STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF HEALTH CARE SERVICES
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

JAMES W. LEETE, M.D.
License No. 43-01-041116
_____/ Complaint No. 43-12-125211

FIRST SUPERSEDING ADMINISTRATIVE COMPLAINT

Attorney General Bill Schuette, through Assistant Attorney General Heidi L. Johnson, on behalf of the Department of Licensing and Regulatory Affairs, Complainant herein, files this First Superseding Administrative Complaint against James W. Leete, M.D., (Respondent), alleging upon information and belief as follows:

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

2. Respondent is currently licensed to practice medicine pursuant to the Code. At all times relevant to this complaint, until the office was closed on August 21, 2012, Respondent was in private practice in Traverse City, Michigan. However,

Respondent continued to write prescriptions for patients after he closed his practice. Respondent holds no board certifications.

3. Section 16221(a) of the Code authorizes the DSC to take disciplinary action against Respondent 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, Respondent's ability to safely and skillfully practice medicine.

4. Section 16221(b)(i) of the Code authorizes the DSC to take disciplinary action against Respondent for incompetence, which is defined in section 16106(1) of the Code as "a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs."

5. Section 16221(b)(ii) of the Code authorizes the DSC to take disciplinary action against Respondent for substance abuse, as defined at MCL 330.1100d(10) as "the taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof."

6. Section 16221(b)(iii) of the Code authorizes the DSC to take disciplinary action against a licensee for a "mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner."

7. Section 16221(b)(vi) of the Code authorizes the DSC to take disciplinary action against Respondent for lack of good moral character. "Good moral character" is defined at section 1 of 1974 PA 381, as amended, MCL 338.41 et seq, as "the propensity on the part of the person to serve the public in the licensed area in a fair, honest, and open manner."

8. Section 16221(c)(iv) of the Code authorizes the DSC to take disciplinary action against Respondent for obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority; or prescribing drugs for other than lawful diagnostic or therapeutic purposes

9. Section 16221(e)(ii) of the Code authorizes the DSC to impose sanctions against Respondent for betrayal of a professional confidence.

10. Section 16221(h) authorizes the DSC to impose sanctions against Respondent for "[a] violation, or aiding and abetting in a violation, of this article or of a rule promulgated under this article."

11. Section 16213(1) provides that an individual licensed under the Code must maintain a record for each person to whom he has provided medical services,

and maintain that record in a manner that protects the record's integrity, ensures confidentiality and proper use, and ensures that the patient can access his or her record.

12. Section 16213(3) provides that when an individual licensed under the Code closes his practice, retires, or otherwise ceases to practice, the licensee may not abandon his patients' records and must send written notice to the department specifying who has custody of the records and how a patient may obtain them, and must also transfer the records to either a successor licensee, the individual patients, or a health care provider with which the licensee has contracted to maintain and protect the records.

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

FACTUAL ALLEGATIONS

14. On October 3, 2012, the department investigator interviewed Respondent pursuant to an allegation that Respondent was consuming alcohol while practicing medicine. Respondent admitted to the investigator that, for an indeterminate amount of time while operating his medical practice in Traverse City, Michigan, he would consume an average of one to two pints of vodka per day. Respondent admitted that he would drink the vodka during work hours and then return to his practice to treat patients under the influence of alcohol.

15. During the same period of time, Respondent delegated performance of medical procedures to unlicensed office staff because his hands were shaking too badly to provide the treatment himself.

16. Respondent also admitted to the department investigator that he routinely provided patients with post-dated controlled substance prescriptions.

17. During this period of time, Respondent's wife, Fran Kessler, managed his office. Ms. Kessler is not a licensed health professional. Nevertheless, Respondent admitted to the investigator that he authorized Ms. Kessler to call in controlled substance prescriptions to pharmacies. Ms. Kessler called in prescriptions to pharmacies even on days during which Respondent had not been in the office to authorize prescriptions.

18. Respondent admitted to the department investigator that when Respondent closed his office on August 21, 2012, the only notice he provided to his patients was a sign on the door. Respondent further admitted that he did not arrange for alternative care for his patients when he closed his office.

19. Upon a request from a patient to obtain the patient's medical records, Respondent provided the patient his or her original medical records and did not keep a copy for himself.

20. After Respondent closed his office and moved to Grand Rapids, Michigan, in approximately August 2012, Respondent delegated to his brother,

sister-in-law, and nephew responsibility for providing confidential patient medical records from the Traverse City office to patients.

21. When Respondent closed his practice in August 2012, he left controlled substances unsecured in the building; namely, fentanyl patches, oxycodone/apap 5/325 mg, ketamine, diazepam, and testosterone cypionate. Respondent also left behind medication bottles from patients, which included controlled substances. Respondent also left 34 prescription pads unsecured in the office. Respondent also left behind a significant amount of non-controlled medications.

22. Respondent repeatedly prescribed dangerous combinations of narcotics to patients, and repeatedly continued prescribing narcotics to patients even after noting in the patient's chart that the patient was a drug abuser, was obtaining narcotics prescriptions from multiple treaters, or had been admitted to the hospital due to a drug overdose. For example:

Patient C.I.

A. Respondent treated patient C.I., (initials used to maintain confidentiality), an adult female, from August 2001 through November 2002. At her first appointment, on August 3, 2001, Respondent prescribed C.I. Xanax 1 mg, Restoril 30 mg, and Paxil 10 mg, with one refill. At the next appointment, Respondent noted that C.I. had been convicted of driving under the influence of alcohol. At that appointment, he continued C.I. on these medications, but increased Paxil to 20 mg.

B. On December 28, 2001, Respondent prescribed C.I. 30 tablets of Restoril 30 mg and 100 tablets of Xanax 1 mg with instructions to take three per day. On the same day, C.I.'s patient chart reflects that Respondent also wrote prescriptions postdated for January 28, 2002

for another 30 tablets of Restoril 30 mg and an unknown quantity of Vioxx 50 mg.

C. On January 31, 2002, C.I. returned to Respondent's office, and he documented that she was receiving prescriptions from another doctor for Vicodin, Lipitor, Vioxx, and Effexor, which he noted were refilled on January 7, 2002. Nevertheless, Respondent wrote prescriptions postdated for March 1, 2002 for 30 tablets of Restoril 30 mg and 90 tablets of Xanax 1 mg with instructions to take three per day. He also wrote prescriptions postdated for March 28, 2002 for 30 tablets of Restoril 30 mg, 90 tablets of Xanax 1 mg with instructions to take three per day, and diabetic test strips.

D. On April 26, 2002, C.I. returned to Respondent's office for medication refills. Respondent prescribed 100 tablets of Restoril 30 mg with three refills and instructions to take two per day, 100 tablets of Paxil 20 mg with two refills, and 100 tablets of Xanax 1 mg with two refills with instructions to take three per day.

E. On June 6, 2002, C.I. returned to Respondent's office for consultation. Respondent noted "Rx abuse" in C.I.'s chart. Nevertheless, Respondent wrote prescriptions postdated for July 25, 2002 for 100 tablets of Xanax 1 mg and 60 tablets of Restoril 30 mg with instructions to take two per day. Respondent also wrote a prescription postdated for August 26, 2002 for 90 tablets of Xanax 1 mg, with instructions to take three per day.

F. On July 5, 2002, C.I. presented to the emergency department of Munson hospital after displaying drunken behavior. Her blood alcohol level was .260.

G. On July 11, 2002, C.I. presented to the emergency department of Munson hospital subsequent to overdose of MS Contin and alcohol, and was admitted to the Intensive Care Unit. C.I. indicated no recollection of events between July 4 and July 12, 2002. C.I. was discharged on July 17, 2002.

H. On September 24, 2002, C.I. presented to Respondent for consultation. Respondent wrote C.I. a prescription postdated to October 25, 2002 for 90 tablets of Xanax 1 mg, with instructions to take three per day.

I. On November 13, 2002, C.I. died. Her death certificate provides "mixed drug overdose" as her immediate cause of death.

Patient D.W.

J. A MAPS report for patient D.W., an adult male, shows that D.W. filled prescriptions written by Respondent from December 1, 2010 through March 31, 2012. D.W.'s MAPS report shows D.W. obtained the following drugs prescribed by Respondent:

(1) Alprazolam 1 mg:

Date	Quantity
12/8/2011	120
12/12/2011	120
1/30/2012	90
2/22/2012	90

(2) Suboxone 8 mg-2 mg:

Date	Quantity
12/8/2011	30
12/9/2011	30
12/14/2011	60
1/30/2012	12
1/31/2012	3
2/4/2012	4
2/6/2012	5
2/7/2012	14
2/8/2012	4
2/10/2012	8
2/12/2012	7
2/14/2012	3

(3) Methadone HCL 10 mg:

Date	Quantity
2/2/2012	120
2/23/2012	120

K. On December 18, 2009, Respondent also signed a medical marihuana certification form for D.W.

L. On March 2, 2012, D.W. died. His death certificate provides "acute methadone toxicity" as his immediate cause of death.

Patient S.M.

M. Patient S.M., an adult male, began treating with Respondent in approximately January 2006. S.M. complained of a stiff neck related to his occupation as a glass-blower. Respondent prescribed tramadol 50 mg. Respondent continued to prescribe S.M. tramadol through the spring of 2007.

N. At an appointment in in the spring of 2007, S.M. presented to Respondent for a burn on his arm and for refills. Respondent prescribed the usual 240 tramadol tablets, but added 20 tablets of Vicodin ES, with one refill.

O. In November 2007, S.M. presented to Respondent complaining of trouble sleeping. Respondent prescribed Xanax 1 mg one to two times per day. Respondent continued prescribing tramadol and Vicodin.

P. On May 30, 2008, S.M. presented to Respondent complaining of continuing insomnia. Respondent prescribed Dalmane 30 mg and advised S.M. to hold off taking any more Xanax. Respondent continued to prescribe tramadol and Vicodin.

Q. In the fall of 2008, S.M. presented to Respondent for a follow-up appointment and advised that S.M.'s girlfriend had been taking the medications prescribed by Respondent for S.M.

R. In approximately September 2008, S.M. presented to Respondent after presenting to the Emergency Department of Munson Medical Center subsequent to experiencing seizures. Respondent's chart for S.M. includes S.M.'s toxicology screen from Munson, which indicated the presence of cocaine and barbituates. Respondent advised S.M. to stop taking tramadol. Respondent prescribed phenobaritol three times per day with seven refills, as well as Ambien 10 mg for insomnia and Prestique once per day.

S. On October 17, 2008, S.M. was taken to the Munson Medical Center ED by city police subsequent to becoming physically abusive after ingesting an unknown quantity of unknown drugs. S.M.'s toxicology results showed a high level of phenobarbital. Respondent's chart includes a record of this hospital stay.

T. On December 1, 2008, S.M. presented to Respondent with various complaints. Respondent noted a history of substance abuse and that S.M. occasionally used cocaine and marijuana. Respondent continued to prescribe Vicodin.

U. On January 25, 2009, S.M. presented to Respondent with continued pain from a serious burn on his right buttock. Respondent prescribed oxycodone 80 mg and advised S.M. to take ½ tablet as needed for pain.

V. On January 27, 2009, Respondent charted that he prescribed S.M. 120 tablets of Norco 10/325, with instructions to take 1-4 per day, and with one refill.

W. On February 9, 2009, S.M. advised Respondent that he did not like the extended release oxycodone. Respondent prescribed 40 mg generic oxycodone every 4-6 hours as needed for pain.

X. On February 13, 2009, S.M. presented to Respondent reporting continued pain from the burn wound. Respondent prescribed 30 tablets of oxycodone 20 mg with instructions to take one tablet three times per day. Respondent noted in S.M.'s chart: "Need careful surveillance of narcotic & other substance abuse."

Y. On February 16, 2009, S.M. presented to Respondent for medication refills. Respondent prescribed 60 tablets of oxycodone 40 mg. Respondent also prescribed 60 tablets of Xanax 1 mg at this appointment. Respondent noted risk of overdose in the S.M.'s chart.

Z. On February 24, 2009, S.M. presented to Respondent complaining that the current dosage of oxycodone was insufficient to manage his pain. Respondent increased S.M.'s dosage of oxycodone to 80 mg and prescribed 60 tablets. Respondent continued to prescribe oxycodone to S.M. throughout the next seven months.

AA. On October 1, 2009, Respondent sent S.M. a letter withdrawing from treating him. Respondent noted on the letter that S.M. had a history of altering prescriptions and excessively using narcotics. Respondent recommended substance abuse counseling.

BB. Notwithstanding his October 1, 2009 letter, Respondent continued to prescribe S.M. narcotics, including oxycodone.

CC. Despite being aware that S.M. was a drug addict, on December 18, 2009, Respondent signed a medical marihuana certification form for S.M.

DD. Respondent continued to prescribed S.M. narcotics, including oxycodone, through October 2010.

EE. On November 7, 2010, S.M. died. His death certificate provides "mixed drug overdose toxicity" as his immediate cause of death.

COUNT I

23. Respondent's conduct as described above constitutes a violation of general duty, consisting of negligence or failure to exercise due care, contrary to section 16221(a) of the Code.

COUNT II

24. Respondent's conduct as described above constitutes incompetence, contrary to section 16221(b)(i) of the Code.

COUNT III

25. Respondent's conduct as described above constitutes substance abuse, contrary to section 16221(b)(ii) of the Code.

COUNT IV

26. Respondent's conduct as described above constitutes a mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner, contrary to section 16221(b)(iii) of the Code.

COUNT V

27. Respondent's conduct as described above constitutes a lack of good moral character, as defined by 1974 PA 381, as amended, contrary to section 16221(b)(vi) of the Code.

COUNT VI

28. Respondent's conduct as described above constitutes obtaining, possessing, or attempting to obtain or possess a controlled substance without lawful authority; or prescribing drugs for other than lawful diagnostic or therapeutic purposes, contrary to section 16221(c)(iv) of the Code.

COUNT VII

29. Respondent's conduct as described above constitutes betrayal of a professional confidence, contrary to section 16221(e)(ii) of the Code.

COUNT VIII

30. Respondent's conduct as described above constitutes a violation of section 16213(1), contrary to section 16221(h).

COUNT IX

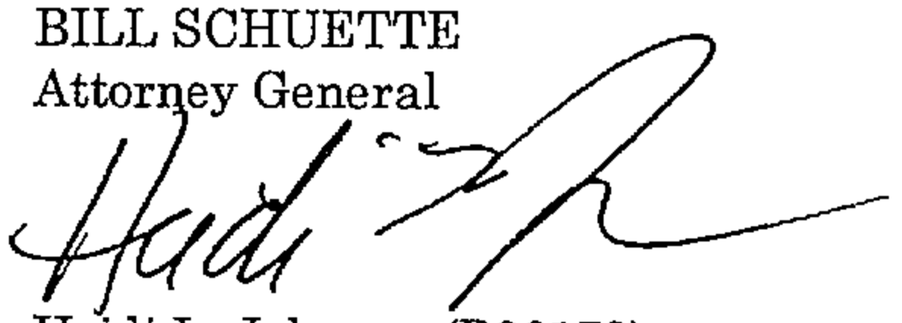
31. Respondent's conduct as described above constitutes a violation of section 16213(3), contrary to section 16221(h).

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(7) of the Public Health Code, Respondent has 30 days from receipt of this complaint to submit a written response to the allegations contained in it. The written response shall be submitted to the Bureau of Health Care Services, Health Professions Division, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, Michigan, 48909, with a copy to the undersigned assistant attorney general. Further, pursuant to section 16231(8), failure to submit a written response within 30 days shall be treated as an admission of the allegations contained in the Complaint and shall result in transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

FURTHER, the administrative complaint previously filed against Respondent on October 8, 2013, is hereby WITHDRAWN and replaced in full by this superseding complaint.

Respectfully Submitted,

BILL SCHUETTE
Attorney General



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Date: April 28, 2014

PROOF OF SERVICE

The undersigned certifies that on the date indicated above a copy of the foregoing document was served upon Brian W. Whitelaw, Attorney for Respondent, by mailing the same enclosed in an envelope bearing first class postage fully prepaid and plainly addressed as follows:

Brian W. Whitelaw
Aardema Whitelaw, P.L.L.C.
5360 Cascade Road, SE
Grand Rapids, MI 49546

Jamie L. LaVigne

LF. 2013-0041697-B/Leete, James W., M D., 125211/0001131295S045/p.FSAC