

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

ROBERT TEAGUE, M.D.

Holder of License No. **3925**
For the Practice of Allopathic Medicine
In the State of Arizona.

**Case No: MD-08-1469A
MD-09-0522A
MD-09-0528A
MD-09-0782A**

**INTERIM FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER
FOR SUMMARY SUSPENSION OF
LICENSE**

INTRODUCTION

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") at an emergency Board teleconference meeting on June 23, 2009. After reviewing relevant information and deliberating, the Board voted to consider proceedings for a summary action against Robert Teague, M.D.'s ("Respondent") license. Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearings or other Board action. A.R.S. § 32-1451(D).

INTERIM 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. 3925 for the practice of allopathic medicine in the State of Arizona.
3. On May 8, 2009, Respondent entered into a Consent Agreement for Practice Limitation that prohibited him from practicing medicine and from prescribing any form of treatment including prescription medications until he applied and received permission from the Board to do so.

1 4. The Board initiated case number MD-09-0782A, after receipt of a complaint
2 from Costco Pharmacy alleging inappropriate prescribing by Respondent. Board staff
3 reviewed the prescriptions submitted with the complaint and determined that four of them
4 were written and signed by Respondent after the effective date of his practice limitation.
5 On June 19, 2009, Board Staff contacted Respondent regarding the allegation and he
6 admitted to practicing medicine, which was in violation of the Practice Limitation.

7 5. On June 22, 2009 Board staff obtained a pharmacy survey indicating that
8 from May 8, 2009 through June 19, 2009, Respondent wrote over 350 prescriptions,
9 including Oxycodone, Hydrocodone, and Oxycontin in violation of the May 8, 2009
10 Practice Limitation.

11 6. The Board initiated case number MD-09-0528A pursuant to a July 21, 2008
12 Practice Limitation for case number MD-07-0237A providing for random chart reviews. A
13 random chart review of four of Respondent's patient records was conducted and
14 deviations were found in all the records. Specifically, there were no records from other
15 treating physicians, there was a consistent lack of adequate patient history, evaluation and
16 physical examination, and there was no documentation addressing the patients various
17 problems during their visits, which included ordering laboratory studies to determine the
18 cause of the patients' problems. Additionally, there were no assessment tools for pain
19 medication management and there was inadequate follow up on multiple issues.

20 7. The standard of care requires a physician to address the patients' various
21 problems during their visits, which includes ordering laboratory studies; to provide
22 assessment tools for pain medication management and to follow up on multiple issues.

23 8. Respondent deviated from the standard of care because he did not note
24 information of previous treating providers in the patients' record; he did not address the
25 patients' various problems during their visits, which included ordering laboratory studies;

1 he did not provide assessment tools for pain medication management and he did not
2 follow up on multiple issues.

3 9. There was potential for medication addiction, abuse and/or overdose, toxicity
4 or possible drug interaction for the four patients.

5 10. A physician is required to maintain adequate legible medical records
6 containing, at a minimum, sufficient information to identify the patient, support the
7 diagnosis, justify the treatment, accurately document the results, indicate advice and
8 cautionary warnings provided to the patient and provide sufficient information for another
9 practitioner to assume continuity of the patient's care at any point in the course of
10 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he did
11 not document information from previous treating physicians; he did not document
12 addressing the patients various problems and there was a lack of adequate patient history,
13 evaluation and physical examination in the patients' records.

14 11. The Board initiated case number MD-09-0522A after Respondent failed to
15 submit a quarterly report from his psychiatrist pursuant to a Stipulated Health Agreement
16 for case number MD-07-0237A. On July 21, 2008, Respondent entered into a Consent
17 Agreement for Practice Limitation and a Stipulated Health Agreement (SHA). The Practice
18 Limitation required that Respondent work no more than four hours per day, five days per
19 week and that he have a supervising physician review his cases daily. The Practice
20 Limitation also provided for random chart reviews by Board Staff or its agent. The SHA
21 required that Respondent enter treatment with a Board approved psychiatrist and submit
22 quarterly reports beginning September 2008. Respondent failed to submit his March 2009
23 quarterly report from his psychiatrist. In response to the Board's investigation, Respondent
24 admitted that he did not submit the report because he had discontinued treatment in
25 violation of the SHA. On May 8, 2009, as noted above, Respondent entered into a

1 Consent Agreement for Practice Limitation that prohibited him from practicing medicine
2 and from prescribing any form of treatment including prescription medications until he
3 applied and received permission from the Board to do so.

4 12. The Board initiated case number MD-08-1469A after receiving a complaint
5 regarding Respondent's care and treatment of a fifty-four year old female patient ("KC"). In
6 November 2007, KC presented to Respondent for various symptoms that included chronic
7 pain, depression and insomnia. KC was taking Oxycontin for her chronic pain. Respondent
8 renewed the prescription five times in less than three months, including two prescriptions
9 for twice the initial dosage and two early refills. Respondent later added Seroquel and
10 continued it at irrationally high doses without discussing the multiple potential risks,
11 including any warning signs of tardive dyskinesia. There also was no indication that
12 Respondent monitored KC for any side effects from the medication. Additionally,
13 Respondent did not document the ongoing monthly prescriptions of controlled substances
14 or the high dose of Seroquel.

15 13. The standard of care requires a physician to rationally prescribe medications
16 for the intended purpose.

17 14. Respondent deviated from the standard of care by prescribing Seroquel in an
18 irrational manner without discussing the multiple potential risks, including any warning
19 signs of tardive dyskinesia and without monitoring KC for side effects.

20 15. Multiple simultaneous central nervous system depressants can result in
21 dependence, abuse and/or overdose. Irreversible tardive dyskinesia is a complication of
22 unnecessary and high doses of Seroquel prescribed continuously over an extended
23 period. A physician assuming care of KC would not have been able to discern the ongoing
24 prescribing of controlled substances by Respondent.

1 **ORDER**

2 Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth
3 above,

4 IT IS HEREBY ORDERED THAT:

5 1. Respondent's license to practice allopathic medicine in the State of Arizona,
6 License No. 3925, is summarily suspended.

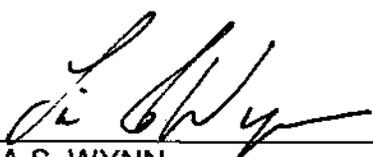
7 2. The Interim Findings of Fact and Conclusions of Law constitute written notice
8 to Respondent of the charges of unprofessional conduct made by the Board against him.
9 Respondent is entitled to a formal hearing to defend these charges as expeditiously as
10 possible after the issuance of this order.

11 3. The Board's Executive Director is instructed to refer this matter to the Office
12 of Administrative Hearings for scheduling of an administrative hearing to be commenced
13 as expeditiously as possible from the date of the issuance of this order, unless stipulated
14 and agreed otherwise by Respondent.

15 DATED this 23rd day of JUNE, 2009.

16 ARIZONA MEDICAL BOARD



19 By: 
20 LISA S. WYNN
Executive Director

21 ORIGINAL of the foregoing filed this
22 23rd day of June, 2009, with:

23 The Arizona Medical Board
24 9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

25 Executed copy of the foregoing mailed by Certified

1 Mail this 23rd day of June, 2009, to:

2 Nancy D. Peterson
3 Law Offices of Nancy D. Peterson P.L.C.
4 5150 N. 16TH Street
5 SUITE A-126
6 Phoenix, Arizona 85016-3986
7 Attorney for Respondent

8 Robert Teague, M.D.
9 Address of Record

10 Executed copy of the foregoing mailed by certified
11 mail this 23rd day of June, 2009, to:

12 Anne Froedge
13 Assistant Attorney General
14 Arizona Attorney General's Office
15 1275 West Washington, CIV/LES
16 Phoenix, AZ 85007

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