NW2d 822 (2005). In civil cases "due process of law" generally means receiving notice of the nature of the proceedings and having an opportunity to be heard before a neutral decision maker. *Id*. at 29. Consequently, because respondent was provided notice of all proceedings, was allowed to introduce all proper evidence, and was fully heard by both the hearing officer and Subcommittee, his right to procedural due process was not violated. *Choike v Detroit*, 94 Mich App 703, 707; 290 NW2d 58 (1980).

In any event, the facts do not support any possible due process claim. Dr. Alexander identified at the disciplinary hearing that, in opining regarding standards of care governing the prescription of controlled substances to treat pain, she consulted, among other sources, a 1998 document generated by the Federation of State Medical Boards, entitled Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. Respondent suggests that Dr. Alexander and the Disciplinary Subcommittee should have instead referred to the Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain. But respondent's argument ignores that the Michigan guidelines track nearly verbatim the model guidelines. A page describing the origin of the Michigan guidelines adopted by the Board of Medicine specifically references their "similar[ity] to . . . [guidelines] issued by the Federation of State Medical Boards of the United States (FSMB) entitled 'Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.'" The substantive portions of the Michigan guidelines and the model guidelines are identical.

Respondent, quoting language from the preamble of the Michigan guidelines and model guidelines, complains that the Disciplinary Subcommittee ignored a policy reflected in the guidelines to "assur[e] . . . practitioners that they will be afforded some leeway in their treatment of chronic pain." Respondent highlights the last three paragraphs of the preamble, which state:

> [p]hysicians should not fear disciplinary action from the Board or other state regulatory or enforcement agency for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. *All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law*.
>
> Each case of prescribing for pain will be evaluated on an individual basis. The [B]oard will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs—including any improvement in functioning—and recognizing that some types of pain cannot be completely relieved.

> *The Board[] will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation*, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board[] consider[s] to be within the boundaries of professional practice. [Emphasis added.]

Respondent's appellate characterization of the guidelines as embodying lenient controlled substance prescribing practices ignores the emphasized declarations about proper documentation.

Respondent's appellate argument also neglects to reference or take into account the substance of the guidelines, set forth in section II of the Michigan guidelines and the model guidelines, and in particular the section requiring detailed record keeping:

> The Boards have adopted the following guidelines when evaluating the use of controlled substances for pain control:
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> *6. Medical Records*
>
> *The physician should keep accurate and complete records to include*
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> *--the medical history and physical examination;*
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> *--diagnostic, therapeutic and laboratory results;*
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> *--evaluations and consultations;*
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> *--treatment objectives;*
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> *--discussion of risks and benefits;*
>
> *--treatments;*
>
> *--medications (including date, type, dosage and quantity prescribed);*
>
> *--instructions and agreements; and*
>
> *--periodic reviews.*
>
> Records should remain current and be maintained in an accessible manner and readily available for review. . . . [Emphasis added.]

Dr. Alexander examined the patient records of KBF, VF, DR, and LH in light of the principles identically set forth in both the Michigan guidelines and the model guidelines, and the Disciplinary Subcommittee adopted Dr. Alexander's findings and conclusions. Therefore, respondent has failed to substantiate the factual premise for his due process contention.

Affirmed.

/s/ Kurtis T. Wilder
/s/ Christopher M. Murray