

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

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

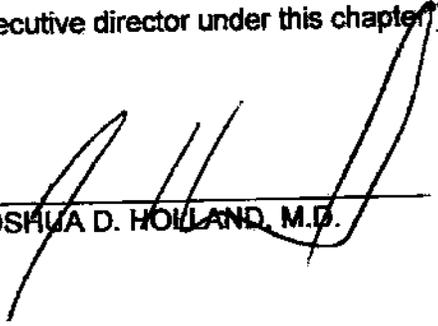
12 7. Upon signing this agreement, and returning this document (or a copy thereof)
13 to the Board's Executive Director, Respondent may not revoke the acceptance of the
14 Consent Agreement. Respondent may not make any modifications to the document. Any
15 modifications to this original document are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

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

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

23 10. If any part of the Consent Agreement is later declared void or otherwise
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force
25 and effect.

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

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JOSHUA D. HOLLAND, M.D.

DATED: 08 MAY 09

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1 **FINDINGS OF FACT**

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

4 2. Respondent is the holder of license number 17551 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-08-1020A after receiving a complaint
7 regarding Respondent's care and treatment of a thirty-two year-old female patient ("MO").
8 During the course of the investigation, concerns were also raised regarding Respondent's
9 alleged inappropriate prescribing of controlled substances to a thirty-five year-old male
10 patient ("JN").

11 4. MO was a close personal friend of Respondent and from November 2003
12 through October 2007, presented to Respondent for chronic pain management.
13 Respondent prescribed a small number of non-scheduled prescription medications to MO
14 in the absence of a documented physician-patient relationship. Respondent also
15 prescribed opioids to MO for complaints of knee pain and with a magnetic resonance
16 imaging scan that showed internal derangement. A pharmacy survey documents
17 increased frequency of prescribing of benzodiazepine by Respondent to MO throughout
18 2006, both prior and subsequent to her knee surgery. Respondent did request an
19 evaluation by a pain management specialist, but he did not follow up on an informal
20 suggestion by the pain management specialist to refer MO to an addiction medicine
21 specialist. Instead, Respondent prescribed escalating dosages and quantities of opioids
22 and benzodiazepines with frequent and early refills without documenting a rationale for the
23 prescriptions. On October 22, 2007, MO presented for her last visit and later died. The
24 medical examiner attributed her death to opioid toxicity and suicide.

1 5. JN was also a close personal friend of Respondent and from August 2001
2 through March 2006, presented to Respondent for chronic pain management. Respondent
3 again prescribed various controlled substances to JN intermittently for approximately eight
4 months in the absence of a documented physician-patient relationship. During treatment,
5 there was no indication that Respondent recognized any red flags suggestive of aberrant
6 drug seeking behavior. Specifically, JN received concurrent prescriptions from Respondent
7 and another provider, he refused to sign Respondent's formal opioid agreement, he
8 reported lost Oxycontin medications requiring replacement and he took unauthorized of
9 opioid dosages that lead to an early exhaustion of medications. There also was no
10 indication that Respondent closely monitored JN or coordinated care with an addiction
11 specialist. Additionally, Respondent provided frequent early refills and escalated doses
12 without documenting a rationale for the prescriptions. On March 6, 2006, JN presented for
13 his last visit and later died. The medical examiner concluded that JN's death was
14 accidental and caused by confluent bronchopneumonia and acute Oxycodone intoxication.

15 6. The standard of care for the treatment for chronic non-malignant pain
16 requires a physician to individualize the treatment and to consider opioid medication,
17 noninvasive techniques, behavioral strategies, physical therapy, nonopioid medications
18 and specialist consultations as indicated. The standard of care also requires a physician to
19 carefully reassess a patient prior to dose escalation and/or introduction of additional
20 controlled substances with abuse potential and to closely monitor for, recognize, and
21 follow up on problems suggestive of noncompliance and/or aberrant drug seeking.

22 7. Respondent deviated from the standard of care because he did not consider
23 behavioral strategies. Respondent also deviated from the standard of care because he did
24 not carefully reassess the patients prior to dose escalation and/or introduction of additional
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1 controlled substances and he did not closely monitor for, recognize, and follow up on
2 problems suggestive of noncompliance and/or aberrant drug seeking.

3 8. The Board's Medical Consultant opined that MO's death was secondary to
4 Fentanyl toxicity and suicide and that Respondent's prescribing likely perpetuated JN's
5 known addictive tendencies and his death. Additionally, there also was a possible
6 overdose by the patients due to Respondent's excessive quantities of controlled
7 substances their noncompliance and there was potential for aspiration, brain damage and
8 death. Further, it is possible that MO had treatable addictive tendencies that were
9 perpetuated by Respondent's prescribing and his failure to obtain an addiction medicine
10 consultation and that MO's treatable psychological condition was inappropriately
11 addressed with escalating benzodiazepines in the absence of an appropriate mental
12 health consultation.

13 9. In response to the Board's investigation, Respondent strongly disagrees with
14 the opinions of the Board's medical consultant contained in paragraph 8 above and also
15 strongly disagree that normal usage of a 50 mcg/hr transdermal fentanyl patch contributed
16 to the death of MO.

17 10. A physician is required to maintain adequate legible medical records
18 containing, at a minimum, sufficient information to identify the patient, support the
19 diagnosis, justify the treatment, accurately document the results, indicate advice and
20 cautionary warnings provided to the patient and provide sufficient information for another
21 practitioner to assume continuity of the patient's care at any point in the course of
22 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he
23 prescribed medications to the patients in the absence of a documented physician-patient
24 relationship and he prescribed escalating dosages and quantities of opioids and
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1 benzodiazepines with frequent and early refills without documenting a rationale for the
2 prescriptions.

3 11. Respondent has completed 15 - 20 hours of Category I Continuing Medical
4 Education (CME) in prescribing and 15 - 20 hours of CME in boundaries. In addition,
5 Respondent provided Board Staff with satisfactory proof of completion on or before August
6 4, 2009.

7 **CONCLUSIONS OF LAW**

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

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

16 **ORDER**

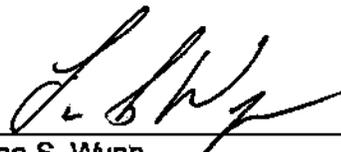
17 IT IS HEREBY ORDERED THAT:

- 18 1. Respondent is issued a Decree of Censure.
19 2. This Order is the final disposition of case number MD-08-1020A.

20 DATED AND EFFECTIVE this 5TH day of AUGUST, 2009.



ARIZONA MEDICAL BOARD

By 

Lisa S. Wynn
Executive Director

1 ORIGINAL of the foregoing filed
2 this 6 day of August, 2009 with:

3 Arizona Medical Board
4 9545 E. Doubletree Ranch Road
5 Scottsdale, AZ 85258

6 EXECUTED COPY of the foregoing mailed
7 this 6 day of August, 2009 to:

8 Debra Hill
9 Osborn Maledon PA
10 2929 N. Central Ave., Suite 2100
11 Phoenix, Arizona 85012-2765

12 EXECUTED COPY of the foregoing mailed
13 this 6 day of August, 2009 to:

14 Joshua D. Holland, M.D.
15 Address of Record

16 Kenya Corley
17 Investigational Review

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