

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **GERALD S. ASIN, M.D.**

4 Holder of License No. 20348  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Case No. MD-10-0131A

**ORDER FOR DECREE OF CENSURE  
AND PRACTICE RESTRICTION AND  
CONSENT TO THE SAME**

7 Gerald S. Asin, M.D. ("Respondent") elects to permanently waive any right to a  
8 hearing and appeal with respect to this Order for Decree of Censure and Practice  
9 Restriction; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to  
10 the entry of this Order by the Board.

11 **FINDINGS OF FACT**

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

14 2. Respondent is the holder of license number 20348 for the practice of  
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-10-0131A after receiving an  
17 anonymous complaint regarding Dr. Asin's care and treatment of patients SS, DK, LR and  
18 JM alleging inappropriate prescribing.

19 **PATIENT S.S.**

20 4. In February 2006, patient SS, a 52 year-old female patient established care  
21 with Respondent. Respondent received a list of daily medications used by SS on the initial  
22 visit, three of which were controlled substances used by SS on a daily basis for chronic  
23 pain. SS's medical condition became increasingly complex with multiple medical  
24 consultants prescribing and evaluating her. Subsequently, SS's analgesic medications  
25 became more potent and were taken more frequently. SS's records indicate that she

1 became more depressed, withdrawn, and eventually stopped working. In June 2009,  
2 Respondent started SS on oxycontin in the place of hydrocodone. SS's mother found SS  
3 dead the following month.

4 **PATIENT D.K.**

5 5. In February 2001, DK, a 49 year-old male patient, first presented to  
6 Respondent. DK reported a long history of back pain and prior work up and treatments  
7 from unnamed physicians in the past that were unsuccessful in alleviating his back  
8 discomfort. Over the ensuing 5½ years, Respondent treated DK with escalating doses of  
9 various opiates, benzodiazepines and stimulant medications. In June 2007, DK died of  
10 drug intoxication.

11 **PATIENT L.R.**

12 6. In May 2002, LR, a 39 year-old female patient, presented to Respondent with  
13 a diagnosis of fibromyalgia that had been treated with soma and Tylenol. Respondent  
14 treated LR for seven years for a variety of pain related and non-pain related conditions. In  
15 July 2005, LR was hospitalized for a prescription drug overdose. The potency and  
16 strength of LR's chronic pain medications were routinely increased during the seven-year  
17 relationship with Respondent. On the date of the last visit, LR was consuming 240  
18 percocet, 120 soma, 60 mscontin, 90 clonazepam and 30 flurazepam on a monthly basis.  
19 On November 7, 2009, LR died. The death certificate indicated that LR died of multi-drug  
20 intoxication.

21 **PATIENT J.M.**

22 7. In 2002, JM, a 27 year-old female, presented to Respondent with a two-year  
23 history of migraine headaches, cervical spine discomfort and diffuse muscular pain. JM  
24 was also diagnosed with fibromyalgia. Prior to JM's establishment with Respondent's  
25 office, she had been managed with ibuprofen, tramadolol and occasional Fioricet for

1 migraine relief. At the time of JM's departure from Respondent's practice, JM was  
2 consuming 20 methadone, 6 oxycodone, 6 dilaudid and up to 4 fioricet on a daily basis.  
3 Dosages of opiate medications were gradually escalated over time. Specialty consultations  
4 were sought, but outcomes did not meaningfully change the course of progressive opiate  
5 requirements. JM's pain medication prescriptions continued to be fulfilled by Respondent  
6 even when JM was not in the country.

7 8. The standard of care for controlled substances management requires a  
8 physician to establish a formal goal oriented treatment plan of the patient, perform periodic  
9 assessments as part of the patient's longitudinal pain management program, and to enter  
10 into a pain treatment contract with the patient.

11 9. Respondent deviated from the standard of care by failing to establish a  
12 formal goal oriented treatment plan of SS, by failing to perform periodic assessments as  
13 part of SS's longitudinal pain management program and by failing to enter into a pain  
14 treatment contract with SS.

15 10. The standard of care for controlled substances management requires a  
16 physician to follow a goal oriented treatment program, attempt to obtain and review prior  
17 patient records, to perform a specific musculoskeletal or neurologic exam and to consult  
18 with appropriate specialists.

19 11. Respondent deviated from the standard of care by failing to follow a goal  
20 oriented treatment program, by failing to attempt to obtain and review DK's prior records,  
21 by failing to perform a specific musculoskeletal or neurologic exam and by failing to consult  
22 with an orthopedic spine specialist or chronic pain specialist.

23 12. The standard of care for controlled substances management requires a  
24 physician to have ongoing regular office assessments and to consult with pain  
25 subspecialists to enhance care and safety of controlled substance therapy.

1           13. Respondent deviated from the standard of care by failing to have ongoing  
2 regular office assessments of LR and by failing to coordinate LR's pain management with  
3 psychiatry and a pain management specialist.

4           14. The standard of care for controlled substances management requires a  
5 physician to enter into a pain treatment contract with the patient, to perform  
6 comprehensive physical or neurologic exams to confirm legitimacy of the patient's pain, to  
7 follow prescriptions with urine drug screens to exclude fraudulent diversion and to assess  
8 the patient's mood disorder.

9           15. Respondent deviated from the standard of care by failing to enter into a pain  
10 treatment contract with JM, by failing to perform comprehensive physical or neurologic  
11 exams to confirm legitimacy of JM's pain, by prescribing large doses of pain medication  
12 that were not followed by urine drug screens to exclude fraudulent diversion, and by failing  
13 to assess JM's depression.

14           16. Respondent caused actual harm to patients DK and JM. In October 2005,  
15 DK was involved in a motor vehicle accident when he fell asleep at the wheel. At the time  
16 of the accident, DK was taking at least 150mg a day of methadone. DK's death was  
17 attributed to accidental drug overdose. JM had an extreme opiate tolerance and  
18 dependency that emerged over her seven-year relationship with Respondent.

19           17. Respondent potentially contributed to SS's depressive mental condition as  
20 well as gastrointestinal ("GI") disturbances by prescribing many medications that had  
21 multiple depressive and sedating properties. Polypharmacy with large quantities of  
22 controlled substances in a depressed patient ("SS") without routine regular office follow up  
23 is a potential risk for misuse and overdose. Many of DK's symptoms could have been  
24 exacerbated, if not caused, by daily use of high dose opiate and benzodiazepine  
25 mediations. Infrequent office visits may have overlooked the severity of LR's depression

1 and emotional instability. More intensive psychiatric support or more frequent primary care  
2 office visits may have averted LR's July 2005 suicide attempt. Enormous quantities of  
3 opiate dispensed at once are high risk for the medication to fall into the wrong hands, and  
4 JM was placed at high risk for serious withdrawal if her medication was not obtained while  
5 JM was outside of the country.

6 **CONCLUSIONS OF LAW**

7 1. The Board possesses jurisdiction over the subject matter hereof and over  
8 Respondent.

9 2. The conduct and circumstances described above constitute unprofessional  
10 conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might be  
11 harmful or dangerous to the health of the patient or the public.”) and A.R.S. § 32-  
12 1401(27)(ll) (“[c]onduct that the board determines is gross negligence, repeated  
13 negligence or negligence resulting in harm to or the death of a patient”).

14 3. If the Board finds that it can take rehabilitative or disciplinary action without  
15 the presence of the doctor at a formal interview it may enter into a consent agreement with  
16 the doctor to limit or restrict the doctor's practice or to rehabilitate the doctor in order to  
17 protect the public and ensure the doctor's ability to safely engage in the practice of  
18 medicine. A.R.S. § 32-1451(F).

19 4. The Board finds that a practice restriction is needed in order to protect the  
20 public.

21 **ORDER**

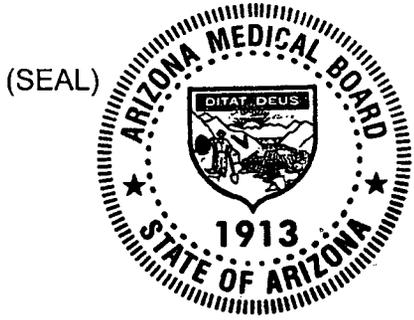
22 IT IS HEREBY ORDERED THAT:

23 1. Respondent is issued a **Decree of Censure**.

24 2. Respondent is prohibited from prescribing, administering, or dispensing any  
25 Schedule II substances in any setting for a period of **five years**. No earlier than six

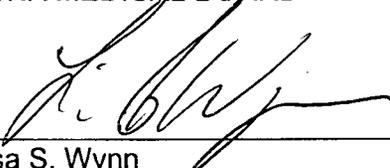
1 months prior to the termination of the practice restriction, Respondent shall complete a  
2 Board approved comprehensive prescribing course.

3  
4 DATED AND EFFECTIVE this 15<sup>th</sup> day of October, 2010.



ARIZONA MEDICAL BOARD

By

  
\_\_\_\_\_  
Lisa S. Wynn  
Executive Director

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8  
9  
10 **CONSENT TO ENTRY OF ORDER**

11 1. Respondent has read and understands this Consent Agreement and the  
12 stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent  
13 acknowledges he has the right to consult with legal counsel regarding this matter.

14 2. Respondent acknowledges and agrees that this Order is entered into freely  
15 and voluntarily and that no promise was made or coercion used to induce such entry.

16 3. By consenting to this Order, Respondent voluntarily relinquishes any rights to  
17 a hearing or judicial review in state or federal court on the matters alleged, or to challenge  
18 this Order in its entirety as issued by the Board, and waives any other cause of action  
19 related thereto or arising from said Order.

20 4. The Order is not effective until approved by the Board and signed by its  
21 Executive Director.

22 5. All admissions made by Respondent are solely for final disposition of this  
23 matter and any subsequent related administrative proceedings or civil litigation involving  
24 the Board and Respondent. Therefore, said admissions by Respondent are not intended  
25 or made for any other use, such as in the context of another state or federal government

1 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
2 any other state or federal court.

3 6. Upon signing this agreement, and returning this document (or a copy thereof)  
4 to the Board's Executive Director, Respondent may not revoke the consent to the entry of  
5 the Order. Respondent may not make any modifications to the document. Any  
6 modifications to this original document are ineffective and void unless mutually approved  
7 by the parties.

8 7. This Order is a public record that will be publicly disseminated as a formal  
9 disciplinary action of the Board and will be reported to the National Practitioner's Data  
10 Bank and on the Board's web site as a disciplinary action.

11 8. If any part of the Order is later declared void or otherwise unenforceable, the  
12 remainder of the Order in its entirety shall remain in force and effect.

13 9. If the Board does not adopt this Order, Respondent will not assert as a  
14 defense that the Board's consideration of the Order constitutes bias, prejudice,  
15 prejudgment or other similar defense.

16 10. Any violation of this Order constitutes unprofessional conduct and may result  
17 in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation,  
18 consent agreement or stipulation issued or entered into by the board or its executive  
19 director under this chapter") and 32-1451.

20 11. Respondent acknowledges that, pursuant to A.R.S. § 32-2533(E), he cannot  
21 act as a supervising physician for a physician assistant while his license is under  
22 restriction.

23  
24  
25 12. ***Respondent has read and understands the conditions of the restriction.***

*Gerald S. Asin M.D.*

DATED: 17 September 2010

GERALD S. ASIN, M.D.

EXECUTED COPY of the foregoing mailed  
this 2<sup>nd</sup> day of October, 2010 to:

Christine Cassetta  
Quarles & Brady LLP  
One Renaissance Square  
Two North Central Avenue  
Phoenix, AZ 85004  
RESPONDENT'S ATTORNEY

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

Arizona Medical Board  
9545 E. Doubletree Ranch Road  
Scottsdale, AZ 85258

*Chris Camp*

Arizona Medical Board Staff