



1           5.     This Consent Agreement does not constitute a dismissal or resolution of  
2 other matters currently pending before the Board, if any, and does not constitute any  
3 waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any  
4 other pending or future investigation, action or proceeding. The acceptance of this  
5 Consent Agreement does not preclude any other agency, subdivision or officer of this  
6 State from instituting other civil or criminal proceedings with respect to the conduct that is  
7 the subject of this Consent Agreement.

8           6.     All admissions made by Respondent are solely for final disposition of this  
9 matter and any subsequent related administrative proceedings or civil litigation involving  
10 the Board and Respondent. Therefore, said admissions by Respondent are not intended  
11 or made for any other use, such as in the context of another state or federal government  
12 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
13 any other state or federal court.

14           7.     Upon signing this agreement, and returning this document (or a copy thereof)  
15 to the Board's Executive Director, Respondent may not revoke the acceptance of the  
16 Consent Agreement. Respondent may not make any modifications to the document. Any  
17 modifications to this original document are ineffective and void unless mutually approved  
18 by the parties.

19           8.     If the Board does not adopt this Consent Agreement, Respondent will not  
20 assert as a defense that the Board's consideration of this Consent Agreement constitutes  
21 bias, prejudice, prejudgment or other similar defense.

22           9.     This Consent Agreement, once approved and signed, is a public record that  
23 will be publicly disseminated as a formal action of the Board and will be reported to the  
24 National Practitioner Data Bank and to the Arizona Medical Board's website.

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1 MD-09-0467A after Board Staff conducted a pharmacy survey that demonstrated that  
2 Respondent violated a Board Order.

3 MD-07-0189A - PATIENT CM

4 4. On February 6, 2004, CM presented to Respondent for pain management.  
5 Despite no documented pain generators or diagnosis, Respondent prescribed Dilaudid  
6 and Hydrocodone and escalated her prescription for Methadone. From March 2004  
7 through 2005, Respondent prescribed numerous escalating doses of Methadone,  
8 Oxycontin, Demerol, Oxycodone, Actiq and Hydrocodone for various complaints that  
9 included cervical degenerative disc and osteoarthritis of multiple sites. Despite magnetic  
10 resonance imaging studies and x-rays that reported mild degenerative changes,  
11 Respondent continued to prescribe escalating doses of narcotics and other controlled  
12 substances.

13 5. On October 16, 2006, CM presented for a follow up visit. CM reported erratic  
14 behavior and that she lost her prescriptions. Respondent ordered a urine drug screen that  
15 was positive for Methadone, which had not been prescribed to CM for at least a year.  
16 There was no indication that Respondent addressed CM's erratic behaviors or the positive  
17 drug screen.

18 6. On April 3, 2007, the Board notified Respondent of its investigation and  
19 requested CM's medical records. Respondent initially provided Staff with CM's medical  
20 records from February 2006 through March 2007. Subsequently, Respondent submitted  
21 the remaining medical records dated February 2004 through 2006; however, the medical  
22 records did not correspond to the initial medical records submitted by Respondent.  
23 Specifically, the diagnosis of Fibromyalgia and a documented physical exam appeared in  
24 each of the subsequent records, but not in the initial records. Additionally, the medical  
25 record dated February 6, 2004 contained the time of an open median nerve

1 decompression surgery CM underwent in December 19, 2005, which Respondent would  
2 not have known about in 2004, indicating Respondent created or altered the record  
3 thereafter.

4 7. The standard of care requires a physician to have indications of pain  
5 generators and corresponding diagnoses before continuing opioid medication and  
6 escalating doses and to assess and appropriately treat break through pain. The standard  
7 of care also requires a physician to appropriately recognize, monitor, and act on worsening  
8 function and pain, significant side effects, or red flags of drug addiction, diversion behavior,  
9 or medication misuse and to address abnormal findings on urine drug test results.  
10 Additionally, the standard of care requires a physician to safely titrate Methadone; to treat  
11 chronic non-malignant pain with medications, psychological approaches, and behavioral  
12 strategies to reduce distress; and to obtain specialist consultations as indicated.

13 8. Respondent deviated from the standard of care because he did not have  
14 present presumed pain generators and diagnoses for continuing opioid medication and  
15 escalating doses for the patient CM; he did not assess and appropriately treat CM's break  
16 through pain. Respondent also deviated from the standard of care because he did not  
17 appropriately monitor and recognize CM's drug addiction and diversion behavior, or  
18 medication misuse and he did not address abnormal findings on her drug test results.  
19 Additionally, Respondent deviated from the standard of care because he did not safely  
20 titrate CM's Methadone doses.

21 9. Respondent's inappropriate management of CM's chronic pain could have  
22 led to Methadone toxicity, overdose, brain damage and death.

23 **MD-07-1027A - PATIENT LM**

24 10. From March 2002 through October 2006, LM presented to Respondent with  
25 a diagnosis of rheumatoid arthritis, fibromyalgia, depression and generalized anxiety.

1 Respondent treated LM with escalating dosages of opioids, antidepressants, muscle  
2 relaxants, stimulants and anxiolytics. There was no indication that Respondent obtained  
3 LM's medical records, lab results or communicated with LM's rheumatologist prior to  
4 prescribing medications. At several office visits, LM reported continued severe pain,  
5 increased depression and anxiety, decreased functionality, somnolence, difficulty  
6 concentrating and poor short-term memory. Despite this, Respondent continued to  
7 prescribe escalating opioid dosages without re-evaluating LM or reviewing past medical  
8 records. Respondent also did not recognize, monitor, or act upon signs of unchanged or  
9 worsening function and pain, significant side effects or red flags of substance misuse.  
10 Additionally, Respondent allowed LM to adjust her medications and dosages.

11 11. On several occasions, Respondent noted that LM had continuing and  
12 escalating complaints of pain, depression and anxiety and that she needed consultations  
13 with specialists in psychiatry, pain management and rheumatology. However, there was no  
14 indication that Respondent referred LM to any specialists. On November 17, 2008, LM  
15 voluntarily admitted herself to inpatient behavioral health due to suicidal ideation.  
16 Subsequently, LM died of Oxycodone and Alprazolam overdose.

17 12. The standard of care requires a physician to have indications of pain  
18 generators and corresponding diagnoses before continuing opioid medication and  
19 escalating doses and to assess and appropriately treat break through pain. The standard  
20 of care also requires a physician to treat chronic non-malignant pain with medications,  
21 psychological approaches, and behavioral strategies to reduce distress; and to obtain  
22 specialist consultations as indicated.

23 13. Respondent deviated from the standard of care because he did not have  
24 present presumed pain generators and diagnoses for continuing opioid medication and  
25 escalating doses for LM. Respondent also deviated from the standard of care because he

1 did not treat LM's chronic non-malignant pain with other non-medication approaches and  
2 he did not obtain speciality consultations for her as indicated.

3 14. LM committed suicide and she was at high risk of accidental overdose from  
4 duplicative depressant medications and Respondent's failure to adjust medications. There  
5 was potential for LM to suffer hepatotoxicity.

6 MD-08-1090A - PATIENT DO

7 15. On February 12, 2003, DO presented to Respondent for pain management.  
8 Despite not obtaining or reviewing any past medical records, diagnostic imaging or  
9 specialist consultations, Respondent prescribed Percocet and Soma. From February 2003  
10 through January 2007, Respondent prescribed escalating doses of Percocet,  
11 Hydromorphone, Flexeril, Baclofen, and Demerol for chronic pain. In October 2004,  
12 Respondent added Oxycodone in anticipation of dental extractions and ordered lumbar  
13 spine films. There was no indication that Respondent communicated with DO's dentist  
14 regarding the extractions and the lumbar spine films showed minimal findings. Despite  
15 this, Respondent continued to prescribe Oxycodone.

16 16. In July 2005, Respondent documented that DO was a high-risk patient and  
17 provided her with samples of antidepressant medication; however, he did not refer her to a  
18 mental health provider. In October 2005, Respondent obtained cervical spine x-rays that  
19 showed minimal findings and bilateral shoulder x-rays that were normal; however,  
20 Respondent continued to prescribe opioid medications for chronic pain. In September  
21 2006, Respondent ordered a urine drug test that was negative for Oxycodone, but positive  
22 for metabolites of Valium, which was not prescribed by Respondent. There was no  
23 indication that Respondent followed up on the test results. Subsequently, DO overdosed  
24 on the prescription medications and required ventilatory support. She was later discharged  
25 without sequelae.

1           17. The standard of care requires a physician to obtain a patient's pain history,  
2 perform a targeted physical exam and review past medical records and diagnostic studies.  
3 The standard of care also requires a physician to appropriately recognize, monitor, and act  
4 on worsening function and pain, significant side effects, or red flags of drug addiction,  
5 diversion behavior, or medication misuse and to address abnormal findings on urine drug  
6 test results. Additionally, the standard of care requires a physician to treat chronic non-  
7 malignant pain with medications, psychological approaches, and behavioral strategies to  
8 reduce distress; and to obtain specialist consultations as indicated.

9           18. Respondent deviated from the standard of care because he did not have  
10 present presumed pain generators and diagnoses for continuing opioid medication and  
11 escalating doses for DO. Respondent also deviated from the standard of care because he  
12 did not appropriately monitor, recognize and act on the patients' worsening function and  
13 pain, significant side effects, red flags of drug addiction, diversion behavior, or medication  
14 misuse. Moreover, he did not address abnormal findings on drug test results for DO.  
15 Finally, Respondent deviated from the standard of care because he did not obtain  
16 specialty consultations for DO as indicated.

17           19. DO suffered a near-fatal overdose requiring mechanical ventilation, and  
18 hospitalization and there was potential for her to develop worsening anxiety and  
19 depression, suicide attempt or completed suicide as a result of Respondent's failure to  
20 refer her to a mental health provider. Additionally, there was potential for perpetuation of  
21 DO's substance misuse, abuse and/or addiction, by not identifying treatable etiologies of  
22 subjective complaints and for interfering with the surgeon's post-operative care and  
23 causing delay in recognizing a post-operative complication.

24           20. A physician is required to maintain adequate legible medical records  
25 containing, at a minimum, sufficient information to identify the patient, support the

1 diagnosis, justify the treatment, accurately document the results, indicate advice and  
2 cautionary warnings provided to the patient and provide sufficient information for another  
3 practitioner to assume continuity of the patient's care at any point in the course of  
4 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he  
5 prescribed escalated dosages of medications to DO without documented indication.

6 21. On June 3, 2008, Respondent was ordered to undergo a PACE evaluation  
7 and to comply with recommendations. On August 11-12, 2008, Respondent attended  
8 Phase I of PACE and it was recommended that he return for Phase II for further evaluation  
9 in a clinical setting. On November 17-21, 2008, Respondent attended Phase II of PACE  
10 and it was recommended that he provide more details in his chart notes and obtain a  
11 prescribing handbook. PACE opined that Respondent demonstrated excellent clinical  
12 knowledge of common clinical problems, but he had limited knowledge of chronic pain  
13 management.

14 **MD-09-0467A - PATIENTS CD and AT**

15 22. Subsequently, the Board initiated case number MD-09-0467A after Board  
16 Staff conducted a pharmacy survey that demonstrated that Respondent violated a Board  
17 Order. On June 18, 2008, Respondent entered into an Interim Consent Agreement for a  
18 Practice Restriction, which restricted him from prescribing no more than #30 short acting  
19 opioids with no refills. However, on December 15, 2008 and January 28, 2009,  
20 Respondent wrote a prescription for #80 Vicodin for patient CD. On April 7, 2009, during  
21 an investigational interview, Respondent admitted that he wrote a prescription for #80  
22 Vicodin for patient CD on two occasions. Additionally, it was noted that Respondent also  
23 prescribed Dantrolene and administered trigger point injections to patient CD without  
24 documenting the spasticity associated with an upper motor neuron disorder. Respondent  
25 subsequently informed Staff that he prescribed Tylenol # 3 to patient AT in January 2009.



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**ORDER**

**IT IS HEREBY ORDERED THAT:**

1. Respondent is issued a Decree of Censure.

2. **Practice Restriction**

a. Respondent is prohibited from prescribing, administering or dispensing any controlled substances for a period of three years (please see (c.) below).

b. Respondent may petition the Board to terminate the practice restriction after two years. The Board may require any combination of staff approved physical examination, psychiatric and/or psychological evaluations, or successful passage of the Special Purpose Licensing Examination or other competency examination/evaluation or interview it finds necessary to assist it in determining Respondent's ability to safely and competently return to prescribing, administering or dispensing Controlled Substances. Respondent is responsible for all expenses related to any evaluation.

c. This restriction does not preclude Respondent from administering controlled substances in life-threatening emergencies.

3. **Probation**

Respondent is placed on probation for three years with the following term and condition:

a. In the event the practice restriction is terminated in less than three years, Respondent shall employ Affiliated Monitors to conduct quarterly chart reviews for the remainder of the probationary period and report results to the Board. Respondent shall pay the expenses of Affiliated Monitors and

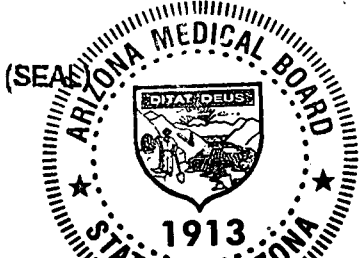
1 all chart reviews and fully cooperate with any requests made by Affiliated  
2 Monitors in conducting the chart reviews.

3 4. Tolling

4 In the event Respondent should leave Arizona to reside or practice outside  
5 the State or for any reason should Respondent stop practicing medicine in Arizona,  
6 Respondent shall notify the Executive Director in writing within ten days of departure and  
7 return or the dates of non-practice within Arizona. Non-practice is defined as any period of  
8 time exceeding thirty days during which Respondent is not engaging in the practice of  
9 medicine. Periods of temporary or permanent residence or practice outside Arizona or of  
10 non-practice within Arizona, will not apply to the reduction of the probationary period.

11 5. This Order is the final disposition of case numbers MD-07-0189, MD-07-  
12 1027A, MD-08-1090A, and MD-09-0487A.

13 DATED AND EFFECTIVE this 14<sup>TH</sup> day of APRIL, 2010.



ARIZONA MEDICAL BOARD

15 By: [Signature]  
16 Lisa S. Wynn  
17 Executive Director

18 ORIGINAL of the foregoing filed  
19 this 15<sup>th</sup> day of April, 2010 with:

20 Arizona Medical Board  
21 9546 E. Doubletree Ranch Road  
22 Scottsdale, AZ 85258

23 EXECUTED COPY of the foregoing mailed  
24 this 15<sup>th</sup> day of April, 2010 to:

25 Darrell J. Jessop, M.D.  
Address of Record

[Signature]  
Investigational Review  
#743228