

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **MARK J. RUBIN, M.D.**

4 Holder of License No. 28310  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona

Case No. MD-12-0175A

**ORDER FOR LETTER OF REPRIMAND  
AND CONSENT TO THE SAME**

7 Mark J. Rubin, M.D. ("Respondent") elects to permanently waive any right to a  
8 hearing and appeal with respect to this Order for Letter of Reprimand; admits the  
9 jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order  
10 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 28310 for the practice of  
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-12-0175A after receiving an  
17 anonymous complaint regarding Respondent's unprofessional conduct involving diversion  
18 of controlled substances and habitual intemperance in the use of controlled substances.

19 4. Respondent, an interventional pain medicine specialist, was both a chronic  
20 pain patient and supervising physician (SP) of his Physician Assistant (PA). In March of  
21 2008, Respondent was seen by the PA for complaints of non-radicular neck and back  
22 pain. Percocet and Ambien were prescribed; however, the dosages and intervals were not  
23 specified. There was no urine drug test obtained.

24 5. By June of 2008, Respondent had no change in his symptoms or exam. The  
25 PA documented that the current medications were refilled and did not specify the

1 medication, dose or dosing intervals. There was no urine drug test obtained. The PA's  
2 progress notes of the next six office visits were identical and there was no urine drug test  
3 obtained.

4 6. In June of 2009, the PA documented an office visit with similar notes from  
5 prior visits, but included two additional sentences. Respondent requested a re-trial of  
6 Ritalin. Unspecified fatigue was added to the diagnosis and there was no documentation of  
7 the dose or dosing interval of Ritalin. No urine drug test was done at this visit.

8 7. The PA's medical record for the remaining ten visits returned to an identical  
9 copy of the previous notes that did not list medication doses, dosing intervals, or the  
10 current medications being refilled. Additionally, there were no urine drug tests performed.

11 8. In August of 2010, after the PA noted that Respondent reported symptoms  
12 consistent with low testosterone, Androgel was dispensed. No labs were ordered.

13 9. The Medical Consultant (MC) found that the PA deviated from the standard  
14 of care in multiple aspects of the care of Respondent over a four year period. The MC  
15 noted that the role of a SP (in this case also Respondent) is to prevent, identify and  
16 ameliorate such deviations by the PA. The MC opined that in regard to his own treatment,  
17 Respondent did not provide supervision of the caliber expected of a pain medicine  
18 specialist.

19 10. The standard of care requires a supervising physician to require the PA to  
20 properly monitor a chronic pain patient prescribed long term controlled substances over  
21 four years.

22 11. Respondent deviated from the standard of care by failing to require the PA to  
23 properly monitor a chronic pain patient prescribed long term controlled substances over a  
24 period of four years.

25

1 12. The standard of care requires a supervising physician to require the PA to  
2 perform adequate past medical record review, diagnostic work up or consideration of a  
3 multidisciplinary approach for a chronic pain patient.

4 13. Respondent deviated from the standard of care by failing to require the PA to  
5 perform adequate past medical record review, diagnostic work up or consideration of a  
6 multidisciplinary approach for a chronic pain patient.

7 14. The standard of care requires a supervising physician to require the PA to  
8 maintain adequate medical records that would allow another treating provider the ability to  
9 identify the current treatment regimen and rationale.

10 15. Respondent deviated from the standard of care by failing to require the PA to  
11 maintain adequate medical records potentially leading to the inability of another treating  
12 provider to identify the current treatment regimen and rationale.

13 16. Potential harms that may result from the failure of a SP to require a PA to  
14 properly monitor a chronic pain patient prescribed long term controlled substances over  
15 four years include prescription drug abuse, misuse, addiction, diversion, overdose, and  
16 death.

17 17. Potential harms that may result from the failure of a SP to require a PA to  
18 perform adequate past medical record review, diagnostic work up or consideration of  
19 multidisciplinary approach for a chronic pain patient include the failure to identify a  
20 potentially treatable etiology of the neck pain, low back pain, or nonspecific fatigue, and  
21 therefore unnecessary perpetuation of use of controlled substances.

22 18. Potential harms that may result from the failure of a SP to require a PA to  
23 maintain adequate medical records includes the inability of another treating provider to  
24 identify the current treatment regimen and rationale.

25

1 **CONCLUSIONS OF LAW**

2 1. The Board possesses jurisdiction over the subject matter hereof and over  
3 Respondent.

4 2. The conduct and circumstances described above constitute unprofessional  
5 conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]conduct that is or might be harmful or  
6 dangerous to the health of the patient or the public.”).

7 3. The conduct and circumstances described above constitute unprofessional  
8 conduct pursuant to A.R.S. § 32-1401(27)(ii) (“[l]ack of or inappropriate direction,  
9 collaboration or direct supervision of a medical assistant or a licensed, certified or  
10 registered health care provider employed by, supervised by or assigned to the physician.”).

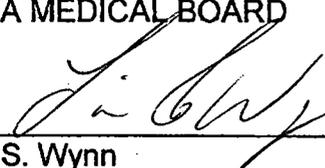
11 **ORDER**

12 IT IS HEREBY ORDERED THAT

13 Respondent is issued a Letter of Reprimand.

14  
15 DATED AND EFFECTIVE this 4<sup>th</sup> day of October, 2012.

16  
17 ARIZONA MEDICAL BOARD

18  
19 By 

20 Lisa S. Wynn  
Executive Director

21 **CONSENT TO ENTRY OF ORDER**

22 1. Respondent has read and understands this Consent Agreement and the  
23 stipulated Findings of Fact, Conclusions of Law and Order (“Order”). Respondent  
24 acknowledges he has the right to consult with legal counsel regarding this matter.

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

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

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

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

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

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

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

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

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

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7 Mark J. Rubin, M.D.

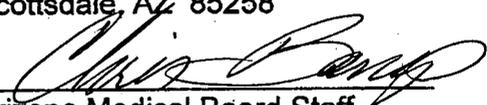
DATED: 8/24/12

8 EXECUTED COPY of the foregoing mailed  
9 this 10th day of Oct, 2012 to:

10 Robert J. Milligan, Esq.  
11 Milligan Lawless, PC  
12 4647 North 32nd Street Suite 185  
13 Phoenix, AZ 85018

14 ORIGINAL of the foregoing filed  
15 this 10th day of Oct, 2012 with:

16 Arizona Medical Board  
17 9545 E. Doubletree Ranch Road  
18 Scottsdale, AZ 85258

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21 Arizona Medical Board Staff  
22  
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