BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **STEPHEN O. MORRIS, M.D.** Holder of License No. **10800** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0358A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on October 11, 2007. Stephen O. Morris, M.D., ("Respondent") appeared before the Board with legal counsel Sarah L. Sato for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 10800 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0358A after receiving a complaint regarding Respondent's care and treatment of a fifty-six year-old male patient ("JN") alleging Respondent's inappropriate and excessive prescribing contributed to JN's overdose and death. JN had a history of multiple psychiatric diagnoses, polysubstance abuse, and non-compliance with medication recommendations. JN was referred to Respondent and had his first visit on February 17, 2004. Over the next fifteen months, Respondent prescribed a broad range of psychoactive controlled substances. JN died on May 9, 2005 from an accidental overdose of prescription medication.

4. Prior to presenting to Respondent, JN was being treated by an allergist/immunologist/internist for depression. This physician noted JN had high blood pressure and her records indicate she prescribed Zyprexa, BuSpar, Trazodone, Lamictal, Klonopin, testosterone injections, Fioricet, and Diovan and she identified an "increased dose of codeine for pain." This physician diagnosed "Bipolar – Depression," headache and pain and also treated JN with all the medications listed above plus Celebrex, Xanax, Imitrex, Tramalol, Ultram, Botox, Effexor and Adderall. On January 29, 2004 this physician noted JN's alcohol abuse had increased and was "probably every day." On this same date, she referred JN to Respondent for psychiatric evaluation. On the first visit Respondent used a standardized SCID form, but did not document a standard mental status examination and did not list any DSM-IV Axis I-IV diagnosis. Respondent indicated there was alcohol and marijuana abuse; depression, which may have been substance induced; irritability, suicidal thoughts; and positive hypomania.

5. Over the next fifteen months that Respondent treated JN he prescribed multiple psychoactive prescriptions often in higher than standard practice doses. Respondent wrote multiple prescriptions for the same Class of medication, particularly sleep medication and controlled Class V medications. Respondent also prescribed methylphenidate for several months with a higher than necessary number of pills prescribed. For instance, when prescribing methylphenidate 20mg tid, Respondent prescribed the 10mg size "2tid" instead of the 20 mg size, resulting in a prescription of 180 controlled substance pills instead of 90. The same dose was available in single capsule, one daily dosing (30 per month) that had a much lower potential for abuse or diversion. Respondent also write prescriptions too close together in time, indicating over-use or abuse. Respondent's record contains no entry indicating concern for possible substance abuse, diversion to others, or of being manipulated for more medication than necessary.

6. Respondent documented that he referred JN to a therapist within his practice, but made no follow-up comments to indicate if JN ever underwent the therapy sessions or how they might impact JN's care or Respondent's further prescribing. Respondent's records show constantly shifting medications; polypharmacy; no clear cut differential diagnosis or primary diagnosis that he was addressing; no rationale when medications, including controlled substances, were abruptly stopped or started for brief periods; no explanation of why higher than recommended amounts were prescribed; and no consultations. Respondent's record does not contain any communication back to the referring physician for coordination of JN's care.

7. On March 25, 2005 JN presented to Respondent's office clearly drugged and admitted to taking Phenobarbital. JN went to St. Luke's and was discharged on Gabitril, Paxil, Neurontin, and Doxepin for sleep. Respondent placed JN on Adderall-XR 15mg q d #30. There is no adequate work-up for ADHD or a diagnosis of ADHD in the records to support the prescribing of Adderall for ADHD. There is also no note that the prescription was for adjunct treatment of depression, for narcolepsy, daytime sleepiness or other off-label use. On April 20, 2005 Respondent prescribed Doxepin 100mg #60, indicating up to 200mg per day, or four times the hospital discharge dose. Respondent prescribed the Doxepin, a first generation tricyclic antidepressant and, on the same day, prescribed Paxil, a second generation antidepressant, at 60mg per day, given as a 40mg and 20mg tablet. In total on this date JN was given Paxil 40mg #30, Paxil 20mg #30, Doxepin 100mg #60 and Imitrex 100mg #5 – a total of 125 pills. Respondent prescribed this amount after JN was hospitalized twice with suicidal ideation, admitted substance abuse, including prescription abuse, and even though JN was highly unstable. The pharmacy refilled the Doxepin 16 days later and also filled a prescription for Lunesta 3mg #30. Two days earlier JN filled a prescription for Neurontin 300mg #270.

8. Respondent's record only reflects that he performed a mental status of JN on his initial visit and not again during his treatment. Respondent does not complete an entire mental

status examination again on patient, rather he does a focused evaluation, but does not always record it. Respondent records contain many of JN's subjective complaints, but not much objective analysis and no assessments or diagnoses. Respondent's January 19, 2005 note, just prior to JN's hospitalization, mentions JN's suicidal ideation and other things, but there is no documentation of any questioning of harm to himself or others.

9. Respondent maintained his doubling and then quadrupling the dose of Doxepin over a short period of time after JN's hospitalization was not a large dose, even though he acknowledged it is typically given in a lower dose and escalated as needed. Paxil and Doxepin interact and the Paxil takes over the P450 enzyme system to the exclusion of the Doxepin and the Doxepin metabolism is slowed down, it tends to linger and build. JN was a patient with known polysubstance abuse and clear patterns of overuse of prescribed medications, yet Respondent did not maintain control over the medications. Respondent agreed that monitoring blood levels of tricyclic antidepressants in a patient who is also on SSRIs is important, yet there was no evidence in JN's records that he did so. Respondent noted the literature reflects that in research blood levels and EKGs are done, but he does not believe doing so has "trickled down" to the clinical level.

10. Respondent maintained JN did not exhibit any signs of Serotonin Syndrome, yet his records reflect that essentially every little thing caused him to tremor more. One of the effects of high brain levels of serotonin is clonus or tremor. However, Respondent never considered that JN might have had Serotonin Syndrome, because JN was not feeling especially anxious and could sit calmly.

11. Respondent's records contain only a narrative that JN was prescribed certain drugs, but there is no rationale for the higher doses of the potentially dangerous drugs prescribed to JN – why the medications were used, the type used, the combination used. For instance, there is no documentation that Respondent was or was not using Paxil for anxiety.

12. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because they did not support his diagnosis, justify the treatment, or provide sufficient information for another practitioner to assume continuity of the patient's care.

13. The standard of care required Respondent to monitor a patient's tricyclic blood levels while he was on concurrent SSRIs.

14. Respondent deviated from the standard of care by failing to monitor JN's tricyclic blood levels while he was on concurrent SSRIs.

15. The standard of care required Respondent to refrain from prescribing a large quantity of tricyclic antidepressants and Ritalin to a patient who was a known risk for overdosing.

16. Respondent deviated from the standard of care by prescribing a large quantity of tricyclic antidepressants and Ritalin to JN who was a known risk for overdosing.

17. The standard of care required Respondent perform regular mental status examinations when treating a patient for multiple psychiatric diagnoses and to conduct repetitive questioning of a depressed patient regarding self harm, suicidal ideation or harm to others.

18. Respondent deviated from the standard of care by failing to perform regular mental status examinations and failing to question JN regarding potential harm to self or others.

19. The standard of care requires a physician to make an adequate DSM I-V diagnosis.

20. Respondent deviated from the standard of care by failing to make an adequate DSM I-V diagnosis.

21. JN overdosed while under Respondent's care and died.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient;") A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient of the public") and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to diagnose and monitor a patient considered to be high risk for drug abuse; for inappropriate prescribing; and for inadequate medical records.

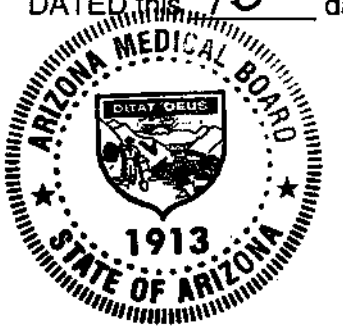
RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a

petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 16th day of January, 2008.



THE ARIZONA MEDICAL BOARD

By _____
AMANDA J. DIEHL, MPA, CPM
Deputy Executive Director

ORIGINAL of the foregoing filed this 16th day of January, 2008 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 16th day of January, 2008, to:

Sarah L. Sato
Olson, Jantsch & Bakker, PA
7243 North 16th Street
Phoenix, Arizona 85020-7250

Stephen O. Morris, M.D.
Address of Record

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