BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **DAVID ALAN RUBEN, M.D.,** Holder of License No. 11382 For the Practice of Allopathic Medicine In the State of Arizona.	Case No.15A-11382-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER (Decree of Censure, Practice Restriction, and Probation)**

On December 1, 2015, this matter came before the Arizona Medical Board ("Board") for consideration of the Administrative Law Judge (ALJ) Diane Mihalsky's proposed Findings of Fact, Conclusions of Law and Recommended Order. David Alan Ruben, M.D., ("Respondent") appeared before the Board; Assistant Attorney General Anne Froedge, represented the State. Christopher Munns with the Solicitor General's Section of the Attorney General's Office, was available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

PROCEDURE

1. Dr. Ruben is the holder of Board-issued License No. 11382 for the practice of allopathic medicine in the State of Arizona.

2. The Board referred this matter to the Office of Administrative Hearings ("the OAH"), an independent state agency, for an evidentiary hearing.

3. On January 30, 2015, the Board issued a Complaint and Notice of Hearing that alleged that three complaints had been filed with the Board against Dr. Ruben, as follows: (1) The sister of Dr. Ruben's patient GM complained that Dr. Ruben had inappropriately prescribed Oxycodone to GM (Case No. MD-13-0315A); (2) Multiple pharmacies complained that Dr. Ruben had inappropriately prescribed controlled substances to seven patients, MB, PG, AT, FS, ME, DB, and CD (Case No. MD-13-0500A); (3) During the Board's investigation of the complaint involving patient MB, Dr. Ruben had given MB the consultant's report; (4) In a separate matter involving inappropriate

prescribing, the Drug Enforcement Administration ("DEA") had disciplined Dr. Ruben by suspending his DEA certificate for a period of one year, effective July 26, 2013; and (5) Dr. Ruben had failed to respond appropriately to patient SE's complaint filed with the Board that Dr. Ruben had failed to provide her medical records at her request.

4. Based on the alleged facts, the Board's Complaint and Notice of Hearing charged Respondent with having committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(a), (e), (p), (q), (s) (specifically A.R.S. §§ 32-1451.01 and 32-3206), and A.R.S. § 32-1401(27)(dd), and provided notice of a hearing in the OAH.

5. An eight-day hearing was held between March 19, 2015, and May 1, 2015, at the OAH's offices in Phoenix and Tucson. During and after the hearing, the Board's attorney withdrew the complaint allegations that Dr. Ruben had deviated from the standard of care by failing to refer GM to a specialist for treatment of his gout (¶ 13 of the complaint) and by failing to respond appropriately to SE's complaint (¶ 82 of the complaint). Because the Board did not otherwise allege that Dr. Ruben had failed to cooperate in its investigation, the Administrative Law Judge deems the Board to have withdrawn the charge that Dr. Ruben committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(dd).

6. The Board submitted 53 exhibits and presented the testimony of three witnesses: (1) Danielle ("Elle") Steger, the Board's Chief Investigator in its Physician Health Program; (2) Rob Ashby, M.D., the Board's expert on the care that Dr. Ruben rendered to patients GM, MB, PG, and AT; and (3) Carol Peairs, M.D., the Board's expert on the care that Dr. Ruben rendered to patients FS, ME, DB, and CD. Dr. Peairs and Dr. Ashby prepared written reports detailing the bases for their opinions regarding the patient files that they reviewed. These reports were admitted into evidence in this case. (Board's Exhs. 21, 25, 28, 33, and 34)

7. Dr. Ruben submitted 65 exhibits and presented the testimony of nine witnesses: (1) George Steven ("Steve") Nash, the Executive Director of the Tucson Osteopathic Medical Society; (2) Margo Andrade, Dr. Ruben's office manager; (3) AT, one of Dr. Ruben's patients whose care was at issue; (4) JJ, AT's significant other (Tr. III at 502); (5) Scott Christopher Forrer, M.D., one of Dr. Ruben's expert witnesses; (6) MB, another of Dr. Ruben's patients whose care and behavior was at issue; (7) Michael Richard Gray,

M.D., who also testified as an expert on Dr. Ruben's behalf; (8) CD, another of Dr. Ruben's patients whose care was at issue; and (9) himself. Neither Dr. Forrer nor Dr. Gray provided written reports detailing the bases for their opinions in this case.

HEARING EVIDENCE

Evidence of Divergent Opinions in the Medical Profession on the Treatment of Chronic Pain Patients and the Experts' Qualifications

8. Dr. Ruben submitted an affidavit prepared by Lynn R. Webster, M.D., who practices at PRA Health Sciences in Salt Lake City Utah. Dr. Webster sits on the Boards of Directors of the American Academy of Pain Medicine and the National Pain Foundation, is a member of the American Pain Society, the American Academy of Pain Medicine, the American Society of Anesthesiologists, and the National Pain Foundation and has published extensively in the area of chronic pain management, including the prescription of Oxycodone and other opioids to treat chronic pain.

9. Dr. Webster's affidavit states that two different schools of thought about the use of opioids in the treatment exist in the medical profession, with one school adopting a skeptical stance towards patients' reports of pain and explanations for incidents such as lost medications, while another school gives patients the benefit of the doubt regarding such matters. Dr. Webster's affidavit stated that many patients do not receive adequate pain control because the use of opioids has become controversial based on the views some professionals who believe that opioids should not be used at all for non-cancer pain.

10. Dr. Webster's affidavit also includes the following statements:

7. People receiving opioids for chronic pain should be monitored.

8. Some patients on chronic opioid therapy will exhibit aberrant drug related behaviors, including: lost medications, early refill requests, inconsistent urine drug tests, and a prescription monitoring report suggesting more than one provider has prescribed an opioid to the patient within the same treatment interval.

9. None of these behaviors alone should be reason to discharge a patient from one's practice.

10. Drug related aberrant behaviors can occur for many reasons including self-medicating, an increase in pain, self-medicating, a co-morbid mental health disorder, lost or stolen medications, or diversion.

11. When a patient exhibits aberrant drug related behavior the physician should ask the patient for an explanation, and the explanation may be sufficient to continue to prescribe.

12. If a patient admits to overusing a medication, then the physician needs to determine if continued opioid therapy is appropriate or an alternative therapy should be explored.

13. It may be that it is best to continue to prescribe despite the aberrant behavior.

14. There is no clinical method to differentiate moderate from severe pain except patient report.

15. There are differences among individuals and interindividual variations in opioid response and analgesia, and these differences and variations must be taken into account when prescribing pain medication for patients.

11. Dr. Webster did not review Dr. Ruben's records for the eight patients, did not offer any opinion on Dr. Ruben's treatment of any specific patient, and was not subject to cross-examination of his opinions since he did not testify at the hearing.

12. Dr. Peairs is an anesthesiologist who specializes in pain management. She is employed by the Department of Veterans Affairs ("VA") at the VA Hospital in Phoenix and as a consultant for the Board. Dr. Peairs is certified by the American Board of Anesthesiology and the American Board of Pain Medicine and is certified to treat opioid addiction by DATA. Dr. Peairs testified that she must keep her knowledge current and that she was required to undergo testing to be recertified in these specialties in 2014.

13. Dr. Peairs testified that she works as a consultant at the VA Hospital providing second opinions and record reviews. She also treats patients on an outpatient basis as part of a multidisciplinary team. Dr. Peairs testified that she has prescribed opioid medications and that her practice is not solely interventional. Dr. Peairs testified that she has treated thousands of chronic pain patients on an outpatient basis since June, 1989, and that she follows patients long-term. (Tr. VIII at 1320-1321). Dr. Peairs has been recognized as an expert on both a state and national level regarding opioid prescribing for chronic pain. (Id at 1324-1326) For example, out of 41,000 members, the American Society of

Anesthesiologists chose Dr. Peairs to provide a national webinar for education of physicians on opioid prescribing for chronic pain. (Id. at 1325). Additionally, the Mayo Clinic and the University of Arizona, College of Medicine invited Dr. Peairs to speak to residents and physician faculty on responsible opioid prescribing for chronic pain. (Id. 1324) Dr. Peairs advised the Arizona Medical Board on developing the Guidelines for treatment of chronic pain with opioids. She testified that "those guidelines specifically say they are for the purpose of reassuring doctors that as long as they prescribe according to current standards of care, that they do not have to fear disciplinary action." (Id.)

14. Dr. Peairs testified that Dr. Webster's statements in his affidavit were based on the ABM's positions from 1996, when most physicians were either in the therapy or dependency school of thought. Dr. Peairs testified that twenty years ago, she was in the therapy school and considered opioids to be safe. Dr. Peairs testified the opioids can improve some patients' quality of life, but that opioids can harm other patients. Dr. Peairs testified that it is not true that opioids do not damage major organs because they can damage the endocrine and male and female reproductive systems.

15. Dr. Peairs testified that over the past 20 years, the two schools have both moved to the center and that Dr. Webster's statements about differences of opinions in the medical profession regarding the use of opioids in the treatment of chronic pain were no longer accurate. Dr. Peairs testified that Dr. Webster's position regarding the use of opioids in treating chronic pain now represents the "fringe" of the medical profession.

16. After Dr. Peairs testified, Dr. Ruben submitted a second affidavit from Dr. Webster that stated that "[t]he two schools of thought . . . have not drawn closer together over the last two decades" and "[t]o the contrary, they have grown steadily apart and are as far apart now as at any time. Evidence can be discovered [by] reading my twitter feed @LynnRWebsterMD." Dr. Webster did not testify and, therefore, was not cross-examined on his opinion.

17. Dr. Ashby is in private practice in Prescott, where he has three treatment centers for detoxification, pain, or pain and addiction. Dr. Ashby is certified by the Board of Anesthesiology and, like Dr. Ruben, he is certified by the Board of Addiction Medicine and the Board of Pain Medicine.

18. Dr. Ashby started his practice in 1984, as an anesthesiologist, but could not continue in that specialty because he had a problem with alcohol and became addicted to opioids to treat a back injury that he suffered as a child. Dr. Ashby spent seven months at Talbott-Marsh Treatment Center to start his recovery. Dr. Ashby has been sober since April 21, 1994. Although Dr. Ashby became employed as an emergency room physician, he became frustrated. Dr. Ashby subsequently went to work with Michael Sucher, Ph.D. at Community Bridges treating patients with addictions.

19. Dr. Ashby studied ancient healing arts and incorporates his studies into his current practice. Dr. Ashby testified that his pain was worse when he was addicted to opioid medication and that a study of 214 patients showed that their pain improved when they were taken off high doses of opioid medications and benzodiazepines. Dr. Ashby testified that he may prescribe opioids, especially Suboxone, which does not provide a high and is not addictive, to maintain his patients who are addicts. He further testified that he prescribes opioids in his current practice "in very carefully selected patients and then with very careful monitoring. For instance, I check the CSPMP every visit. I do frequent urines." (1367) Dr. Ashby does not consider dependence to be separate from addiction under the Diagnostic and Statistical Manual V.

20. Dr. Ashby testified that there are studies that show that opioid medications do not effectively treat chronic pain, especially considering the risks of opioid treatment, and that other alternative treatments should be considered. Dr. Ashby acknowledged that a respectable minority of physicians who practice chronic pain management use low-dose opioids to treat their patients. When Dr. Ruben's attorney asked Dr. Ashby whether he had committed any crimes while he was actively addicted to opioids, Dr. Ashby invoked his federal Fifth Amendment right against self-incrimination.

21. Dr. Ruben is trained as a psychiatrist has practiced allopathic medicine since 1979 in Tucson. He is a diplomat on the American Board of Psychiatry, the American Board of Addiction Medicine, and American Board of Pain Management. Dr. Ruben is certified by the American Board of Child and Adolescent Psychiatry and the American Board of Psychiatry and Neurology.

22. Dr. Ruben operates a clinic in south Tucson treating patients with chronic, non-malignant pain. Dr. Ruben testified that most of his patients are poor and many lack insurance. Dr. Ruben testified that he founded the Southern Arizona Pain Society, which is a subchapter of the Pima County Medical Society, because the under-treatment of chronic pain is a national problem. Dr. Ruben testified that he started treating chronic pain patients because they had such limited access to care and that he thought as a psychiatrist, he could perform such work without facing the consequences that other doctors faced.

23. Dr. Ruben testified that only 2 or 3 physicians and 5 to 10 nurse practitioners in Tucson currently practice chronic pain management and that nurse practitioners do most of the prescribing of opioids to treat chronic pain. Dr. Ruben testified that most professionals are reluctant to treat chronic pain because they are afraid of pressure from their licensing agencies. Dr. Ruben testified that because patients with chronic non-malignant pain are discriminated against, he feels an ethical obligation to continue treating his patients.

24. On rebuttal, Ms. Steger testified that she was born in Tucson and that her whole family lives there. Ms. Steger testified that according to the Board's website, there are many pain management specialists in Tucson and that only five chronic pain specialists in Tucson had their licenses revoked or suspended. Ms. Steger testified that when she called to see if any pain management specialists were taking new patients, most informed her that they would accept her as a patient if she had a referral from her primary care provider, even if she did not have insurance. Ms. Steger testified Dr. Ruben's office was 2.8 miles from the building where the hearing was held and only nine minutes from the University of Arizona. (Tr. VIII at 1380) She further testified that only one of the eight patients who are subject of this case showed an address in South Tucson. (Tr. VIII at 1381)

25. Dr. Forrer has practiced allopathic medicine since 1987 and has been Board-certified in psychiatry and neurology since 1993. Dr. Forrer is currently in private practice at the Tucson Neuroscience Center. Dr. Forrer testified that as a psychiatrist and neurologist, he is familiar with the standard of care for treating chronic pain. Dr. Forrer testified that although most of his patients have pain complaints, he stopped prescribing opioids to treat their chronic pain in 2008 or 2009, because he feared harassment from the Board. Dr.

Forrer expressed extreme bias against the Arizona Medical Board. For example, he testified that he did not believe the Board acted in good faith in this case and he referred to use of its experts as "sham peer-reviewed." ((Vol. IV 667)

26. Dr. Forrer testified that his practice is upscale and caters to high income patients. In contrast, the chronic pain patients that Dr. Ruben treats in south Tucson are mostly low income and Hispanic. Dr. Forrer testified that the standard of care must consider the treatment setting. Dr. Peairs testified that she treats homeless patients. (1353) She testified that impoverished patients are an "extremely vulnerable at-risk-population" and that the rates of misuse as well as overdose deaths are highest among poor and rural populations. (1338)

27. Dr. Ruben submitted articles to support his contention that chronic pain patients are undertreated because so many practitioners fear heightened scrutiny and retaliation from their regulating agencies.

28. Dr. Gray completed his residency at the Cook County, Illinois hospital between 1974 and 1978. After practicing internal medicine for 3 or 4 yours, he entered occupational medicine, with an emphasis on toxicology. Dr. Gray is certified by the American Board of Preventative Medicine, the American Board of Toxicology, and the American Board of Emergency Medicine.

29. Dr. Gray also has a masters' degree in Public Health and was recruited to the University of Arizona's College of Medicine ("U of A"). Between 1978 and 1981, Dr. Gray was the Chairman of the Occupational & Internal Medicine Department of Family and Community Medicine at U of A. Dr. Gray testified that his work became the curriculum that is distributed to every medical school.

30. Dr. Gray is currently the Medical Director of the Progressive Healthcare Group, the Chief of Staff of Benson Hospital, the Medical Director and Founding Board Member of Healthcare Innovations Inc., all in Benson, Arizona, and the Medical Director and Founding Board Member of Arrowhead Healthcare, dba Showlow Emergency Medical Services.

31. Dr. Gray has held leadership positions in various organizations, has been involved in peer review, has spent six years on the Board of Health for Cochise County, has

spent 6 years as the appointee of two different Arizona governors on the Medical Directions Committee, which was formed to establish written protocol for first responders, and in the early 1990's, worked with undocumented agricultural workers.

32. Dr. Gray testified that physiological dependence is a habit, not a cognitive choice and that dependence is not necessarily the same thing as addiction, which is dependence with negative effects.

33. Dr. Gray testified that the patients in his practice in Benson are similar to Dr. Ruben's patients in south Tucson. Dr. Gray met Dr. Ruben when he was the Director of the Ramsay Canyon psychiatric facility. Dr. Gray testified that at the toxicology clinic, patients' chronic pain symptoms are often treated as psychosomatic, but that may not be appropriate because a problem may have been missed. Dr. Gray testified that he referred 5 to 10% of his patients with reported chronic pain issues who request pain medications to Dr. Ruben's clinic in Benson for pain management for validation.

Evidence on Dr. Ruben's Care of the Eight Patients

GM

34. Dr. Ruben first saw GM, a 28-year-old male, on May 11, 2009. GM reported that he swam three times a week, had been married for a year, had a two-month-old child, and was employed as a mechanical engineer. Dr. Ruben's treatment note indicates that he contacted the previous provider and was informed that although GM had several incidents of lost medications, he was otherwise compliant, that his opiate dose was between 90 and 180 mg per day, and that he was currently on medication.

35. Dr. Ruben's records contain a note from City Med dated February 3, 2009, stating that GM had been prescribed Oxycodone 15 mg every four hours, but that the provider had told him "that I will not be able to see him anymore as he lost his prescriptions for three times. While he has police reports, he violates the pain agreement of unable to keep his pain meds in a safe place."

36. A urine drug screen ("UDS") for GM taken on May 11, 2009, was positive for opiates and tricyclic antidepressants, but negative for Oxycodone. Dr. Ruben's file did not contain a Controlled Substances Prescription Monitoring Program pharmacy survey ("CSPMP") for GM dated May 9 or 11, 2009.

37. In the history section of the May 9, 2009 note, Dr. Ruben stated that GM "drinks occasional soda," did not smoke, and "[t]here is no history of abuse." GM complained of pain in his lower extremities. Dr. Ruben reported that his examination of GM showed a stiff gait, favoring the left side, 50% mobility impairment in the lower extremities, a tender and swollen left big toe, and a tender left knee through the medial and lateral joint lines, and decreased range of motion. Dr. Ruben diagnosed GM with gout, osteoarthritis, and chronic pain. The Board agreed at the hearing that Dr. Ruben had appropriately referred GM to a specialist for treatment of his gout.

38. Dr. Ashby testified that gout occurs when uric acid forms crystals in the joints, causing them to become red and inflamed. Dr. Ashby testified that gout is usually treated with anti-inflammatory and analgesic medications and that although an acute gout flare-up may be treated with high-dose opioids, it does not require a steady dose.

39. Dr. Ashby's Medical Consultant's Report opined that Dr. Ruben's initial evaluation of GM was inadequate because it did not include documentation of a pain generator and that the standard of care required the underlying pain generator to be identified so that it could be treated. Dr. Ashby testified that the x-rays characterized GM's osteoarthritis as mild or moderate and that opioids do not work for chronic non-malignant pain. Dr. Ashby testified that Dr. Ruben also failed to question GM regarding tobacco use, alcohol use, or use of illicit drugs.

40. Dr. Gray testified that Dr. Ruben's initial assessment of GM was reasonably comprehensive and that Dr. Ruben acknowledged moderate risk factors in GM's issues with his prior provider and lost medications. Dr. Gray pointed out that Dr. Ruben stated that GM did not smoke and his note that GM drank soda on occasion indicated that GM stated that he did not drink alcohol. Dr. Gray testified that the May 9, 2009 office note indicated that Dr. Ruben queried GM about his personal habits.

41. Dr. Gray testified that Dr. Ruben had adequately identified the source of GM's pain and noted that according to his medical record, he had injured his left ankle on April 7, 2008, which was consistent with GM's reported pain. Although the injury occurred more than a year before Dr. Ruben's initial assessment, Dr. Gray testified that without surgical intervention, there is no reason to believe the condition changed. Dr. Gray acknowledged

that the October 6, 2008 and April 12, 2009 studies of GM's left knee were read as normal but that the radiologist did not secure the prior study. Dr. Gray testified that osteoarthritis results from wear and tear on joints and it is well-known to practitioners that the condition may require pain medication. Although x-rays are one piece of evidence, Dr. Gray testified that a physician must integrate his practice and interact with the patient.

42. Dr. Ruben testified that the October 6, 2008 x-ray of GM's left knee and the April 7, 2008 x-ray of his left ankle showed that GM had osteophytes on his left ankle and that his bones had lost density and that there was a narrowing space behind his left kneecap. Dr. Ruben testified that the March 29, 2008 x-ray showed mild dorsal soft tissue swelling in the left ankle. The February 3, 2009 City Med records showed abnormalities in GM's musculoskeletal system. Although the report of the April 12, 2009 x-ray of GM's left knee stated that there was no evidence of effusion or negative findings, other x-ray evidence provided objective evidence that the disease process was underway. Dr. Ruben noted that his May 9, 2009 examination of GM also noted tenderness, swelling, and complaints of pain.

43. On May 11, 2009, Dr. Ruben prescribed Oxycodone 30 mg four to five times a day #135.

44. Dr. Ashby testified that 150 mg of Oxycodone per day is a high dose. Dr. Ashby testified that the May 11, 2009 UDS that was negative for the prescribed Oxycodone raised concerns that GM either was not taking his medication or selling it.

45. Dr. Ruben testified that if a patient is trying to avoid running out of medication, he may not take it as prescribed, which may result in undetectable levels of the medication in a UDS.

46. At an appointment on June 26, 2009, GM revealed a history of child abuse, which caused anxiety, and stated that his pain was still 6/10, but that his energy had improved. Dr. Ruben prescribed Xanax .25 mg twice a day for GM's reported panic attacks and 30 mg Oxycodone 6 times a day #180.

47. Dr. Ashby testified that Oxycodone and Xanax are synergistic and increase the risk of overdose or death. Most deaths from opioids result when they are taken with a sedative like alcohol or benzodiazepine like Xanax. Dr. Ashby testified that a physician

should get an informed consent if he prescribed such drug combinations and should document in his notes that he warned the patient about the risks.

48. Dr. Gray testified that it is not below the standard of care to prescribe a narcotic with a benzodiazepine, although there are risks that need to be attended to. Such prescription requires careful monitoring.

49. Dr. Ruben testified that at every one of GM's office visits, he discussed medications and side effects and provided a printout for GM to take home. Dr. Ruben testified that he discussed the risks and benefits of medications. Although GM only signed the consent to treatment form once, in reality, Dr. Ruben discussed treatment recommendations and obtained GM's consent at every office visit.

50. On July 7, 2009, GM reported that his car had been broken into and his medications stolen. Dr. Ruben's note contains the police report number, as well as the following summary of his investigation of the incident:

> Officer spoken to who identified evidence of break in. Pain contract gone over again. Pattern of lost meds reviewed. Repeated direction to carry only days meds with him in a labeled pharmacy bottle with the remainder locked in a safe at home. Discussed that any further instances will result in discharge from clinic.

A UDS for GM on July 7, 2009, was positive for benzodiazepines, opiates, and Oxycodone. Dr. Ruben referred GM to MHC for mental health problems and increased monitoring to two weeks and noted a change in risk level to high (red).

51. Dr. Ashby testified that reported multiple thefts are red flags for opioid abuse or diversion and that the provider should discharge the patient or consider other treatment alternatives.

52. Dr. Gray testified that lost or stolen medications, the use of multiple pharmacies, and early refills does not imply that Dr. Ruben's care of GM fell below the standard. Instead, GM presented with management problems and Dr. Ruben appropriately responded to these concerns when he increased his monitoring of GM on July 7, 2009, to every two weeks.

53. On August 18, 2009, Dr. Ruben returned to monthly monitoring of GM and continued the prescriptions for .25 Xanax twice a day and 30 mg Oxycodone six times a day #180.

54. GM was seen by Dr. Slaski on September 1, 2009, and September 29, 2009. Dr. Slaski increased GM's prescriptions for 30 mg Oxycodone to eight times a day #240 and his .25 mg Xanax to four times a day. At the hearing, Dr. Ruben indicated that at one time, Dr. Slaski, Dr. Skinner, Nurse Practitioner Ida Heath, and another nurse practitioner had shared his office. These providers' treatment notes were included in the records that Dr. Ruben provided to the Board.

55. On October 27, 2009, Dr. Ruben again saw GM and continued him on 30 mg Oxycodone eight times a day because the higher dose was helpful in treating GM's pain and .25 mg Xanax to four times a day because GM's anxiety had increased due to marital problems.

56. On November 24, 2009, and December 17, 2009, Dr. Slaski again saw GM. Dr. Slaski's December 17, 2009 note stated that GM had taken more than was ordered due to acute injury and was counselled.

57. On December 23, 2009, GM was seen by Dr. Skinner. Dr. Skinner reported that GM's medications had been stolen from his apartment when he had been held up at gunpoint.

58. GM was seen by Dr. Slaski on January 9, 2010, Dr. Skinner on January 18, 2010, Dr. Slaski February 16, 2010, Dr. Skinner on March 15, 2010, Dr. Slaski on April 10, 2010, and Dr. Slaski on May 13, 2010.

59. Dr. Ashby reported that between June 18, 2010, and June 29, 2010, GM was hospitalized for depression and suicidal ideation. Dr. Ashby's report noted that the complete records were not available.

60. GM was seen by Dr. Skinner on July 6, 2010.

61. Between July 13, 2010, and July 26, 2010, GM was admitted to Palo Verde Behavioral Health Hospital. The admission note stated that GM had previously been involved in O'Reilly, a drug treatment program, and that he had multiple previous hospitalizations for depression and pain medication use. When GM was discharged, he was

given a prescription for five days' of Oxycodone and advised to follow up with Dr. Ruben. His discharge diagnoses were major depressive disorder, unipolar without psychosis, opiate dependence, and opiate withdrawal. Among his assets was a pain management team. The treatment modalities were to resume medications and check pain medications.

62. Dr. Ashby testified that a psychiatric history and a history of drug abuse were risk factors for prescription of opioids.

63. Dr. Ruben next saw GM on July 29, 2010. Dr. Ruben noted that during GM's recent hospitalization, he had been put on Wellbutrin. Dr. Ruben continued GM on 30 mg Oxycodone 8 times a day and noted that with the hospitalization, GM would have sufficient pain medication until September 10, 2010.

64. Dr. Ruben saw GM on August 18, 2010, and did not prescribe any more Oxycodone at the time.

65. On September 10, 2010, Dr. Slaski saw GM and prescribed Oxycodone 30 mg six times a day #180.

66. On October 9, 2010, a nurse practitioner saw GM and reinstituted Xanax 1 mg t.i.d. #90 and continued the Oxycodone dose.

67. On November 9, 2010, Dr. Slaski saw GM and noted that he had increased pain. Dr. Slaski increased GM's Oxycodone 30 mg to seven times a day #210.

68. On November 29, 2010, Dr. Slaski saw GM early for medication. GM stated that he was flying to Tokyo for work. Dr. Slaski noted that GM had cut back on his pain medication during and after his hospitalization and increased GM's Oxycodone dose to 30 mg two tabs four times a day a day #240.

69. On January 4, 2010, Dr. Slaski saw GM.

70. On February 1, 2011, a nurse practitioner saw GM and noted that he had increased pain in his knee. The nurse practitioner prescribed Tramadol 50 mg 1-2 times a day. Dr. Ashby's report criticized this prescription because the note included "no reason listed [and] no discussion of risk or benefits."

71. On February 25, 2011, a nurse practitioner treated GM. She noted that he reported that he had been involved in a motor vehicle accident, that he had gone to the emergency room for his pain, that he had taken an extra two Oxycodone for his pain, and

that he had been prescribed additional pain medication in the emergency room. The nurse practitioner prescribed Oxycodone 30 mg eight times a day and a cervical x-ray.

72. On March 31, 2011, and April 29, 2011, GM was seen by a nurse practitioner. On April 29, 2011, the nurse practitioner reported that GM had stated that he had no problems going on the March of Dimes walk the next day and that he did not need to take Xanax on a daily basis.

73. On May 29, 2011, a nurse practitioner saw GM and reported that he had had a bad month, that he had more pain on less medication, and that his anxiety was worse. The nurse practitioner increased GM's Oxycodone 30 mg to nine times a day #270 and his Xanax to 1 mg 4 times a day #120.

74. On June 28, 2011, a nurse practitioner saw GM, diagnosed him with upper back and cervical pain following the motor vehicle accident, and continued him on the same dose of Oxycodone and Xanax. Dr. Ashby testified that reported pain had to be evaluated before it could be treated.

75. On July 22, 2011, a nurse practitioner saw GM and noted that he was at the cutoff for pain medications because the pharmacy did not accept the prescriptions for pain medications from the emergency room. The nurse practitioner increased GM's Oxycodone 30 mg prescription to #300.

76. The CSPMP pharmacy survey for August 19, 2011, showed multiple prescribers, including the two nurse practitioners, Dr. Slaski, and three urgent care centers, but not Dr. Skinner or Dr. Ruben, and multiple pharmacies.

77. Dr. Ashby testified that GM was "doctor shopping," which violated the standard pain management's contract requirement that the patient obtain controlled medications only from the contracted provider.

78. On August 22, 2011, Dr. Ruben saw GM. Dr. Ruben's note stated GM "acknowledges and avoids beer and meat" and that GM's "opiate dose has been raised over the last year by other practitioners and we discussed the problem with higher doses and need to continue to pursue physical medicine and medicine specific for gout as well [as] anti inflammatory meds with his PCP for better pain relief." Dr. Ruben's plan included adding Abilify 2.5 mg for anxiety and that GM would begin to decrease his Oxycodone dose.

Despite this plan, Dr. Ruben did not decrease GM's Oxycodone and prescribed Oxycodone 30 mg 10 times a day #300, but did not prescribe Xanax.

79. On September 2, 2011, Dr. Ruben saw GM. Dr. Ruben's note for the office visit states in relevant part as follows:

> [GM] lost his prescription and his credit card. He has made a police report which we verified with them. He had a similar problem when his car was broken into when he began with us in 2009 and several instances reported by his previous physician. We went over again keeping prescriptions and medication secure and his responsibility for this. He has a safe at home to keep his medicine in and will keep us informed on a weekly basis of his progress. These events occur when stress in his life overwhelms him. He has lost his job and marital problems as well as his chronic pain. He was told that he must resume psychiatric treatment immediately for us to continue his care.
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> I do not see the benefit of following through with discharge at this point. The patient has a history of PTSD and difficulty with life stressors. I do not believe [he] is abusing his medication and do believe his chronic pain is debilitating. The need here is to require follow through on his part for psychiatric care. If this does not occur, then measures as giving limited amounts of medication at a time would be the next step. Pill counts, and calling in are also a way to stay in more touch with him and offer support. Discharge [at] this point would likely result in him being unsupervised and acquiring controlled medi[c]ation non prescription, not solving the problem.

80. On September 2, 2011, despite the plan to decrease the Oxycodone, Dr. Ruben did not decrease the Oxycodone but again prescribed Oxycodone 30 mg 10 times a day #300 to GM.

81. Dr. Gray testified that the fact that GM had used more medication than Dr. Ruben had prescribed was not a reason for Dr. Ruben to stop prescribing Oxycodone because GM would seek drugs elsewhere.

82. Dr. Ashby testified that Dr. Ruben was not considering the possibility that GM was addicted to opioids and that Dr. Ruben should have quit prescribing opioids. Dr. Ashby testified that to continue prescribing opioids because the patient could get them elsewhere violated federal law.

83. On September 22, 2011, a nurse practitioner saw GM. She noted that he had been admitted to Palo Verde Behavioral Health Hospital on September 9, 2011, and

discharged on September 20, 2011, after he had lost his job and his wife asked for a separation. The nurse practitioner lowered GM's Oxycodone 30 mg dose to 4-5 times a day #70, continued Xanax 1 mg #120, and added Zoloft.

84. Between September 25, 2011, and October 11, 2011, GM was admitted to Tucson Medical Center for suicidal ideation, severe depression, and anxiety. GM was prescribed Wellbutrin and Zoloft to manage his depression. The discharge diagnoses were major depressive disorder, severe, recurrent, without psychotic features, anxiety disorder, and opiate dependence. The Discharge Plan was that GM was to "follow up with Dr. Ruben for ongoing psychiatric care" and that GM "was advised . . . to seek treatment for his opiate dependence as needed."

85. On October 27, 2011, and November 17, 2011, the nurse practitioner saw GM. On October 27, 2011, GM's UDS was positive for benzodiazepines and Oxycodone. On November 17, 2011, the nurse practitioner prescribed Oxycodone 30 mg prescription to 4-5 times a day #255 to GM.

86. On December 19, 2011, the nurse practitioner again saw GM and noted that he reported that on November 20, 2011, he had fallen when he was carrying bags from a hotel in San Diego, was diagnosed with a broken right calcareous, and was wearing a splint with a boot. The nurse practitioner prescribed Oxycodone 30 mg 4 times a day and at bedtime #270, and Xanax 2 mg #60.

87. On January 12, 2012, the nurse practitioner again saw GM. She noted that he and his wife were in marriage counselling, he had lost 10 pounds by watching his diet, and that he was doing better.

88. On February 10, 2012, a nurse practitioner saw GM.

89. On March 2, 2012, Dr. Ruben saw GM. Dr. Ruben reported as follows:

> Patient was hospitalized at Palo Verde 9 25 11 and has kept us informed of his follow up with them on a regular basis. He is going to counseling with his wife and attending assertiveness training for himself. He is working in optics at a job he enjoys. He fractured his R foot which is in a walking cast.

Dr. Ruben continued GM on Oxycodone 30 mg 9 times a day #270 and required GM to continue in psychiatric care, even though he had finished the outpatient intensive program.

90. On April 2, 2012, Dr. Ruben saw GM and reported that he had fallen and fractured his left foot, which was casted, and that GM had been told that he would need surgery and appliances. GM was not wearing his cast at work because it would not fit into the sterilized suit that he had to wear, but his orthopedic doctor had approved not wearing the cast at work. Dr. Ruben required GM to continue with psychiatric support and to report any changes.

91. Dr. Gray testified that Dr. Ashby's statement in his report that the falls that GM reported on December 19, 2011, and April 2, 2012, "are increased with the medications prescribed" is too broad because there is only an increased risk if excessive medication was prescribed. There is no indication in the records that GM was impaired.

92. GM was seen by the nurse practitioner on April 26, 2012, May 24, 2012, June 22, 2012, and July 16, 2012. The July 16, 2012 note stated that GM's divorce had gone through and that he had been robbed at a Circle K the week before.

93. GM's file includes notes that on August 9, 2012, a nurse at the Crisis Response Center clinic had called to inquire about his medications because he was an inpatient there and on August 13, 2012, the nurse had discussed GM's treatment with the nurse practitioner who had been treating him at Dr. Ruben's office.

94. Between September 18, 2012, and September 28, 2012, GM was hospitalized at Tucson Medical Center after he had attempted suicide by cutting his wrist and had been transferred from the Crisis Response Center. The discharge note provided the following past psychiatric history:

> The patient has been hospitalized twice before at Palo Verde Hospital. He reports this is his first suicide attempt. His hospitalizations in the past have taken place as a result of depression secondary to the estrangement from his wife. On an outpatient basis he has been receiving medications prescribed by Dr. Ruben including 50 mg Zoloft, 100 mg Wellbutrin, 300 mg allopurinol for his gout. He also takes ibuprofen. He has also been taking oxycodone 40 mg every 3 hours and alprazolam 2 mg once to twice a day. He started all treatment approximately a year ago.

The discharge diagnoses were adjustment disorder with depression and anxiety, generalized anxiety disorder with recurrent depression, opiate dependence, and nicotine dependence. GM was not given Xanax or Oxycodone while he was in the hospital. The

discharge plan was that GM would start taking gabapentin and Tramadol, and continue taking Oxycodone after his discharge.

95. GM was seen by the nurse practitioner on October 1, 2012, October 26, 2j012, November 29, 2012, December 27, 2012, and January 24, 2013.

96. The last time Dr. Ruben or anyone else in his office saw GM was on February 21, 2013. Dr. Ruben's final note states in relevant part as follows:

> The patient was again hospitalized on 9 28 12 and has been following up in care since that time. He continues to experience anxiety at times and sadness over the loss of his marriage. He is doing well at work and his activity level has increase[d] with healing of his fractured foot and rehabilitation. Tramadol has been added and helped reduce his pain level and allowed significant reduction in his opiate medications over the last year. Anxiety is also less with a reduction in Alprazolam to 1 mg per day. Sleep, appetite, energy ok, pain 6/10.
>
> He continues with less frequent gout flare ups, better controlled with medication. He has pain in his L elbow, from his L calcaneal fx and primarily in his knee.

Dr. Ruben prescribed Oxycodone 30 mg 7 times a day #210 and Tramadol 50 mg 2-3 times a day #75 to GM.

97. Dr. Ashby testified that Dr. Ruben's treatment of GM fell below the standard of care because Dr. Ruben never referred GM for substance abuse treatment. Dr. Ashby testified that there is no evidence that opioids were treating GM's chronic pain effectively. Dr. Ashby testified that GM lost his job, his wife, and his child and became depressed and tried to kill himself while Dr. Ruben was prescribing Oxycodone, which are classic symptoms of addiction. Dr. Ashby testified that especially after GM's hospitalizations, he was vulnerable and it was unconscionable for Dr. Ruben to continue to prescribe high doses of opioids.

98. Dr. Ruben pointed out that the cost of inpatient or outpatient treatment for substance abuse or dependence can be high. Sierra Tucson charges $60,000 per month and most other inpatient treatment cost $20,000 month, which GM could not afford. Dr. Gray testified that some drug abuse treatment programs are supported by the state and don't cost anything. Dr. Ruben testified that chronic problems with drug abuse do not just go away.

99. Dr. Gray testified that the earliest hospitalizations referred to the records occurred before Dr. Ruben started treating GM. Dr. Ashby disputed this testimony and stated that the first hospitalization occurred after GM had been in treatment with Dr. Ruben. (1263-1264) Dr. Gray noted that Dr. Ruben did not see changes in GM's behavior and that the comments on the medical records from the hospitals were made by others. Dr. Gray testified that Dr. Ruben initially increased GM's Oxycodone dose due to Dr. Ruben's belief that GM needed more to manage his pain. Dr. Gray testified that the problem with opioid tolerance is that over time, a patient's liver produces enzymes that destroy the drug, so doses must escalate to achieve the same effect. Dr. Gray explained escalating doses result from physiology, not from the patient's character. Dr. Gray testified that when pain generators are resolved, people often go off their pain medication with no or minimal withdrawal, but if the patient continues to experience pain, he needs his pain medication.

100. Dr. Gray testified that GM suffered severe deterioration in function, but that Dr. Ruben's care helped GM and that Dr. Ruben appropriately cared for GM and responded to concerns based on the information that was available at the time.

101. Dr. Gray acknowledged that GM exhibited multiple behaviors that could be considered red flags, such as frequent lost or stolen medications and early refills. Dr. Gray testified that although such red flags must be addressed, the concept for even a high-risk patient is that a physician must be attentive to the patient's needs.

102. Dr. Gray testified that Dr. Ruben's notes were generally legible and that his typewritten notes especially provided sufficient information to maintain the continuity of care.

103. Dr. Ruben testified that he always prepares a handwritten note of his day-to-day treatment and then usually prepares a typed note that may provide more detail. Dr. Ruben noted that new voice recognition technology allows dictation after the visit to be transcribed contemporaneously.

104. Dr. Forrer testified that GM was also seen by a nurse practitioner and other providers between 2009 and 2013, and that Dr. Ruben was not responsible for the other providers' treatment. Dr. Forrer generally disagreed with Dr. Ashby's opinions about the specific deficiencies in Dr. Ruben's care of GM.

105. Dr. Ruben testified that he evaluated GM every month and diagnosed him according to his current complaints and other evidence. Dr. Ruben testified that GM had difficulties at home and was hospitalized to treat psychiatric conditions due to stress at home and that there is no evidence that Dr. Ruben's treatment caused GM's divorce or loss of job.

106. Dr. Ruben testified that on February 21, 2013, the last time he saw GM, GM reported that he was doing well at work, that his activity level was better, and that he felt the Tramadol reduced his pain. Dr. Ruben testified that by that time, he had reduced GM's Xanax and opioid prescriptions. Dr. Ruben testified that his treatment helped GM get through rough times in his life and that by February 21, 2013, GM was stabilized.

MB

107. MB was a 31-year-old male who established care with Dr. Ruben on July 30, 2012, for complaints of low back, bilateral elbow, wrist, knee, ankle, and jaw pain.

108. According to the records in Dr. Ruben's file, on June 14, 2012, Millennium Health and Balance ("Millennium") wrote a letter to MB, severing its relationship with him and providing the names of other pain management providers because on May 25, 2012, MB had been admitted to the emergency room at University Medical Center for an overdose of prescribed medication.

109. MB testified that he did not go to University Medical Center for an overdose and that instead, after he had taken the morphine that Millennium had prescribed, he felt like he could not breathe and his mother called the paramedics. MB testified that after he was transported to the emergency room, he could breathe.

110. Dr. Ruben's July 30, 2012 note stated that MB had been seen by Dr. Slaski and that he was currently on 30 mg Oxycodone 10 tabs daily. MB was employed as a welder and reported that he had anxiety with panic attacks that was treated with Clonazepam by CODAC. MB reported that he had a history of substance abuse, that he was self-medicating, that his current dose of pain medication was too low, and that he was on AHCCCS.

111. Dr. Ruben's response to the complaint stated that because MB had no insurance, he had to pay cash.

112. MB testified that he checked that he had a history of substance abuse because he was self-medicating, but that he has never been diagnosed or treated with substance abuse. MB testified that he told Dr. Ruben that he did not believe that he abused his medications.

113. The Board submitted a court order in Pinal County Superior Court Case No. 201301711 dated March 30, 2004, sentencing MB to probation after his guilty plea to possession of marijuana for sale, a class 4 felony.

114. Ms. Andrade testified that she generally does a background check of new patients to see if they have ever been charged or convicted of a drug crime. Although prior drug charges does not necessarily disqualify a new patient from being treated by Dr. Ruben, prior charges may give Dr. Ruben insight into the patient. Ms. Andrade did not know why MB's chart did not include the prior drug offense.

115. The July 30, 2012 CSPMP showed that MB had been most recently prescribed Clonazepam on July 1, 2012, and Oxycodone HCL 30 mg #30 on May 18, 2012.

116. MB's July 30, 2012 UDS was positive for marijuana and barbiturates, neither of which had been prescribed, negative for Oxycodone, and positive for benzodiazepines, which had been prescribed. Dr. Ruben reported the result as consistent with MB's account.

117. MB testified that the UDS report for barbiturates was a false positive.

118. Dr. Ashby testified that MB was a high risk patient for whom Dr. Ruben should have required a UDS and checked the CSPMP on every visit. Dr. Ashby testified that although there was no standard, low risk patients could be monitored only two or three times a year. Dr. Ashby testified that an opioid should not be prescribed to a patent with a history of drug abuse unless he is in stable recovery, but that Dr. Ruben did not enquire into MB's reported history of substance abuse.

119. Dr. Ashby testified that the cost of a UDS could be as low as $5.00 for a test that just showed the presence of various substances, although the test was prone to false positives, and that a UDS that provided additional detail could cost as much as $1,600.00.

120. Dr. Ashby's report noted that radiology revealed osteoarthritic changes to "ankle" and right knee and that MB had tripartite right patella, otherwise both unremarkable, and that a lumbar spine x-ray was normal. Dr. Ashby testified that MB's medical records did

not provide objective evidence of a pain generator that justified prescribing opioids to manage his pain.

121. Dr. Ruben's July 30, 2012 note reflected that on the straight leg raise, MB's right knee was tender with post-edema and limited range of motion, his left ankle showed tenderness posterior and anterior, and had decreased range of motion in all planes. Dr. Ruben diagnosed MB with anxiety with panic and chronic pain and prescribed Oxycodone 15 mg #105. Dr. Ruben also noted in the margin that MB reported that he was over-sedated on morphine.

122. Dr. Ruben testified that a radiologic report from April 28, 2011, diagnosed degenerative changes in MB's left ankle, probably as a result of trauma. Dr. Ruben also testified that other studies showed a tripartite patella, which means the knee bone is in various parts. Although the January 16, 2013 MRI for MB was negative, it did show a bone island that may be erosion. In addition, radiologic studies taken on March 19, 2012, showed abnormalities.

123. According to the medication log, on July 31, 2012, Dr. Ruben prescribed Oxycodone 15 mg 3-4 times a day #105 to MB.

124. Dr. Ruben testified that MB had a history of being on Oxycodone 30 mg ten times a day and that Dr. Ruben prescribed dose of 15 mg Oxycodone 3-4 times a day was a smaller dose.

125. Dr. Ruben next saw MB on August 27, 2012. Dr. Ruben noted continued pain.

126. Dr. Ruben next saw MB on September 25, 2012. Dr. Ruben continued the 15 mg Oxycodone q.i.d. and noted that MB would like to get back to being a welder and getting his life on track and that his family situation was fine.

127. On November 28, 2012, Dr. Ruben noted that MB was out of Oxycodone and gave him an early refill because MB was going on vacation and would have to extend the dosage. Dr. Ruben testified that MB had used up his medicine early because he was in pain. Dr. Ruben testified that he increased MB's Oxycodone dose to 15 mg up to 5 times a day. Dr. Ruben testified that at that time, MB was on 75 mg/day of Oxycodone, in contrast to the 300 mg/day that he had been on when he had started treatment with Dr. Ruben.

128. On December 18, 2012, Dr. Ruben next saw MB and noted that an x-ray of MB's ankle showed arthritic changes, but the x-ray showed MB's knees and wrists were normal. MB continued to complain about pain in his wrists, ankles, and knees and Dr. Ruben's note indicated that he continued MB on the same doses of medication.

129. On January 18, 2013, Dr. Ruben noted that MB's pain was a little worse at 7/10, that he was sleeping only 4 hours a night, but that he was building low-riders and doing metal fabrication. Dr. Ruben stated "[h]e will continue the oxycodone 30 mg five times a day."

130. Dr. Ashby stated that Dr. Ruben's medical records were unclear and did not justify doubling MB's Oxycodone dose.

131. Dr. Ruben testified that on January 18, 2013, he raised MB's Oxycodone dose to 150 mg/day because the previous dose did not effectively control MB's pain. Dr. Ruben noted that MB was still taking far less Oxycodone than he had been.

132. Dr. Gray testified that Dr. Ruben complied with the standard of care in his treatment of MB and that MB benefitted from Dr. Ruben's treatment. Dr. Gray noted that although Dr. Ruben did not explain why he increased MB's Oxycodone dose on January 18, 2013, the notes stated that "[m]edication education was done and informed consent was obtained." Dr. Gray noted that at the next visit on March 18, 2013, MB reported that he was sleeping better and opined that Dr. Ashby overstated a minor departure from the standard of care.

133. On March 18, 2013, Dr. Ruben again saw MB and noted that MB was receiving Clonazepam from CODAC but because it did not help his panic attacks, MB was not taking it. Dr. Ruben noted that MB was sleeping six hours a night and stated that he would add Imipramine and Xanax for MB's panic attacks and that MB would discontinue the Clonazepam. Dr. Ruben testified that Clonazepam could be stopped abruptly without causing withdrawal and that Xanax is slower acting.

134. Dr. Ruben's March 18, 2013 report also noted that he administered trigger point injections in MB's paraspinals and lumbar region and counselled MB to lose weight. Dr. Ruben testified that he was trying to do many different things with MB to effectively treat his pain and panic attacks.

135. Dr. Ruben testified that it was significant that MB was sleeping better because it was crucial for patients to be able to sleep to repair the damage of the day.

136. Dr. Ashby's report criticized the March 18, 2013 report because Dr. Ruben did not mention coordinating care with CODAC to avoid duplicate medications.

137. Dr. Ruben testified that Clonazepam is a long-acting benzodiazepine that was not working well to control MB's anxiety. Dr. Ruben testified that he therefore prescribed Xanax and told MB to discontinue the Clonazepam. Dr. Ruben testified that he communicated numerous times with MB's physician at CODAC, Dr. McMillan, about finding a more appropriate medication to manage his panic attacks and that the information on his notes about MB's past treatment came from his communications with Dr. McMillan.

138. Dr. Ashby testified that MB violated his controlled substances contract. A physician should enforce and discuss with the patient any deviations from the contract. Dr. Ashby testified that Dr. Ruben exposed MB to potential harm by not addressing his drug abuse and overdose and by prescribing Oxycodone while MB was taking benzodiazepines prescribed by CODAC. Dr. Ashby also criticized Dr. Ruben for prescribing Oxycodone IR with benzodiazepines and Soma.

139. Dr. Ruben testified that he had reduced MB's Oxycodone dose 50% and was looking for pain control that allowed MB to function. Dr. Ruben was also treating MB's high blood pressure, panic attacks, and difficulty sleeping. Dr. Ruben testified that a short-acting benzodiazepine can help manage pain by treating specific symptoms. Dr. Ruben testified that although previous providers had prescribed Soma to MB, he did not prescribe Soma to MB. The medication log for MB does not show a prescription for Soma.

140. Dr. Gray and Dr. Forrer both testified that Dr. Ruben had appropriately treated MB and that he had benefitted from Dr. Ruben's care.

141. MB testified that at the time of the hearing, he was working full-time, on his feet all day, and taking ibuprofen. MB testified that his hand was hurting and that if he were told that he would never get opioids again, he would be depressed.

142. Dr. Ruben testified that he did not believe that MB was better off, even though he was not taking opioids, because he was in pain. Dr. Ruben testified that MB was a reliable informant and the CSPMPs showed that he only took the medications that were

prescribed to him. Unfortunately, there was no one in the community that he could refer MB to for treatment of his chronic pain.

PG

143. PG was a 27-year-old female who established care with Dr. Ruben on August 15, 2011. PG complained of back, neck, and shoulder pain that resulted from a motor vehicle accident in December 2010, as well as migraines and carpal tunnel syndrome. At the time, Dr. Ruben's notes reflect that PG was being treated by two different providers and on July 14, 2011, had been given #180 30 mg Oxycodone and #90 of 15 mg Oxycodone, as well as #90 350 mg Soma. PG reported that in June 2011, she had a stolen prescription and had some police documentation of that. PG reported getting about six hours of disrupted sleep per night and that she cared for her five children during the day. PG denied a history of depression, chemical dependency, or legal issues. PG had not undergone any physical therapy. PG reported that pain from her migraine was sharp and constant and that she had headaches every other day. PG rated her pain as 7/10. Dr. Ruben reported that his physical examination of PG was normal, except that straight leg raising was positive on the right and PG had spasms and tenderness in the trapezius muscles, dorsally bilaterally but more on the right than on the left.

144. Records were obtained from a previous provider that showed diagnoses of cervical and low back pain and migraine. A UDS was positive for Oxycodone. A CSPMP survey showed she was getting multiple prescriptions for Oxycodone from multiple providers.

145. Dr. Ruben diagnosed PG with migraines, cervical pain and spasms, lower back pain, some of which may have been carpal tunnel related to a radiculopathy radiating from her cervical area. Dr. Ruben stated that he would like to prescribe opiates to PG to treat her pain, that PG understood the need for a pain contract going forward, and that he would contact PG's two previous providers and inform them that he would be the only prescriber and that he would continue Soma and add Depakote to prevent headache pain. He would see PG again in a month.

146. Dr. Ashby testified that PG's previous records and tests that were performed after she started treatment with Dr. Ruben did not show a pain generator and that although

Dr. Ruben ordered physical therapy for PG, there is no evidence that she ever obtained physical therapy. Dr. Ashby testified that the fact that PG had obtained 225 mg Oxycodone immediate release from two different physicians was concerning.

147. On or about August 15, 2011, PG signed a Controlled Medication and Pharmacy Policy contract in which she agreed that she would obtain controlled medications only from Dr. Ruben and that she would fill her prescriptions for controlled medications at a single pharmacy.

148. Dr. Ruben testified that migraine is a vascular condition that involves photosensitivity, nausea, and throbbing pain. PG was irritable and reported that her sleep was disturbed. Dr. Ruben testified that it is common for people with chronic pain to be irritable. Dr. Ruben testified that it was not possible to treat depression without also treating reported pain.

149. On November 1, 2011, PG cancelled her pain contract with Dr. Ruben because she had returned to her previous provider, Dr. Slaski.

150. The nurse practitioner in Dr. Ruben's office saw PG on March 29, 2012, and reported that her previous provider had given her 330 mg Oxycodone per day. Dr. Ruben did not write these prescriptions.

151. Dr. Ruben next saw PG on April 13, 2012, and prescribed 30 mg Oxycodone ten times per day. Dr. Ruben noted a history of cervical and lumbar back pain and that PG was scheduled for carpal tunnel surgery.

152. A May 17, 2012 MRI of PG's lumbar spine showed a grade 1 spondylolisthesis and an L5-S1 disk protrusion abutting the nerves bilaterally.

153. Dr. Ashby testified grade 1 is the lowest level of spondylosis and is not considered a source of pain. Although a disk bulge may be impinging on nerves, the usual treatment is surgery or epidural steroids. Dr. Ashby testified that there is no evidence that a disk bulge can be effectively treated with opioids.

154. Dr. Ruben testified that a positive result on straight leg raise test is usually indicative of a problem with the spinal cord. If pain travels down the leg, it indicates impingement of the nerve where it exits the spinal column, which was confirmed on the April 7, 2011 MRI. Dr. Ruben testified that PG suffered from degenerative disk disease. The

March 13, 2012 EMG that diagnosed PG's carpal tunnel disease provided more objective evidence of a pain generator.

155. Dr. Ruben noted that PG's previous treating physician, Dr. Slaski, had prescribed Oxycodone, Flexeril, Xanax, and other medications. Dr. Ruben pointed out that he prescribed a lower dose of Oxycodone to PG than her previous providers had prescribed.

156. On May 24, 2012, Dr. Ruben again saw PG and continued Oxycodone 30 mg ten times a day and Alprazolam t.i.d.

157. On June 19, 2012, Dr. Ruben saw PG and gave her a two-month supply of the Oxycodone.

158. On October 5, 2012, PG reported that her boyfriend's brother had stolen her medications; she told Dr. Ruben that she would get a floor safe for her medications. Dr. Ruben gave her a four days' supply of Oxycodone, and stated that he would not provide more until she could produce evidence that the safe was installed. Dr. Ruben subsequently renewed PG's prescription for Oxycodone.

159. The police report of the September 24, 2012 incident indicated that a television, game console, and games were stolen. PG denied to the police that anything else was missing.

160. Dr. Ashby testified that it was concerning that a chronic pain patient would not notice the theft of her medication.

161. On October 8, 2012, Dr. Ruben received information that PG was selling her medications. Dr. Ruben indicated that PG was to be called in for a pill count and UDS within an hour of the call, but the next day Dr. Ruben decided to wait until the weekend because PG "just got her medications."

162. Dr. Ashby testified that Dr. Ruben's initial response to get PG into the office immediately was correct because if given time, the patient can buy replacement drugs on the street. Dr. Ashby testified that waiting to perform a UDS and pill count makes no sense.

163. Dr. Ruben testified that he does not telegraph to a patient that he plans to do a pill count, because patients can always purchase replacement drugs on the street. Dr. Ruben testified that his handwritten note indicated that PG had brought in a photograph of

the floor safe that she had installed. Dr. Ruben testified that it is better to wait until the dust settles to perform a pill count.

164. On October 27, 2012, PG sent a letter stating that she missed her October 10, 2012 appointment, saw a nurse practitioner in Dr. Ruben's office on October 13, 2012, and received a two-month prescription. The medication log stated PG had last received Oxycodone on October 8, 2015.

165. Dr. Ashby testified that no other chronic pain doctor in Arizona would have given a high risk patient like PG a two-month supply of Oxycodone. Dr. Ashby tested that PG was high risk because she had received multiple early refills, had been accused of selling her medication, and had alleged that her medication had been stolen.

166. On November 12, 2012, Dr. Ruben's office note stated that PG's husband was in jail and charged with murder and that four of her five children were hyperactive. Dr. Ruben prescribed 30 mg Oxycodone eight times a day and noted that PG had run out of medication a little early due to increased pain, so he would give her a refill now. The note also stated that PG preferred Soma to the Flexeril, and so he prescribed Soma. The record included a handwritten note that the pain contract was renewed and that the "pill count 10-15 was accurate. Allegation discussed and denied."

167. Dr. Ashby testified that Dr. Ruben was rewarding PG by giving her an early prescription after she ran out of pain medication. Dr. Ashby testified that Soma has a high street value because it increases the high or euphoria of Oxycodone.

168. On December 4, 2012, Dr. Ruben's notes reflected that PG stated that she was taking non-prescribed Adderall, "[b]ut she does not give a true history of attention deficit disorder, at least on this point." Dr. Ruben's report also notes that PG reported that another patient had borrowed some pills, but that her account was "consistent and believable." The note indicated that PG now had a safe in the home and that she would be very careful about keeping her medication safe, secure, and away from her children.

169. Dr. Ashby testified that taking Adderall that was not prescribed was illegal because it was a stimulant. Dr. Ashby testified that he has no tolerance for drug diversion because it compromises the safety of the community. By allowing the other patient to

borrow pain medication, PG committed a felony. Dr. Ashby opined that Dr. Ruben should have refused to write further prescriptions for Oxycodone for PG.

170. Dr. Ruben testified that PG was having trouble at home and still needed his help. Although one school of thought would have dismissed PG, it is a question of medical judgment whether a patient can be counselled to manage all areas of her life. Dr. Ruben testified that because he was concerned with keeping PG and her children safe, he continued to try to help her.

171. On January 4, 2013, Dr. Ruben's note reflected that CPS had taken PG's children because her house was untidy. Dr. Ruben noted that PG had been disorganized and that she provided a long-term history of fidgeting, being distractible, and having troubles organizing. Dr. Ruben prescribed Adderall and a 30-day supply of Oxycodone to PG.

172. Dr. Ashby testified that Dr. Ruben failed to fill out a workup form to diagnose PG with ADHD and that PG did not meet criteria for the diagnosis.

173. Dr. Ruben testified that PG was a disorganized person and that many of the red flags were not signs of diversion, but of disorganization. As a psychiatrist, he recognized the symptoms of ADHD, which is a physiological dysfunction, in PG.

174. On January 31, 2013, Dr. Ruben again saw PG and gave her a 2-month supply of her medication. Dr. Ruben noted that PG's headaches were improved and that her anxiety was under control. Although she was still receiving 30 mg Oxycodone seven times a day, Dr. Ruben indicated that he would reduce that dose in the future.

175. Dr. Ruben testified that PG's headaches had improved because treatment of her ADHD made her more stable.

176. On April 4, 2013, Dr. Ruben again saw PG and continued all of her prescriptions. A handwritten note acknowledged that PG has had some "red flags," but that Dr. Ruben would increase monitoring of her compliance and continue to support her on a variety of issues. Dr. Ruben testified that the reason for his handwritten note that he was making recommendations for social services, since there was an open CPS case and he was trying to help PG organize her life.

177. Dr. Ruben testified that by April 4, 2013, PG's pain had improved to 6 out of 10 and that she was able to work at home and care for her children, whom she had gotten

back from CPS. Dr. Ruben testified that although PG's behavior included some red flags, he was able to increase his monitoring of her, and her condition improved. Dr. Ruben explained that sometimes, if a provider increases requirements, the patient may not return or may give up treatment altogether and self-medicate. Dr. Ruben testified that his goal is to get patients where they are functional on the lowest possible dose of an opioid.

178. Dr. Ruben testified that according to his handwritten note for the April 4, 2014 office visit, PG was working at Denny's and her children's father was helping out at home. PG was finally getting consistency in her life and if he had dismissed her from his practice, she would not have reached this point.

179. Dr. Ashby testified that Dr. Ruben's treatment harmed PG because although drug addiction is treatable, PG was not evaluated or treated for drug addiction.

180. Dr. Forrer disagreed with Dr. Ashby's opinions that Dr. Ruben's initial evaluation of PG was inadequate, that Dr. Ruben had departed from the standard of care by prescribing high doses of opioids, or that PG had not benefitted from Dr. Ruben's treatment.

181. Dr. Gray testified that Dr. Ruben's treatment of PG complied with the standard of care and that the treatment helped PG.

AT

182. AT is a 52-year-old man who established care with Dr. Ruben on October 28, 2010, while he was employed as a bus driver, for shoulder, mid-thoracic, and hip pain. AT reported that he had a motor vehicle accident 20 years ago and that physical therapy had not been helpful. Radiology reports indicated narrowing at L4-5 with osteophytes and facet arthrosis. AT reported that he was taking "non rxn" oxycodone five times a day.

183. Dr. Ashby testified that Dr. Ruben's record for AT was confusing. He assumes that by "non rxn," Dr. Ruben mean medication that was not prescribed to AT. Dr. Ashby stated that is not the standard of care and makes continuity of care difficult. A controlled substance database would have been useful, but was not done.

184. Dr. Ashby testified that a UDS for AT on October 28, 2010, was negative for Oxycodone, with the notation, "send out," but there was no indication that this was ever done.

185. Dr. Ruben testified that if a patient is trying to avoid running out of medication, he may not take it as prescribed, which may result in undetectable levels of the medication in a UDS.

186. A physical therapy report from August 19, 2010, indicated that AT was not compliant with his therapy, that he was not wearing his heel lift to correct his leg length discrepancy, and that he "will not be able to completely resolve his back symptoms."

187. On October 28, 2010, Dr. Ruben diagnosed AT with DJD L4 to S1, pain over thoracic, shoulders and right hip, and prescribed "pain program, explore alternative meds to opiates," exercise and diet, Oxycodone 15 mg q.i.d., Flexeril, and Cyclobenzaprine ER 15 mg q.h.s.

188. Dr. Ashby testified that there was no documented need for AT to have Oxycodone or Flexeril. A diagnosis of pain is purely subjective and there is no evidence that Dr. Ruben considered the physical therapist's note that AT was noncompliant with physical therapy and refused to wear a lift.

189. Dr. Ruben testified that the motor vehicle injuries were substantiated by the radiology reports, and his examination showed that AT could not perform knee bends or squats and that his ability to reach his toes were decreased 50%. AT had tenderness in his trapezius muscles with spasm.

190. Dr. Ruben testified that many pain patients with musculoskeletal pain do not benefit from physical therapy because the therapists must show progress and may push the patients beyond their abilities. AT said that he tried physical therapy, but did not get any benefit.

191. Other practitioners saw AT on November 22, 2010, December 23, 2010, January 20, 2011, February 23, 2011, and March 11, 2011, April 11, 2011, and August 11, 2011, at which visit it was noted that AT fell asleep in the waiting room.

192. AT's significant other, JEJ, was present in Dr. Ruben's office when AT fell asleep. (Tr. Vol. II at 512.) When questioned on cross-examination regarding this incident, JEJ stated that "he was always falling asleep back then because, like I said, we had just found out that he had congestive heart failure." *Id.* Nonetheless, Dr. Ruben continued to prescribe Oxycodone knowing that AT was working as a bus driver.

193. Dr. Ruben next saw AT on September 11, 2011. AT reported that he was driving ten hours a day, four days a week, and that he had increased pain in his left shoulder and low back. Dr. Ruben prescribed Oxycodone 30 mg 5-6 times per day.

194. A nurse practitioner saw AT on October 14, 2011.

195. Dr. Ruben next saw AT on December 9, 2011. Dr. Ruben noted that AT had more pain in his left lower back, that the pain went up the medial side of his knee, and that he was having more pain at night. AT was not driving his bus route, but that was not helping his pain much. Dr. Ruben advised AT to use a Pilate's ball and prescribed Soma 350 mg at night and 30 mg Oxycodone six times a day.

196. Dr. Ashby testified that Dr. Ruben should have advised AT not to drive because although patients on Oxycodone alone are not generally impaired, when a benzodiazepine is added, they are at a greater risk for impairment. Dr. Ashby noted that while AT was being seen by other practitioners, he frequently ran out of medications, which is a classic sign of addiction.

197. Dr. Ruben testified that the Soma was not continued after December 9, 2011, and that AT was prescribed Flexeril. Dr. Ruben testified that he observed AT at every visit to gauge how his medications were affecting him. Dr. Ruben testified that Soma and Flexeril were administered and night, so the patient can sleep, and at the doses that he prescribed would wear off by morning. Dr. Ruben testified that his job is to treat patients by maintaining and improving their well-being. Dr. Ashby testified that Flexeril has a half-life of 18 hours and that Soma metabolizes into Meprobamate which has a half-life of 10 hours and would still be in AT's bloodstream when he is driving a bus even if he took it at night. (Tr. VIII at 1358-1359) Dr. Ashby testified that, after reviewing Dr. Ruben's testimony, he observed "basic lack of knowledge with basic pharmacology, that puts patients, especially AT, and the public in harm's way." (Tr. VIII at 1356)

198. Dr. Ruben pointed out that when Dr. Slaski saw AT on November 22, 2010, Dr. Slaski increased AT's Oxycodone prescription due to increased pain. Dr. Ruben testified that it was common for a patient to run out of medicine if the dose was not sufficient to address his pain. Dr. Ruben testified that Dr. Slaski raised AT's dose to what he had taken in the past.

199. Dr. Ruben testified that if a patient claims that he is in pain that other indicators correlate, a physician may rely upon his clinical judgment to prescribe pain medication. Dr. Ruben testified that musculoskeletal studies show that in only 20 to 30% of cases do radiological studies correlate with a patient's reported pain.

200. Dr. Ruben next saw AT on January 9, 2012. AT reported that he was back to driving the bus, but that bouncing around all day without protection caused him pain. AT rated his pain as 7 out of 10. Dr. Ruben advised AT to walk and to use the Pilate's ball, and prescribed 30 mg Oxycodone six times a day.

201. Dr. Ruben saw AT on February 9, 2012, March 8, 2012, April 5, 2012, May 7, 2012, June 17, 2012, and July 5, 2012. At each visit, Dr. Ruben noted that AT's condition was stable and renewed the prescriptions for 30 mg Oxycodone six times a day and Flexeril.

202. A nurse practitioner saw AT on October 14, 2012, and November 1, 2012.

203. Dr. Ruben saw AT on December 10, 2012, January 10, 2013, and March 13, 2013. Dr. Ruben continued prescribing the same medications. Dr. Ruben performed regular UDSs on AT, all of which confirmed the presence of the prescribed substances.

204. Dr. Ashby testified that Dr. Ruben exposed AT to the risk of addiction and problems with mood and his endocrine system. Dr. Ashby testified that the street value of Oxycodone is 50 cents to a dollar per milligram, or $20 - $25 per pill.

205. AT testified that his pain took away the joy of living. AT testified that physical therapy did not help him, which is why he went to Dr. Ruben. Dr. Ruben talked to him about exercises and he did what Dr. Ruben asked. AT testified that he did not take drugs to get high, but to help him in his work. AT testified that he had benefitted from Dr. Ruben's care. AT testified that he uses a lift in his shoe. AT's wife confirmed his testimony.

206. Drs. Forrer and Gray disagreed with the Board's criticisms of Dr. Ruben's care of AT.

FS

207. FS is a 28-year-old male who was seen for initial evaluation by Dr. Ruben on April 10, 2012. FS complained of diffuse pain over his back and knees and Dr. Ruben noted that FS had suffered different injuries over time. FS reported that he had received Oxycodone 5 mg from another physician several years ago, and that he currently takes non-

prescription medication and Oxycodone three to seven times a day. FS rated his pain as 8/10 and described it as sharp.

208. Dr. Ruben performed a physical examination and noted that FS had limited mobility, a positive straight leg raise, knee pain, pain and tenderness in his paraspinals, cervical and lumbar spine and triggers in anterior thighs, and allodynia in the right exterior calf.

209. FS's April 10, 2012 UDS was positive for opiates, amphetamines, benzodiazepines, and Oxycodone, and the forms that FS had filled out indicated that FS had rationed the Oxycodone that had been prescribed. Moreover, FS stated that he was taking non-prescribed opioids. A handwritten notation identified that amphetamine as Adderall, a current medication.

210. A CSPMP that Dr. Ruben obtained on April 10, 2012, showed that FS had been prescribed Oxycodone-Acetaminophen 5 - 325 #16 on March 7, 2012, and that he had not been prescribed Xanax or Adderall in the past twelve months. The CSPMP also showed a prescription for Suboxone 2 mg #7 on January 13, 2012, five prescriptions for Oxycodone 30 mg between November 2011, and January 2012, for a total of 959 tablets.

211. Dr. Peairs' report noted that the CSPMP did not identify any prescriptions for benzodiazepines or amphetamine salts and that a methamphetamine would result in a positive UDS, but that Dr. Ruben's note did not indicate that made any inquiry into FS's possible use of methamphetamine. Dr. Peairs testified that a follow up UDS should have been performed to distinguish between amphetamine and methamphetamine.

212. Dr. Peairs opined that Dr. Ruben failed to adequately assess FS to identify an etiology for subjective pain complaints and to determine whether opioids were clinically indicated. Dr. Ruben also failed to consider an orthopedic consult for FS's subjective low back and knee complaints.

213. Dr. Ruben testified that a follow up test to distinguish substances is very expensive and that FS was uninsured. Dr. Ruben testified that he chose to monitor FS rather than to force him to incur the expense because he thought the result might have been a false positive.

214. On April 10, 2012, Dr. Ruben prescribed 30 mg Oxycodone 2-3 times a day, Xanax .5 mg twice a day, and Amitriptyline 25 mg at bedtime.

215. Dr. Peairs opined that the standard of care required that the initial opioid dosage for chronic pain patients should take into account the patient's opioid use within the last four weeks. Dr. Ruben failed to meet this standard by prescribing a high dose opioid (up to 275 mg morphine equivalent daily) to a patient who was presumed to be opioid naïve.

216. Dr. Peairs testified that Xanax is a benzodiazepine, which is a central nervous system depressant, and that studies showed that the combination of an opioid and benzodiazepine increased the chance of death. A physician should document a good reason for prescribing opioids and benzodiazepines. Dr. Peairs opined that Dr. Ruben failed to meet this standard.

217. Dr. Peairs also noted that Suboxone is used to treat drug addiction, but that Dr. Ruben never asked FS the reason for the prescription on the CSPMP. Dr. Peairs testified that on April 10, 2012, Dr. Ruben did not adequately assess the source of FS's reported pain or perform an adequate risk assessment.

218. Dr. Ruben testified that FS had been given Suboxone for one week for pain relief, not to treat addiction. Although Suboxone may be used to prevent a response to or withdrawal from opiates, it may also be used as a short-term bridge. Dr. Ruben testified that he counseled FS about non-prescribed drug use.

219. On April 10, 2012, FS signed a pain contract that included a provision that if his pain medication were stolen, he would have to provide a police report and pay $50 before Dr. Ruben would consider writing a replacement prescription. Dr. Peairs testified that she has never seen this term in a pain contract and that most pain contracts simply say that if the patient loses or allows his medication to be stolen, it will not be replaced. The implication that medication will be replaced for a fee is problematic.

220. Dr. Ruben testified that the $50 charge was from an old contract. He was working on incentivizing patients not to lose their prescription medications. Dr. Ruben testified that he has never charged a patient $50 to replace a prescription, but it takes time and energy to investigate lost or stolen prescriptions. Dr. Ruben testified that 55% of the time, he has stopped refilling or replacing stolen prescriptions.

221. According to the CSPMP and Dr. Ruben's medical log, on April 17, 2012, he prescribed a second prescription to FS for Oxycodone 30 mg. Dr. Ruben's file contains a police report that states that on April 15, 2015, FS was a passenger in a vehicle that was involved in an accident, he left his medication in the vehicle that was later towed to the wrecking yard, and the medication was stolen.

222. Dr. Ruben testified that he had his staff follow up on the police report by calling the officer and FS's roommates, who were the driver and other passengers in the car, to corroborate the story. Dr. Ruben testified that it took his office a while to get the police report. In the meantime, he counseled FS.

223. A June 19, 2012 MRI showed that FS had desiccation of L4-L5 and narrowing and bulging disks, desiccation and herniation at L5-S1, irregular inferior posterior endplate at L5 and facet osteoarthritis at L4-L5 and S1.

224. Dr. Peairs opined that the MRI demonstrated mild findings that did not correlate with the symptoms that Dr. Ruben had noted on his April 10, 2012 physical examination, which is the only examination documented in Dr. Ruben's reports for FS. Dr. Peairs opined that Dr. Ruben failed to adequately assess FS. Dr. Peairs opined that Dr. Ruben prescribed a high dose (up to 275 mg morphine equivalent daily) for subjective pain and criticized Dr. Ruben's failure to consider an orthopedic consultation to determine an etiology or definitive treatment regarding his complaints of low back and knee pain.

225. Dr. Ruben denied that he failed to adequately assess FS. Dr. Ruben testified that FS's reported pain of 8/10 was debilitating, and that FS denied drug, alcohol, or legal problems, but stated that some of his family members had arthritis, fibromyalgia, and autoimmune disorder. The trigger points showed muscle tears or injuries. The term "allodynia" means hyperalgesia, which means that just touching an area causes pain.

226. Dr. Ruben next saw FS on July 13, 2012. Dr. Ruben reported that FS continued to have lower back pain that goes to his right knee and that his overall pain level is 4/10. Dr. Ruben reported that FS "had a problem with medication some time ago and has police reports of that. We talked about the contingencies of his pain contract and way to keep his medications safe."

227. On August 13, 2012, FS was seen by a nurse practitioner.

228. On September 13, 2012, FS was seen by Dr. Ruben. FS reported pain in his legs that he had been doing day labor, which Dr. Ruben stated "he should not be doing." Dr. Ruben continued FS on Xanax .5 mg b.i.d, Amitriptyline 25 mg at night, Naproxen 500 mg b.i.d., and Oxycodone 30 mg five times a day, #150. Dr. Ruben did not report any physical examination of FS.

229. On November 12, 2012, FS was seen by Dr. Ruben. Dr. Ruben noted that FS was working in day labor, sometimes shoveling, which Dr. Ruben noted was "bad for his back." FS reported that his pain was 9/10, that he slept four hours a day, but that his mood was okay. FS reported that Amitriptyline made him groggy. Dr. Ruben increased the Xanax to .5 mg t.i.d., and continued to prescribe Oxycodone 30 mg five times a day and Naproxen 500 mg b.i.d.

230. On November 12, 2012, a call was received from a pharmacy regarding a prescription for FS that had been altered, specifically, that the #150 for Oxycodone had been turned into #180. Dr. Ruben's office instructed the pharmacy not to fill the prescription.

231. On December 10, 2012, FS was seen by Dr. Ruben. It was noted that a prescription had been altered at the pharmacy. FS stated that another patient of Dr. Ruben's had taken the prescription, but that FS had spoken to the pharmacist, who said he would fill the prescription after determining the correct amount. Dr. Ruben stated that "we need to call [the pharmacist] and get this straightened out and also to investigate this a little further." Dr. Ruben continued FS on Naproxen, Xanax and Oxycodone 30 mg five times a day. He noted that "medication education was again reviewed and an informed consent was reaffirmed.

232. Dr. Ruben testified that he spoke to FS and contacted the patient who FS said had taken the prescription to the pharmacy. Dr. Ruben testified that because there was no clear evidence that FS was responsible, he resolved to investigate the matter further. Dr. Ruben testified that the circumstances had to be considered as a whole: If he cannot substantiate each incident as a violation of the pain contract, he gives the patient the benefit of a doubt. Dr. Ruben testified that if the patient is abusing or diverting medication, the incidents will continue. Dr. Ruben testified that as long as numerous repeated questionable incidents do not occur, if the patient is benefitting from his care, he will continue to prescribe

medication to the patient. Dr. Ruben testified that he believes it is unethical to fire a patient because people with chronic pain, especially if they are younger, may have abused drugs in the past. Dr. Ruben testified that his goal is to help his patients get back on track. Dr. Ruben pointed out that FS's last UDS was consistent with the drugs that were prescribed.

233. There are two handwritten notes on the bottom of the December 10, 2012 typed office note: "December 27, 2012, fill oxycodone eight times a day number (illegible)" and "January 14, 2012, oxycodone 30 mg x 6 per day will decrease 20 (illegible)." According to the medication sheet, on December 10, 2012, FX received a prescription for 30 mg Oxycodone five times a day #40, and on December 18, 2012, received a prescription for 30 mg Oxycodone eight times a day #40.

234. Dr. Ruben obtained a CSPMP report on December 10, 2012, for FS's prescriptions over the last 12 months. The CSPMP showed that on October 8, 2012, FS had successfully filled a prescription for #180 Oxycodone 30 mg. The CSPMP also showed that on August 15, 2012, FS obtained a prescription for #240 Oxycodone 30 mg outside the office of Dr. Ruben only two days after August 13, 2012, when he had received a prescription for #120 Oxycodone from Dr. Ruben's office.

235. Dr. Peairs testified that she had been on a task force in 2008, and that the CSPMP was readily available to Dr. Ruben in 2012. Dr. Peairs testified that it was important for practitioners who prescribed opioids to monitor the CSPMP for their patients.

236. Dr. Ruben testified that FS had been prescribed Oxycodone by a nurse practitioner in another doctor's office. He contacted the doctor's office and was told that there was no record of FS having been seen on this date. Dr. Ruben testified that he went to see the doctor personally and the doctor stated that he had never written the prescription. Dr. Ruben testified that he contacted the pharmacy board, but there was no way to follow-up on the inquiry and that he wrote a note in FS's chart.

237. FS's chart includes a note from someone in Dr. Ruben's office that on December 10, 2012, she called the pharmacist and that the pharmacist stated that she had told him to fill November 12, 2012 prescription. When she stated that she had not told him to fill the prescription, he changed his story and said someone else had instructed him to fill the prescription, but that he had given FS a strong warning about altering prescriptions.

238. On January 29, 2013, Dr. Ruben saw FS. FS reported that his pain was 8/10, that he had lost 25 pounds, and that his appetite was low. Dr. Ruben increased FS's Oxycodone prescription to 30 mg 6 times a day, and increased the Xanax to .5 mg three times a day.

239. On March 5, 2013, Dr. Ruben saw FS. Dr. Ruben stated that "[w]e discussed the confusion over altered script and we went over his account of another patient (since discharged) who he believed was involved. Patient was restricted to weekly fills for two months and has complied." The medication log confirms that since December 10, 2012, FS had been receiving his Oxycodone weekly. Dr. Ruben's March 5, 2013 note stated that since he had no other evidence on this point, he would return to a regular schedule and would continue to monitor FS.

240. Dr. Ruben testified that he had put FS on notice that Dr. Ruben would help with structure to enable FS to responsibly manage his medications. Dr. Ruben testified that chronic pain patients are motivated to comply with their pain contracts because providers are hard to find.

241. On April 4, 2013, FS is seen in follow-up by Dr. Ruben. FS reported that he had a new relationship that he was happy with, that he had a customer service job, that his anxiety was down, that his appetite and energy were better, and that he was doing well. Dr. Ruben continued FS on Oxycodone 30 mg 6 times a day #180 and Xanax.

242. Dr. Peairs testified that Dr. Ruben had ignored numerous red flags for opioid abuse or addiction, including the prescription for Suboxone three months prior to establishing care, the presence of non-prescribed controlled substances on the UDS, the misrepresentation of the current opioid and benzodiazepine usage, the report of stolen narcotic medicine, CSPMP documentation of the simultaneous acquisition of a large quantity of narcotic outside the licensee's practice, CSPMP evidence that suggested an altered prescription in October 2012, and documented evidence of an altered prescription in November 2012.

243. Dr. Peairs testified that Dr. Ruben had exposed FS to an unreasonable risk of harm because Dr. Ruben had perpetuated FS's drug abuse and diversion, as evidenced by a reported theft of medication, an altered prescription, and filling two prescriptions for

Oxycodone within days. Dr. Peairs testified that the combination of a benzodiazepine and escalating doses of Oxycodone exposed FS to a risk of death. Dr. Peairs testified that the risks to FS outweighed the benefits of Dr. Ruben's treatment.

244. Dr. Ruben testified that FS had issues for investigation. He had investigated the issues and counselled FS and in Dr. Ruben's clinical judgment, decided to continue prescribing opioids. He discussed with FS how to keep his medications safe. Dr. Ruben testified that he saw FS at least monthly and that he was monitoring FS closely.

245. Dr. Ruben testified that at the beginning of his treatment, FS was not on a sufficient dose of pain medication for optimal functioning. Dr. Ruben testified that there was no evidence that FS was addicted to or diverting medications. He did not get early refills and kept his appointments. Dr. Ruben testified that FS was taking his medication responsibly and benefitted from Dr. Ruben's treatment.

246. Dr. Forrer testified the evidence indicated that FS was not opioid naïve when Dr. Ruben first prescribed opioids to him, that Dr. Ruben's assessment was adequate, and that FS benefitted from Dr. Ruben's treatment.

247. Dr. Gray testified that Dr. Ruben's care of FS met the applicable standard of care and that Dr. Ruben helped FS.

ME

248. ME established care with Dr. Ruben on March 20, 2006, when she was 38 years old. ME had been diagnosed with depression and had a history of smoking three packs of cigarettes a day, obesity, somnolence, and abusive relationships. She had started taking oxygen for COPD/respiratory problems in 1996, and had been taking pain medications for five years, or as of 2001.

249. On March 20, 2006, Dr. Ruben performed a targeted physical examination of ME to include vital signs, gait analysis, sensory examination, motor examination, and reflexes. Dr. Ruben prescribed benzodiazepine (Valium) 5 mg 2-3 times a day for muscle spasm, Lidocaine transdermal patch, and Oxycodone 5 mg up to 4 times a day. Dr. Ruben's March 20, 2006 note also stated that he would follow up with ME's mental health provider, pulmonologist, neurologist, and others. ME's chart reflects that Dr. Ruben had

these conversations, and that all of ME's other healthcare providers concurred in his treatment.

250. Dr. Peairs opined that a physician adequately identify an etiology for subjective pain complaints and assess whether opioids were clinically indicated and that Dr. Ruben departed from that standard.

251. Dr. Ruben testified that ME had a history of degenerative disk disease, radiculopathy, spinal stenosis, and nerve impingements that caused pain. His March 20, 2006 examination also identified spasms on both sides of her spine. Dr. Ruben testified that ME had objectively verifiable pain generators.

252. Dr. Ruben testified that a May 9, 2007 MRI of ME's right knee showed a medial meniscus tear and a hairline fracture at the top of the tibia. Dr. Ruben testified that ME underwent surgery for the condition and that she subsequently had trouble with her knee brace. Dr. Ruben testified that chronic knee pain is difficult to treat because people use the knee in various ways, and they may start to limp, which affects other parts of the body.

253. Dr. Ruben testified that an October 31, 2007 ultrasound noted slight scattered focal atherosclerotic changes in ME's main arterial segments of her lower extremities. Dr. Ruben testified that arteries getting clogged up could decrease pulses in ME's lower extremities and that the body tries to get rid of plaque by inflammation, which can cause pain. A May 20, 2008 CT of ME's abdomen and pelvis showed adenopathy, or swollen lymph nodes. Dr. Ruben pointed out that ME had vague complaints of pain in her lower extremities. Although the studies showed that there was a disease process going on, they did not support a clear diagnosis.

254. Between May 8, 2006, and August 28, 2006, ME was seen by Dr. Ruben or a nurse practitioner six times. On July 31, 2006, ME was prescribed Methadone and MS Contin.

255. On August 29, 2006, Amitab Puri performed a sleep study on ME and found significant hypoventilation with saturation to 86% during both REM and non-REM sleep, but no obstructive sleep apnea. The impressions were obesity, based on ME's BMI of 30.9, and

hypoventilation as a consequence of narcotic use. Dr. Puri's recommendations included the following:

1. Weight loss.
2. Avoidance of alcohol and soporific medications.
3. The patient may benefit from decreasing her use of Methadone to help improve her respiratory drive. In addition, discontinuing Valium may also help improve her respiratory drive. She takes 20 mg of Methadone, 5 mg of Valium and 60 mg. of MS Contin prior to bedtime.
4. Supplemental oxygen may be of some benefit.

256. ME's attorney stated in her December 31, 2009 letter claiming disability benefits on ME's behalf that she had cut back on pills when asked to do so by her doctors, but continued to have pain and symptoms.

257. Dr. Ruben submitted his notes of a recent telephone conversation with ME's pulmonologist, Todd Locher, MD, regarding a conversation on January 20, 2014, as follows:

> [Dr. Locher] state[s] that [ME's] head injury in 2008 might make her sensitive to narcotics. He had diagnose[d] her with Dysmotile Cilia Syndrome by examination of a biopsy with electron microscop[e]. He related her history of chronic sinus and pulmonary infections and Coci empyema, that she doesn't breath symmetrically, hypoventilates, has hyperviscos secretions and profound, difficult to treat hypothyroidism with a chronically elevated TSH. We discussed her . . . smoking and obesity as factors in her difficulties as well as hypoxia predating opiates and her caregivers['] observation that stopping them did not decrease her symptoms . . . .

ME's attorney noted that she had a history of having a rock dropped on her head as a child.

258. Dr. Ruben submitted a letter from Dr. Puri dated February 12, 2014, addressed to Dr. Ruben that provided in relevant part as follows:

> [S]tudies were read as allotted. And they were read with the available data in the chart. This usually included, a brief questionnaire, and any notes that may have been sent by the referring physician. Data available at that time indicated that the patient was on narcotic medications. Sleep apnea of significance was not noted. Snoring was identified. Though she was noted to hypoventilate. Recommendations regarding narcotics and sedatives were made based on the available data.

> Since then, after discussion with you, I have learned, that the patient had ciliary dysmotility syndrome. She had suffered a closed head injury in the past and suffered from a post concussive syndrome. And on your discussion with Dr. Locher, pulmonologist, had emphysema [COPD]. She had an established diagnosis of respiratory failure, hypoxic and had been on oxygen for several years prior to this sleep study.
>
> Her hypoxia, then certainly could be related to multifactorial reasons. Respiratory disorder such as emphysema, will cause V/Q mismatch, and are a known cause of hypoxia. She was also noted to have a body mass index of 31, this could have been a confounding feature too. Narcotics could add to this hypoxia.

259. On September 7, 2006, October 10, 2006, and November 1, 2006, interventional pain specialist Reid Bullock, MD examined ME. Dr. Bullock had seen ME two and a half years earlier and in 2004, had a CT performed that demonstrated disc degeneration at L4-5 and L5-S1 and a repeat lumbar MRI was indicated to determine the source of ME's new complaint of leg pain and chronic low back pain.

260. Dr. Ruben noted that on October 10, 2006, Dr. Bullock recommended an epidural to treat ME's back pain. Dr. Ruben testified that epidurals are only effective one-third of the time and that they may provide relief for two weeks or two months. Dr. Ruben testified that a poorly placed epidural can cause paralysis or stop a patient's breathing. Dr. Ruben testified that an epidural may cost $1,000.00 and that it is more profitable than Dr. Ruben's practice of counselling a patient about her pain medications.

261. Dr. Peairs opined in her report that Dr. Ruben departed from the standard of care that required him to keep adequate and legible medical records of ME, "with particularly significant deviations from 2006-2011, during which time medical records were extremely sparse and poorly legible."

262. ME was seen 56 times by a nurse practitioner and six times by Dr. Ruben to evaluate her medications and conditions. The CSPMP and UDSs were consistent with her prescribed medications. ME continued to complain of pain in her knee, shoulders, abdomen, neck, and back.

263. Dr. Ruben saw ME on March 2, 2012, January 18, 2013, February 25, 2013, March 22, 2013, and April 19, 2013. During that time, she was on Oxycodone 30 mg 5

times a day and Valium 5 mg 4 times a day. Intermittently, she was also given Methadone 10 mg 6 times a day or Dilaudid 4 mg 3 times a day.

264. On January 18, 2013, Dr. Ruben noted that ME's sleep was six hours and that she was breeding dogs, living by herself, and "doing okay." On February 25, 2013, ME's sleep was okay, except when she work up with pain and she needed to lose weight, but did not seem motivated, but her mood was okay and her mental status was stable. By April 19, 2013, ME was doing "pretty good; she [was] much more mobile, walks better and feels better. Being off the methadone and substituting the Dilaudid helped."

265. Dr. Peairs testified that ME has severe underlying pulmonary impairment, which means that she had low oxygen in her blood and was oxygen-dependent. Dr. Peairs testified that ME was a high-risk patient for any central nervous system depressant. It was very concerning and below the standard of care for Dr. Ruben to have prescribed benzodiazepines in combination with high-dose opioids to ME.

266. Dr. Peairs testified that although Dr. Locher's 2004 CT scan showed disk degeneration, Dr. Ruben had failed to update that information through physical examination, imaging, or any other means. Dr. Ruben did not know the degree of disease progression or whether ME's condition could have been improved by treatment of her back condition. Dr. Peairs testified that Dr. Ruben fell below the standard of care by not considering alternatives to pain medication prescription.

267. Dr. Peairs testified that Dr. Ruben had placed ME at an unreasonable risk of harm by prescribing opioids and benzodiazepines to her, because it perpetuated her oxygen dependence and placed her at a risk for death.

268. Dr. Gray testified that Dr. Ruben's records showed that ME was carefully monitored and actively managed. Dr. Gray disagreed that treatment with pain medications perpetuated ME's oxygen dependence and testified that people with respiratory conditions are routinely treated with pain medications.

269. Dr. Forrer testified that the Board's criticisms of Dr. Ruben's care of ME were unfounded and that she had benefitted from his care.

CD

270. Dr. Ruben first treated CD on November 15, 2012. Dr. Ruben's note of that visit provides on relevant part as follows:

> INITIAL EXAMINATION
>
> [CD] is a 42-year-old-male. He injured his right knee in 2003 in a motor vehicle accident. This has caused him continued pain and discomfort. He injured his left hip about a year ago and he now also has pain in his upper back which causes him to have decreased mobility of his neck. It is pinching and sharp; it varies but is constant. It causes him daily headaches. The headaches are daily; sometimes they are mild but are pounding on the left side. They do not often cause nausea or vomiting. Sometimes the pain goes from his neck and down to his left waist. It is unclear if the pain is from the left hip and goes up but he has difficulty standing for more than 15 to 20 minutes. He cannot do his machine operating at work as he cannot turn his head; bending and flexing is difficult.
>
> He sleeps three to four hours at night. His appetite is up and down. His energy is low and he is irritable at home. He denies chemical dependency or legal problems. He has hypertension and asthma but does not take medication. He denies any weakness or numbness but there is spasm in his neck.
>
> He has tried massage which has been of no help. He has not had a TENS unit or acupuncture. He had some physical therapy which was of some help. He has taken Excedrin and Vicodin which have not helped much. He took oxycodone 30 mg t.i.d. for a short time which was helpful. Flexeril made him tired.
>
> . . . .
>
> PHYSICAL EXAMINATION
>
> He is well developed, well nourished. His gait is okay. He can do tandem but was unable to do a squat. Flexion and rotation of the trunk were intact. Upper and lower hip flexion were intact; sensation of the upper and lower extremities is intact. Reflexes are 1:4 patellar bilaterally. Straight leg raising was basically negative. He has some tenderness in the areas of his left his left hip anteriorly, the right knee and also the left trapezius and cervical paraspinals. He had decreased rotation to the left of his head and deceased flexion. Grip is 3:4, biceps/triceps strength is 2:4, range of motion is okay. Hip flexion shows pain on the left.

271. Dr. Ruben diagnosed CD with right knee pain, left hip pain, pain in right cervical paraspinals and trapezius, and an old fracture of the right collar bone. Dr. Ruben's plan for CD included the following:

> 1. We will get the CSPMP and urinalysis. We will give him some Soma 350 mg a day, pioxicam 20 mg with food. We will check to see what other radiology we can find. He will probably need more radiology o0f the upper neck as he has not had that before. We will give him a low-dose of oxycodone.
>
> 2. We will have him in the pain program. Hopefully he will be able to qualify for AHCCCS so that we can get him some physical therapy. We will see what else we may be able to do for his neck pain; he most like[ly] has degenerative disc disease in his neck. . . .

272. The only CSPMP in Dr. Ruben's file for CD is dated April 26, 2013, and shows only the Oxycodone that Dr. Ruben prescribed. CD filled the prescriptions at three different pharmacies.

273. CD's UDS on November 15, 2012, was positive for marijuana and benzodiazepines.

274. On November 15, 2012, Dr. Ruben prescribed Soma 35 mg #30 and Piroxicam 10 mg #30.

275. Dr. Peairs opined that the standard of care requires a physician to adequately identify an etiology for subjective pain complaints and assess whether opioids are clinically indicated. Dr. Ruben had departed from this standard.

276. On December 13, 2012, Dr. Ruben again saw CD and reported that CD "[did] not have any reports yet," but that "he had an x-ray at El Rio that he will bring in tomorrow to see if we can justify giving him more pain medication."

277. On December 13, 2012, CD completed a self-report, stating that he had no insurance, that his pain had increased slightly and that he experienced new pain since the last visit, that he had undergone physical therapy, but it did not help, and that his pain medication was not sufficient to manage his pain.

278. Dr. Ruben's file contains radiology studies of CD's cervical and thoracic spine taken by El-Rio Community Health Center taken on December 13, 2012, that were negative. A study taken of DB's lumbosacral spine showed spondylitis involving the pars of L5 on the

left, mild degree of anterior spondylolisthesis of L5 over S1 of approximately 5 mm, but no other significant abnormalities. Dr. Ruben's file also contains reports from 2002 and 2003 of a broken right clavicle and effusion in the right knee, but no fracture.

279. On December 14, 2012, Dr. Ruben prescribed Oxycodone 15 mg 3-4 times a day #120 to CD.

280. On January 21, 2013, Dr. Ruben again saw CD. CD continued to have pain in his lower back and both hips, which he rated as 8/10. Physical therapy had been recommended before considering surgery. "He had been out of medication for a while."

281. On January 21, 2013, Dr. Ruben prescribed Flexeril 10 mg 3 times a day #90, Oxycodone 30 mg 3 times a day #90, and physical therapy to evaluate and treat upper and lower back pain and injury.

282. CD's January 21, 2013 self-report indicated that he had insurance through AHCCCS, but that he continued to be self-pay at Dr. Ruben's office, that his pain medication was still insufficient, and that his activity level has increased slightly.

283. The last time that Dr. Ruben saw CD was on February 21, 2013. Dr. Ruben noted that CD's lower back pain and hip pain continued, that he had hurt his back more in November when he was on the job on a forklift, and that he had to stop working that day, but that he had not made a claim for the injury. Dr. Ruben noted that CD reported that the pain continued to be significantly different than it was before, that he has not worked since the accident, and that he could only sleep four hours at night due to the pain. Dr. Ruben's plan/medications provided as follows:

> He ran out of medications about a week ago; his pain levels are approximately 7-8:10. The piroxicam did not help much and the Flexeril just helped a little bit. He still had some left. He also takes ibuprofen which helps minimally. We will increase his oxycodone 30 mg to q.i.d. He was again given instructions on using the Pilates ball and advised to walk on soft surfaces. We also gave him the name of an attorney . . . to follow-up on his Worker's Compensation. Medication education was again reviewed and informed consent was reaffirmed.

284. On February 21, 2013, Dr. Ruben prescribed Oxycodone 30 mg 4 times a day #120 to CD.

285. Dr. Peairs opined that Dr. Ruben had failed to meet the standard of care because he had failed to adequately identify an etiology for CD's subjective pain complaints and to assess whether opioids were clinically indicated. Dr. Peairs criticized Dr. Ruben for initiating and escalating CD's opioid use to a maximum dose of 180 mg morphine equivalent.

286. Dr. Ruben pointed to CD's history of traumatic injury and the documented abnormalities in his lumbosacral spine and numerous areas of tenderness that Dr. Ruben noted on his November 15, 2012 report. Dr. Ruben therefore started CD on pain medication, muscle relaxants, and anti-inflammatories, along with physical therapy, exercise, and Pilate's ball.

287. Dr. Peairs opined that Dr. Ruben had also failed to meet the standard of care because he had failed to recognize and follow up on CD's red flags that suggested non-compliance and/or aberrant drug-seeking, specifically the marijuana and benzodiazepine on the November 15, 2012 UDS and CD's repeated unauthorized dose escalations, which had resulted in CD repeatedly running out of medication early.

288. Dr. Ruben testified that he counseled CD after the November 15, 2012 UDS and concluded that CD was not abusing drugs. A subsequent UDS was negative for everything but Oxycodone. Dr. Ruben testified that he advised CD to obtain an Arizona medical marijuana card and provided the necessary paperwork so that CD could legally use marijuana to treat his chronic pain, but that CD failed to follow through for personal reasons.

289. Dr. Peairs testified that Dr. Ruben exposed CD to potential harms, including addiction and making CD's pain worse through inappropriate prescribing.

290. CD testified that he first came to see Dr. Ruben because he had been experiencing pain for years. He was referred to Dr. Ruben so that he could get medications to address his pain issues and keep functioning. CD testified that Dr. Ruben had performed a complete physical examination and had completed substantial paperwork. Although Dr. Ruben sent CD to physical therapy, it made his pain worse. On Dr. Ruben's suggestion, CD still uses a Pilate's ball, although he did not think that it helped. CD testified that in the informed consent that he signed, he obtained information about drugs.

291. CD testified that Dr. Ruben was very patient and never rushed through CD's office appointments. CD testified that it is frustrating to be in pain and that with the medications that Dr. Ruben prescribed, he was able to continue working and functioning in the world. CD testified that he had never abused or sold drugs. CD testified that Dr. Ruben provided a schedule of when to take drugs and advised him to take drugs only when necessary. CD testified that he did not want to die, become addicted, or get high. When he ran out of medication at the end of the month, CD testified it was because he still felt pain.

292. CD testified that he rides quads and motorcycles and participates in other sports such as basketball. He has had accidents. If he has surgery, he will be out of commission for six months. CD testified that although he did not have insurance when he first came to Dr. Ruben, his wife has since obtained a job with insurance benefits.

293. CD testified that he still smokes marijuana at night to go to sleep, due to his pain. CD testified that he has not obtained a medical marijuana card because he does not want it to be public knowledge that he smokes marijuana because there is a negative perception of the activity.

294. CD testified that he stopped seeing Dr. Ruben when the DEA made it impossible for him to prescribe medication and CD went to another provider. CD said that he went to different pharmacies after pharmacists refused to fill his prescriptions for pain medications. CD did not know that it was legal for pharmacists to refuse to fill a prescription that was necessary to maintain health and functioning.

295. Dr. Gray testified that Dr. Ruben's treatment of CD complied with standards and that CD benefitted from his treatment.

DB

296. DB is a 37-year-old man who established care with Dr. Ruben on March 18, 2013. DB is MB's brother. In November 2012, DB had been in a motor vehicle accident in which he had re-injured his right knee and hit his head, requiring suturing over his eyebrow. DB reported that after the accident, he started having 3-4 migraines per week, twice as many as before the accident, with light sensitivity, nausea, and vomiting. DB reported that the migraines started when he was involved in another accident 20 years earlier, in which he had lost consciousness and which had resulted in scarring of his right lateral head. DB

reported that he was dazed and confused after the most recent accident, and Dr. Ruben opined that DB "obviously had a brain contusion."

297. DB reported that he also previously had another accident in which he had fractured his right femur and had a Kutcher Nail put in. DB reported that since the most recent motor vehicle accident, he had increased pain in his right knee, primarily on the lateral side, with tenderness.

298. DB denied a history of chemical dependence or legal problems. DB reported that he had tried ibuprofen, Piroxicam, and Tramadol for his pain, with no affect. DB reported that his mother had rheumatoid arthritis with deformities and that he had taken some of her Oxycodone, which was helpful.

299. Dr. Ruben reported that on physical examination of DB, his gait was okay, he had some tenderness on the lateral knee, but had mobility of the knee, with no looseness or swelling, his grip was 1 out of 4 bilaterally, that he had swollen hands and some deformities of the fourth and fifth fingers, right and left, he had some slowness in coordination of his hands and some tenderness in the proximal interphalangeal joints, that he had some tenderness of the first metatarsal joint and first digit on his right foot, and that although the cranial nerves were intact, he had a scar on his forehead and a scar on the right lateral side of his head from the old accident and some scarring over his eyebrows from the most recent accident.

300. Dr. Ruben diagnosed DB with swelling and arthritic changes in both hands and perhaps the right big toe, increased migraine headaches with nausea and vomiting, and a history of head injuries and a fractured right femur with an appliance. Dr. Ruben's plan for DB was to get the CSPMP and urinalysis, to perform lab testing to see if DB needed to be referred to a rheumatologist, and to prescribe Oxycodone for pain relief.

301. DB's March 18, 2013 UDS was positive for marijuana and methadone, but negative for Oxycodone. Dr. Ruben's handwritten note on the UDS states, "took one methadone, counseled, and will [illegible] pain contract reviewed."

302. A CSPMP that Dr. Ruben obtained for DB on March 18, 2013, showed that Compass Behavioral Health Care had prescribed Suboxone 2 mg #11 on December 18, 2012, December 26, 2012, and January 3, 2013, and Suboxone 2 mg #14 June 21, 2012,

and that University of Arizona Medical Center had prescribed Oxycodone 5 mg #28 on November 28, 2012, and Oxycodone-Acetaminophen #20 on November 18, 2012. There were no prescriptions for benzodiazepines.

303. On March 18, 2013, Dr. Ruben prescribed Oxycodone IR 15 mg #90 2-3 times a day to DB.

304. Dr. Peairs testified that Dr. Ruben had departed from the standard of care by failing to obtain a substance use history or to address DB's use of Suboxone, which is approved to treat opioid addiction, at Compass Behavioral Health Care. Dr. Peairs testified that there is no legitimate prescription for methadone documented on the CSPMP.

305. Dr. Peairs testified that Dr. Ruben had departed from the standard of care by prescribing an initial opioid dosage of nearly 70 mg morphine equivalent to a presumably opioid naïve individual. Because the only Oxycodone prescription on the March 18, 2013 CSPMP in the previous twelve months was almost four months earlier for a single month in a 5 mg dosage, DB was presumed to be opioid naïve. Dr. Peairs testified that in addition, Dr. Ruben prescribed opioids in the absence of a documented significant pain generator.

306. Dr. Ruben testified that DB had told him that he had been taking up to 90 mg of Oxycodone a day, and that on March 18, 2013, Dr. Ruben prescribed only 37.5 mg a day. Dr. Ruben testified that DB may have been rationing his Oxycodone, which is why it did not show up on the March 18, 2013 UDS.

307. Dr. Ruben testified that in both his handwritten and typewritten notes for March 18, 2013, DB had denied his own or family members' aberrant behaviors or substance abuse.

308. Dr. Ruben stated that his handwritten note indicated that DB said that he had taken 10 mg of methadone for pain and that Dr. Ruben had counselled him that such behavior would violate his pain contract.

309. Dr. Ruben obtained radiological reports for DB, including an x-ray of DB's bilateral hands, on April 2, 2013. The report shows arthritic changes with subluxation of the proximal interphalangeal joint of the 4th finger of the left hand and arthritic changes of the first metacarpophalangeal joint of the right hand, which could be posttraumatic, but no evidence for erosive arthritic process. A November 12, 2012 CT scan of DB's head and

cervical spine showed postsurgical changes related to prior right frontal craniotomy and mild multilevel degenerative changes of the cervical spine, without significant central canal stenosis. A January 11, 2013 x-ray of DB's right knee showed no acute fracture, an intramedullary rod fixation for a proximal femoral fracture, and a small right knee joint effusion and soft tissue edema about the right knee.

310. Dr. Ruben pointed out that the radiology reports provided objective evidence of conditions that could cause DB to experience pain.

311. Dr. Ruben next saw DB on April 18, 2013. DB reported that he still had pain in his hands, toes, and right knee and that he need a little higher dose of Oxycodone because he was used to taking 30 mg two or three times a day, and that DB ran out of medications early. A handwritten note on the typewritten office note stated "UDS consistent."

312. DB's UDS for April 18, 2013, was positive for opiates, benzodiazepines, and Oxycodone.

313. On April 18, 2013, Dr. Ruben prescribed Oxycodone 30 mg 2-3 times a day #80 to DB.

314. Dr. Peairs testified that Dr. Ruben prescribed escalating doses of opioids to DB based solely on subjective complaints and in the absence of evidence about whether he was opioid tolerant or naïve. Dr. Peairs testified that DB's statement that he had been using his mother's Oxycodone indicated a non-medical use. There was no explanation in the CSPMP or in Dr. Ruben's notes for the benzodiazepines on the second UDS.

315. Dr. Ruben testified that he increased DB's Oxycodone dose to what he reported to having taken before because the lesser dose did not adequately control DB's pain. DB needed more medicine to function. UDSs frequently result in false positives. There was no evidence that DB was an addict or that he was diverting his medications.

316. Dr. Ruben testified that DB did not run out of his medications early because April 18, 2013, was more than 30 days after March 18, 2013, and since DB's UDS was positive for Oxycodone, at worst he may have been rationing his medicine.

317. Dr. Peairs' report noted that Dr. Ruben also departed from the standard of care by failing to investigate and/or adequate address numerous red flags that MB presented, including his self-report of using his mother's Oxycodone, the presence of non-

prescribed Methadone on the initial UDS, the presence of marijuana on the initial UDS, the presence of non-prescribed benzodiazepines on the second UDS.

318. Dr. Peairs testified that Dr. Ruben had exposed DB to unreasonable risks of harm, including accidental overdose, which even if not fatal could result in brain damage, damage to major organ systems, and addiction or diversion.

319. Dr. Forrer and Dr. Gray testified that Dr. Ruben's treatment of DB complied with all standards and that DB benefitted from Dr. Ruben's care.

Evidence on Whether Dr. Ruben Shared Dr. Ashby's Report with MB

320. Ms. Andrade testified that she showed Dr. Ashby's report to MB but covered the letterhead and that she told MB about the Board's allegations but nothing else.

321. Ms. Andrade testified that she did not recall how the letter with MB's signature on it was prepared because she did not type the letter. Ms. Andrade testified that her predecessor may have typed the letter. Ms. Andrade testified that she was present when MB came in to sign the letter.

322. Dr. Ruben testified that he understood that the Board's communications are private and should not be shown to others. Dr. Ruben denied ever furnishing Dr. Ashby's name to MB. Dr. Ruben testified that he shared some of the criticisms in Dr. Ashby's report with MB because Dr. Ruben has a right to investigate issues to defend himself.

323. Dr. Ruben testified that he drafted the response to Dr. Ashby's criticism based on a transcription of MB's comments. MB's signed letter refers to Dr. Ashby by name in the first and third line. Dr. Ruben testified that when MB signed the response, the first three lines, the second sentence, and the sixth sentence where blanked out. Dr. Ruben testified that he has respect for the Board and would never disclose a consultant's name to a patient.

324. MB testified that he signed a letter that Dr. Ruben had typed because Dr. Ruben asked him to. MB denied that Dr. Ruben had shown him any documents from the Board.

Factors in Aggravation and Mitigation of the Penalty

325. On or about April 1, 2009, the Board and Dr. Ruben entered into a Consent Agreement for a Letter of Reprimand and Probation to resolve one Board case, under which Dr. Ruben agreed to complete 15-20 hours continuing medical education in pain

management, to be placed on probation for a term of one year, and during that time, to allow Board staff or its agents to conduct periodic chart reviews. The factual bases for the April 1, 2009 Consent Agreement were Dr. Ruben's care of a single chronic pain patient between November 17, 2006, and October 19, 2007.

326. Dr. Ruben agreed not to contest the validity of the Findings of Fact and Conclusions of Law in the Board's April 1, 2009 order. The April 1, 2009 Consent Agreement also provided that any admission that Dr. Ruben made was solely to resolve the administrative complaint and was "not intended or made for any other use, such as the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court."

327. On or about June 10, 2010, the Board and Dr. Ruben entered into a Consent Agreement for an Order for Decree of Censure, Practice Restriction, and Probation to resolve five Board cases, under which Dr. Ruben agreed to accept a decree of censure, to not prescribe opioids for a period of one year, which would commence after the 60 days that the Board allowed Dr. Ruben to terminate care of patients that required opioids to allow them to find other providers, to complete a PACE prescribing course, to be placed on probation for a term of two years, and to enter into a contract with Affiliated Monitors to provide quarterly chart reviews during the probationary term. The factual bases for the June 10, 2010 Consent Agreement were Dr. Ruben's care of nine chronic pain patients between 2005 and 2009.

328. Dr. Ruben agreed not to contest the validity of the Findings of Fact and Conclusions of Law in the Board's June 10, 2010 order. The June 10, 2010 Consent Agreement also provided that any admission that Dr. Ruben made was solely to resolve the administrative complaints and was "not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court."

329. Over the Board's objection for lack of relevance to the current case, Dr. Ruben submitted affidavits or letters of commendation from eight other providers that were written in 2010. Dr. Ruben also submitted other physicians' positive reviews of the charts of the ten patients whose care was at issue in the April 1, 2009 Consent Agreement and the June 10,

2010 Consent Agreement and affidavits or positive reviews from 23 patients, some of whose care had been at issue in the April 1, 2009 Consent Agreement or the June 10, 2010 Consent Agreement.

Evidence and Argument on the Effect of the DEA's Suspension of Dr. Ruben's DEA Privileges

330. On or about June 26, 2013, federal Drug Enforcement Administration's ("DEA's") Administrator Michelle M. Leonhart issued a decision suspending Dr. Ruben's DEA certificate for one year. The genesis of the DEA's complaint was that between April 9, 2008, and June 6, 2008, two cooperating sources, posing as patients, had visited Dr. Ruben's office and the had prescribed Schedule II controlled substances to them without a physical examination.

331. A hearing had been held before federal Administrative Law Judge ("ALJ") Timothy D. Wing between January 10, 2012, and January 12, 2012. ALJ Wing found that the DEA did not establish that Dr. Ruben had improperly written prescriptions for the federal agents masquerading as patients. ALJ Wing found that the Findings of Fact alleged in the April 1, 2009 Consent Agreement and June 10, 2010 Consent Agreement showed that Dr. Ruben lacked a legitimate purpose in prescribing controlled substances to numerous patients, potentially furnishing cause to sanction his DEA certificate, but that Dr. Ruben had "credibly accepted responsibility for his past misconduct and demonstrated that he has implemented various corrective measures to ensure that his practice is consistent with the public interest." ALJ Wing therefore recommended that Dr. Ruben's DEA certificate be continued subject to the condition that he comply with the terms of the June 10, 2010 Consent Agreement and notify the DEA field office of any changes in the terms of the agreement.

332. Administrator Leonhart rejected this recommendation because she found that the Board's June 10, 2010 Consent Agreement established cause to suspend Dr. Ruben's DEA certificate under the federal Controlled Substances Act, 21 U.S.C. § 824(a)(4), and principles of collateral estoppel . Administrator Leonhart therefore required that Dr. Ruben's DEA certificate be suspended for a period of one year based on the repeated acts of unprofessional conduct that formed the basis of the June 10, 2010 Consent Agreement. Dr.

Ruben has appealed Administrator Leonhart's decision and his appeal is presently pending before the Ninth Circuit Court of Appeals.

333. On or about March 11, 2015, Dr. Ruben's attorney filed a motion in limine to preclude admission of evidence of the past Consent Agreements or the DEA sanction because consideration of the evidence "would violate each of the doctrines of judicial estoppel, equitable estoppel, and un clean hands as well as the due process clause of the United States and Arizona Constitutions." On or about March 18, 2015, oral argument was held on the motions in limine and the undersigned ALJ issued an order denying Respondent's motion in limine. The ALJ considers the motion when she recommends the weight that the Board should give the Consent Agreements and Administrator Leonhart's decision suspending Dr. Ruben's DEA certificate.

CONCLUSIONS OF LAW

1. The Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona. This matter lies within its jurisdiction.

2. The Board bears the burden of proof to establish cause to sanction Respondent's license to practice allopathic medicine and factors in aggravation of the penalty by clear and convincing evidence. Dr. Ruben bears the burden to establish affirmative defenses and factors in mitigation of the penalty by the same evidentiary standard. Clear and convincing evidence is "[e]vidence indicating that the thing to be proved is highly probably or reasonably certain."

THE DEA'S SUSPENSION OF DR. RUBEN'S DEA PRIVILEGES

3. Although Dr. Ruben has appealed the DEA's suspension of his DEA certificate, unless and until Administrator Leonhart's decision finding cause to suspend his certificate under the federal Controlled Substances Act is reversed on appeal, the decision is conclusive. Therefore, the Board has established by clear and convincing evidence that Dr. Ruben committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(a) and (p).

4. The same conduct that Administrator Leonhart cited as bases to suspend Dr. Ruben's DEA certificate for one year, to wit, the Board's June 10, 2010 consent

agreement, had already resulted in Dr. Ruben's agreement to not prescribe opioids for one year over a different time period. There is no evidence that Dr. Ruben failed to comply with this term or any of the other terms of the April 1, 2009 consent agreement and June 10, 2010 consent agreement. Administrator Leonhart's decision did not find that Dr. Ruben committed any new acts that constituted unprofessional conduct as defined in Arizona law or in violation of federal statute.

FAILING OR REFUSING TO FURNISH ADEQUATE RECORDS ON A PATIENT

5. On June 10, 2010, Dr. Ruben accepted the Board's consent agreement under which, among other things, he agreed to complete a PACE prescribing course. He began treating GM on May 9, 2009, and ME on March 20, 2006, before he completed the PACE prescribing course. Dr. Peairs noted that Dr. Ruben's medical records for ME between 2006 and 2011, were "extremely sparse and poorly legible." After 2011, he kept typewritten office notes, as well as handwritten notes.

6. Dr. Ruben's medical records after 2011, mostly contained sufficient information to identify the patient, document the results, indicate advice and cautionary warnings provided to the patient, and to support the diagnosis and justify the treatment, at least according to the standards of what Dr. Ruben called the therapeutic school of chronic pain management. After 2011, Dr. Ruben's records were sufficiently complete and legible for Dr. Ashby and Dr. Peairs to provide detailed criticism of Dr. Ruben's care and Dr. Ruben, Dr. Forrer, and Dr. Gray to defend Dr. Ruben's care of the eight patients over eight days of testimony.

7. Nonetheless, Dr. Ruben testified to conversations with MB, FS, and ME and/or their other providers to defend against Dr. Ashby's and Dr. Peairs' criticisms. This information should have been in the patients' medical records. Therefore, the Board established by clear and convincing evidence that Dr. Ruben failed to keep adequate records as defined by A.R.S. § 32-1401(2) and committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(e).

CONDUCT OR PRACTICE THAT IS OR MIGHT BE HARMFUL OR DANGEROUS TO THE HEALTH OF THE PATIENT OR THE PUBLIC

8. A.R.S. § 32-1401(27)(q) defines "unprofessional conduct" to include "[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public." The Arizona Court of Appeals has acknowledged that this definition is broad in the context of medical treatment:

> Many appropriate forms of medical treatment entail potential harm. There is some potential for harm in most prescription medication; and some forms of treatment—radiation and chemotherapy, to name two—involve near certainty of harm, yet harm accepted and acceptable in the effort to alleviate still greater harm.

In response to the argument that A.R.S. § 32-1401(27)(q) is unconstitutionally vague or overbroad, the Court held that in enacting the statute, the legislature "intended rather to proscribe only those forms of treatment whose potential or actual harm is *unreasonable* under the circumstances, given the applicable standard of care."

9. The evidence submitted at hearing demonstrated that chronic pain management involves patients' psychological as well as physical characteristics. Because different patients may experience and react differently to similar radiological or other objective indicia of a pain generator, a substantial minority of allopathic physicians believe that chronic pain management standards of care may be found at the interstices among psychiatric, neurological, anesthetic, and addiction practices. Moreover, the location of the practice and the nature of the patients served, including the patients' access to insurance or ability to pay for various treatments, may affect the standard of care.

10. Dr. Peairs testified that "you can say someone has subjective pain without a pain generator. However, it is the objective identifiable cause that you are treating with opioids." (Tr. VIII at 1348) She further testified that it is below the standard of care of any respectable minority of any pain treating physicians in the state of Arizona to prescribe opioids when they cannot locate an objective pain generator such as an abnormal x-ray. (Tr. VIII at 1349) Dr. Ashby testified that he is not aware of any physicians who believe you can use opioids even if you cannot find an objective cause of the pain, such as an abnormal x-ray or other objective test. (Tr. VIII at 1372) Dr. Ashby also testified that "the

pain generator is a pathologic condition that should explain the pain involved. And so the problem I saw in general with these patients is that many times they would have a minor x-ray abnormality that might explain some minor pain, but it would not explain pain needed to treat with high-dose opiates." (Tr. VIII at 1360)

11. Dr. Gray is does not specialize in psychiatry, neurology, addiction medicine, or chronic pain treatment. Because this is an administrative matter involving the standard of care, rather than a civil action for malpractice, the Administrative Law Judge considers all the experts' testimony. The members of the Board also may rely on their own expertise to evaluate this decision. All four experts were qualified to render opinions on the standard of care, although only Dr. Peairs and Dr. Ashby are board certified in pain management.

12. Dr. Slaski, Dr. Skinner, and the nurse practitioners all worked out of the same office as Dr. Ruben, at least during some of the times at issue. Dr. Ruben is not responsible for supervising these other providers, but he is responsible for monitoring the care they provided for continuity of care. If Dr. Ruben did not agree with care rendered by other providers, he needed to inform the patient and/or alert the agency that licensed the providers.

13. Based upon the foregoing Findings of Fact, the Board finds that Respondent committed unprofessional conduct by violating A.R.S. §32-1401(27)(q), conduct that is or may be harmful or dangerous to the patient or public, as follow:

GM

14. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to document an objective pain generator warranting treatment with opioids at GM's initial visit.

15. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to attempt treatment of GM's gout with safer modalities instead of immediately instituting opiate therapy.

16. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to re-evaluate the treatment plan based upon GM's severe deterioration in function.

17. The Board established by clear and convincing evidence that GM became very depressed and suicidal and also had multiple treatments for chemical dependency. Additionally, GM suffered fractures from falls on two occasions, as the risk for falls is increased with the medications that were prescribed. Respondent's prescribing high doses of opiates to GM placed GM at high risk for overdose and death.

MB

18. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to perform a complete pain history and by failing to work up or consider other causes for widespread pain.

19. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to review the treatment plan when MB had early refills and ran out of his medications and by doubling the oxycodone dose with little change in MB's pain level.

20. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing oxycodone IR for MB in high doses along with benzodiazepines.

21. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to coordinate MB's care with the mental health provider who was prescribing benzodiazepines which have significant drug interactions with opiates.

22. The Board established by clear and convincing evidence that MB did not receive appropriate care for his chronic pain as evidenced by his decrease in functioning over the course of his treatment. Respondent's treatment of MB could have resulted in overdose, aspiration, hypoxia, or death given that he was on two benzodiazepines and soma with a history of drug abuse, self-medicating, and a recent overdose. Additionally, MB may have become dependent on the medications or diverted them.

PG

23. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by performing a brief and limited initial evaluation without identifying an objective pain generator or pain syndrome.

24. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing extremely high doses of opiates for musculoskeletal pain.

25. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by continuing to prescribe oxycodone IR 30mg to PG in the face of multiple aberrant behaviors without changing the treatment plan or increasing monitoring for abuse.

26. The Board established by clear and convincing evidence that PG was never adequately evaluated for drug dependency and the public was placed at risk due to diversion of her medications. Additionally, there was potential for overdose with respiratory depression, aspiration, neurologic damage, and death.

AT

27. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by performing a brief and inadequate history without a pain generator or pain syndrome documented.

28. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing opiates without any justification.

29. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to consider the increased risk of overdose and death when sedatives were prescribed.

30. The Board established by clear and convincing evidence Respondent deviated from the standard of care by ignoring AT's aberrant behaviors and by failing to discontinue prescribing or modify the treatment plan and increase monitoring.

31. The Board established by clear and convincing evidence that AT abused medications that were not medically indicated. Respondent's conduct placed AT at risk of complications of opiates including impaired function, mood, endocrinologic, and immune disorders. The public was placed at risk in that AT, who was a bus driver, was prescribed opiates and sedatives with no consideration of driving impairment. Further, the public was placed at risk due to possible diversion of easily abused and highly sought after drugs.

FS

32. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to adequately assess FS to determine if opioids were clinically indicated.

33. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing a potentially fatal opioid dose to a patient presumed to be opioid naïve.

34. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by initiating and escalating opioids and benzodiazepine without investigating and/or adequately addressing red flags for opioid abuse and/or addiction.

35. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing escalating doses of combined opioid and benzodiazepine with essentially no diagnostic work-up to identify indications commensurate with the significant associated risks.

36. The Board established by clear and convincing evidence that Respondent's conduct placed FS at risk of respiratory depression, accidental overdose, and death. Additionally, Respondent's conduct may have perpetuated drug seeking, abuse, addiction, and/or diversion.

ME

37. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to recognize the significant risk of continued narcotic and benzodiazepine in a patient with documented severe pulmonary impairment, hypoventilation, hypoxemia, and oxygen dependence.

38. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to adequately assess ME's subjective complaints in order to determine if opioids were clinically indicated.

39. The Board established by clear and convincing evidence that Respondent's conduct resulted in perpetuation of ME's hypoventilation, hypoxemia, and oxygen dependence. Further, ME was exposed to all of the medical risks associated with long-

term opioid use in a setting absent objective pathology to warrant such treatment given her hypoxemia and hypoventilation.

CD

40. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to adequately assess CD in order to determine if opioids were clinically indicated.

41. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by initiating and escalating opioids without addressing red flags for aberrant drug-seeking behavior.

42. The Board established by clear and convincing evidence that, as a result of Respondent's conduct, CD was exposed to the entirety of medical risks associated with long-term opioid use in a setting absent objective pathology to warrant such treatment.

DB

43. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to adequately assess DB to determine if opioids were clinically necessary.

44. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing an initial opioid dosage of nearly 70mg morphine equivalent daily to a presumed opioid naïve patient.

45. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by initiating and escalating opioids without adequately reviewing, monitoring, and addressing red flags for aberrant drug-seeking behavior.

46. The Board established by clear and convincing evidence that Respondent's conduct perpetuated addiction and/or diversion in providing narcotic prescriptions to a patient with minimal objective findings who demonstrated commonly recognized red flags for aberrant drug-seeking behavior. Additionally, DB was exposed to the entirety of medical risks associated with long-term opioid use in a setting absent objective pathology to warrant such treatment.

ORDER

Based on the foregoing, IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

2. Practice Restriction

a. Respondent is prohibited from prescribing, administering or dispensing any Schedule II controlled substances for a period of two years.

b. Respondent must petition the board to lift the practice restriction after two years from commencement of this Order.

3. Probation

Respondent is placed on probation for two years under the following terms and conditions:

a. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona.

b. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

4. This Order is the final disposition of case numbers MD-13-0315A and MD-13-0500A.

5. If Respondent violates this Order the Board may take further disciplinary action against his license after affording Dr. Ruben notice and an opportunity to be heard.

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 4th day of December, 2015.

THE ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this 4th day of December, 2015 with:

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

Executed copy of the foregoing mailed by U.S. Mail this 4th day of December, 2015 to:

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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of, **DAVID ALAN RUBEN, M.D.** Holder of License No. 11382 for the Practice of Allopathic Medicine in the State of Arizona, Respondent.	Case No: 15A-11382-MDX **STATE'S MOTION TO MODIFY/REJECT ALJ'S RECOMMENDED DECISION**

The State, through the undersigned Assistant Attorney General, offers the following Motion to Modify/Reject the Administrative Law Judge's Recommended Decision in the above-captioned matter. Pursuant to A.R.S. § 41-1092.08(B), the Board may accept, reject or modify the decision. The State respectfully urges the Board to accept, modify, and reject, in part, the ALJ's decision.

I. FINDINGS OF FACT

The State requests that the Board ACCEPT Findings of Fact 1-3, 8-10, 12, 14-15, 18, 20-23, 27-77, 79, 81-97, 100-119, 121-191, 193-196, 198-217, 219-270, 272-328, 330-333.

The State requests that the Board modify the following Findings of Fact based upon evidence presented at hearing. **Proposed modifications to the Findings of Fact appear in bold.**

The State requests the Board to **MODIFY** Findings of Fact Nos. 4 and 5 to delete (tt) and reflect the correct statutory section of **(dd)**:

The State requests the Board to **MODIFY** Finding of Fact No. 6 so it reads:

6. The Board submitted 53 exhibits and presented the testimony of three witnesses: (1) Danielle ("Elle") Steger, the Board's Chief Investigator in its Physician Health Program; (2) Rob Ashby, M.D., the Board's expert on the care that Dr. Ruben rendered to patients GM, MB, PG, and AT; and (3) Carol Peairs, M.D., the Board's expert on the care that Dr. Ruben rendered to patients FS, ME, DB, and CD. **Dr. Peairs and Dr. Ashby prepared written reports detailing the bases for their opinions regarding the patient files that they reviewed. These reports were admitted into evidence in this case. (AMB Exhs. 21, 25, 28, 33, and 34.)**

The State requests the Board to **MODIFY** Finding of Fact No. 7 so it reads:

7. Dr. Ruben submitted 65 exhibits and presented the testimony of nine witnesses: (1) George Steven ("Steve") Nash, the Executive Director of the Tucson Osteopathic Medical Society; (2) Margo Andrade, Dr. Ruben's office manager; (3) AT, one of Dr. Ruben's patients whose care was at issue; (4) JJ, AT's **significant other (Tr. III at 502)**; (5) Scott Christopher Forrer, M.D., one of Dr. Ruben's expert witnesses; (6) MB, another of Dr. Ruben's patients whose care and behavior was at issue; (7) Michael Richard Gray, M.D., who also testified as an expert on Dr. Ruben's behalf; (8) CD, another of Dr. Ruben's patients whose care was at issue; and (9) himself. **Neither Dr. Forrer nor Dr. Gray provided written reports detailing the bases for their opinions in this case.**

The State requests the Board to **MODIFY** Finding of Fact 11 so it reads:

11. Dr. Webster did not review Dr. Ruben's records for the eight patients, did not offer any opinion on Dr. Ruben's treatment of any specific patient, and **was not subject to cross-examination of his opinions since he** did not testify at the hearing.

The State requests the Board to **MODIFY** Finding of Fact 13 to more adequately reflect Dr. Peairs qualifications so it reads:

13. Dr. Peairs testified that she works as a consultant at the VA Hospital providing second opinions and record reviews. She also treats patients on an outpatient basis as part of a multidisciplinary team. Dr. Peairs testified that she has prescribed opioid medications and that her practice is not solely interventional. **Dr. Peairs testified that she has treated thousands of chronic pain patients on an outpatient basis since June, 1989, and that she follows patients long-term. (Tr. VIII at 1320-1321). Dr. Peairs has been recognized as an expert on both a state and national level regarding opioid prescribing for chronic pain. (Id at 1324-1326) For example, out of 41,000 members, the American Society of Anesthesiologists chose Dr. Peairs to provide a national webinar for education of physicians on opioid prescribing for chronic pain. (Id. at 1325). Additionally, the Mayo Clinic and the University of Arizona, College of Medicine invited Dr. Peairs to speak to residents and physician faculty on responsible opioid prescribing for chronic pain. (Id. at 1324) Dr. Peairs advised the Arizona Medical Board on developing the Guidelines for treatment of chronic pain with opioids. She testified that "those guidelines specifically say they are for the purpose of reassuring doctors that as long as they prescribe according to current standards of care, that they do not have to fear disciplinary action." (Id.)**

The State requests the Board to **MODIFY** Finding of Fact 16 so it reads:

16. After Dr. Peairs testified, Dr. Ruben submitted a second affidavit from Dr. Webster that stated that "[t]he two schools of thought . . . have not drawn closer together over the last two decades" and "[t]o the contrary, they have grown steadily apart and are as far apart now as at any time. Evidence can be discovered [by] reading my twitter feed @LynnRWebsterMD." **Dr. Webster did not testify and, therefore, was not cross-examined on his opinion.**

The State requests the Board to **MODIFY** Finding of Fact 17 so it reads:

17. Dr. Ashby is in private practice in Prescott, where he has three treatment centers for detoxification, pain, or pain and addiction. Dr. Ashby is certified by the Board of Anesthesiology **and, like Dr. Ruben, he is certified by the** Board of Addiction Medicine and the Board of Pain Medicine.

The State requests the Board to **MODIFY** Finding of Fact 19 so it reads:

19. Dr. Ashby studied ancient healing arts and incorporates his studies into his current practice. Dr. Ashby testified that his pain was worse when he was addicted to opioid medication and that a study of 214 patients showed that their pain improved when they were taken off high doses of opioid medications and benzodiazepines. Dr. Ashby testified that he may prescribe opioids, especially Suboxone, which does not provide a high and is not addictive, to maintain his patients who are addicts. **He further testified that he prescribes opioids in his current practice "in very carefully selected patients and then with very careful monitoring. For instance, I check the CSPMP every visit. I do frequent urines." (Tr. VIII at 1367)** Dr. Ashby does not consider dependence to be separate from addiction under the Diagnostic and Statistical Manual V.

The State requests the Board to **MODIFY** Finding of Fact 24, 25, and 26 so they read:

24. On rebuttal, Ms. Steger testified that she was born in Tucson and that her whole family lives there. Ms. Steger testified that according to the Board's website, there are many pain management specialists in Tucson and that only five chronic pain specialists in Tucson had their licenses revoked or suspended. Ms. Steger testified that when she called to see if any pain management specialists were taking new patients, most informed her that they would accept her as a patient if she had a referral from her primary care provider, even if she did not have insurance. **Ms. Steger testified Dr. Ruben's office was 2.8 miles from the building where the hearing was held and only nine minutes from the University of Arizona. (1380) She further testified that only one of the eight patients who are subject of this case showed an address in South Tucson. (Tr. VIII at 1381)**

25. Dr. Forrer has practiced allopathic medicine since 1987 and has been Board-certified in psychiatry and neurology since 1993. Dr. Forrer is currently in private practice at the Tucson Neuroscience Center. Dr. Forrer testified that as a psychiatrist and neurologist, he is familiar with the standard of care for treating chronic pain. Dr. Forrer testified that although most of his patients have pain complaints, he stopped prescribing opioids to treat their chronic pain in 2008 or 2009, because he feared harassment from the Board. **Dr. Forrer expressed extreme bias against the Arizona Medical Board. For example, he testified that he did not believe the Board acted in good faith in this case and he referred to use of its experts as "sham peer-reviewed." (Tr. IV at 667)**

26. Dr. Forrer testified that his practice is upscale and caters to high income patients. In contrast, the chronic pain patients that Dr. Ruben treats in south Tucson are mostly low income and Hispanic. Dr. Forrer testified that the standard of care must consider the treatment setting. **Dr. Peairs testified that she treats homeless patients. (Tr. VIII at 1353) She testified that impoverished patients are an "extremely**

vulnerable at-risk-population" and that the rates of misuse as well as overdose deaths are highest among poor and rural populations. (Tr. VIII at 1338)

The State requests the Board to **MODIFY** Finding of Fact 78 so it reads:

78. On August 22, 2011, Dr. Ruben saw GM. Dr. Ruben's note stated GM "acknowledges and avoids beer and meat" and that GM's "opiate dose has been raised over the last year by other practitioners and we discussed the problem with higher doses and need to continue to pursue physical medicine and medicine specific for gout as well [as] anti inflammatory meds with his PCP for better pain relief." Dr. Ruben's plan included adding Abilify 2.5 mg for anxiety and that GM would begin to decrease his Oxycodone dose. **Despite this plan,** Dr. Ruben **did not decrease GM's Oxycodone and** prescribed Oxycodone 30 mg 10 times a day #300, but did not prescribe Xanax.

The State requests the Board to **MODIFY** Finding of Fact 80 so it reads:

80. On September 2, 2011, **despite the plan to decrease the Oxycodone,** Dr. Ruben **did not decrease the Oxycodone but again** prescribed Oxycodone 30 mg 10 times a day #300 to GM.

The State requests the Board to **MODIFY** Findings of Fact 98 and 99 so they read:

98. Dr. Ruben pointed out that the cost of inpatient or outpatient treatment for substance abuse or dependence can be high. Sierra Tucson charges $60,000 per month and most other inpatient treatment cost $20,000 month, which GM could not afford. **Dr. Gray testified that some drug abuse treatment programs are supported by the state and don't cost anything. (Tr. V at 869)** Dr. Ruben testified that chronic problems with drug abuse do not just go away.

99. Dr. Gray testified that the earliest hospitalizations referred to the records occurred before Dr. Ruben started treating GM. **Dr. Ashby disputed this testimony and stated that the first hospitalization occurred after GM had been in treatment with Dr.**

Ruben. (Tr. VIII at 1363-1364) Dr. Gray noted that Dr. Ruben did not see changes in GM's behavior and that the comments on the medical records from the hospitals were made by others. Dr. Gray testified that Dr. Ruben initially increased GM's Oxycodone dose due to Dr. Ruben's belief that GM needed more to manage his pain. Dr. Gray testified that the problem with opioid tolerance is that over time, a patient's liver produces enzymes that destroy the drug, so doses must escalate to achieve the same effect. Dr. Gray explained escalating doses result from physiology, not from the patient's character. Dr. Gray testified that when pain generators are resolved, people often go off their pain medication with no or minimal withdrawal, but if the patient continues to experience pain, he needs his pain medication.

The State requests the Board to **MODIFY** Finding of Fact 120 to correct a typographical error for the word **spine.**

The State requests the Board to **MODIFY** Finding of Fact 192 to more accurately reflect the actual testimony of the witness so it reads:

192. **AT's significant other, JEJ, was present in Dr. Ruben's office when AT fell asleep. (Tr. II at 512.) When questioned on cross-examination regarding this incident, JEJ stated that "he was always falling asleep back then because, like I said, we had just found out that he had congestive heart failure."** ***Id.*** **Nonetheless, Dr. Ruben continued to prescribe Oxycodone knowing that AT was working as a bus driver.**

The State requests the Board to **MODIFY** Finding of Fact 197 so it reads:

197. Dr. Ruben testified that the Soma was not continued after December 9, 2011, and that AT was prescribed Flexeril. Dr. Ruben testified that he observed AT at every visit to gauge how his medications were affecting him. Dr. Ruben testified that Soma and Flexeril were administered and night, so the patient can sleep, and at the doses that he

prescribed would wear off by morning. Dr. Ruben testified that his job is to treat patients by maintaining and improving their well-being. **Dr. Ashby testified that Flexeril has a half-life of 18 hours and that Soma metabolizes into Meprobamate which has a half-life of 10 hours and would still be in AT's bloodstream when he is driving a bus even if he took it at night. (Tr. VIII at 1358-1359) Dr. Ashby testified that, after reviewing Dr. Ruben's testimony, he observed "basic lack of knowledge with basic pharmacology, that puts patients, especially AT, and the public in harm's way." (Tr. VIII at 1356)**

The State requests the Board to **MODIFY** Findings of Fact 218 and 271 to correct a typographical error in Dr. **Ruben's** name.

The State requests the Board to **MODIFY** Findings of Fact 329 so it reads:

329. **Over the Board's objection for lack of relevance to the current case,** Dr. Ruben submitted affidavits or letters of commendation from eight other providers that were written in 2010. Dr. Ruben also submitted other physicians' positive reviews of the charts of the ten patients whose care was at issue in the April 1, 2009 Consent Agreement and the June 10, 2010 Consent Agreement and affidavits or positive reviews from 23 patients, some of whose care had been at issue in the April 1, 2009 Consent Agreement or the June 10, 2010 Consent Agreement.

II. CONCLUSIONS OF LAW

With respect to the Conclusions of Law, the State requests that the Board **ACCEPT** Conclusions of Law 1-4, 6-9 **(now 5-8)**, 11 **(now 9)**, 12 **(now 11)**, 15 **(now 12)**, and 24-26 **(now 47-49).**

The State requests the Board to **REJECT Conclusions of Law Nos. 5, 10, 13, and 14.**

The State requests the Board to **ADD new Conclusions of Law No. 10 as follows:**

10. Dr. Peairs testified that "you can say someone has subjective pain without a pain generator. However, it is the objective identifiable cause that you are treating with opioids." (Tr. VIII at 1348) She further testified that it is below the standard of care of any respectable minority of any pain treating physicians in the state of Arizona to prescribe opioids when they cannot locate an objective pain generator such as an abnormal x-ray. (Tr. VIII at 1349) Dr. Ashby testified that he is not aware of any physicians who believe you can use opioids even if you cannot find an objective cause of the pain, such as an abnormal x-ray or other objective test. (Tr. VIII at 1372) Dr. Ashby also testified that "the pain generator is a pathologic condition that should explain the pain involved. And so the problem I saw in general with these patients is that many times they would have a minor x-ray abnormality that might explain some minor pain, but it would not explain pain needed to treat with high-dose opiates." (Tr. VIII at 1360)

The State requests the Board to **MODIFY Conclusion of Law Nos. 12 (renumbered as 11) so it reads:**

11. Dr. Gray is does not specialize in psychiatry, neurology, addiction medicine, or chronic pain treatment. Because this is an administrative matter involving the standard of care, rather than a civil action for malpractice, the Administrative Law Judge considers all the experts' testimony. The members of the Board also may rely on their own expertise to evaluate this decision. All four experts were qualified to render opinions on the standard of care, **although only Dr. Peairs and Dr. Ashby are board certified in pain management.**

The State requests the Board to **ADD new Conclusions of Law Nos. 13-46 as follows:**

13. Based upon the foregoing Findings of Fact, the Board finds that Respondent committed unprofessional conduct by violating A.R.S. §32-1401(27)(q), conduct that is or may be harmful or dangerous to the patient or public, as follow:

GM

14. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to document an objective pain generator warranting treatment with opioids at GM's initial visit.

15. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to attempt treatment of GM's gout with safer modalities instead of immediately instituting opiate therapy.

16. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to re-evaluate the treatment plan based upon GM's severe deterioration in function.

17. The Board established by clear and convincing evidence that GM became very depressed and suicidal and also had multiple treatments for chemical dependency. Additionally, GM suffered fractures from falls on two occasions, as the risk for falls is increased with the medications that were prescribed. Respondent's prescribing high doses of opiates to GM placed GM at high risk for overdose and death.

MB

18. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to perform a complete pain history and by failing to work up or consider other causes for widespread pain.

19. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to review the treatment plan when MB had early refills and ran out of his medications and by doubling the oxycodone dose with little change in MB's pain level.

20. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing oxycodone IR for MB in high doses along with benzodiazepines.

21. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to coordinate MB's care with the mental health provider who was prescribing benzodiazepines which have significant drug interactions with opiates.

22. The Board established by clear and convincing evidence that MB did not receive appropriate care for his chronic pain as evidenced by his decrease in functioning over the course of his treatment. Respondent's treatment of MB could have resulted in overdose, aspiration, hypoxia, or death given that he was on two benzodiazepines and soma with a history of drug abuse, self-medicating, and a recent overdose. Additionally, MB may have become dependent on the medications or diverted them.

PG

23. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by performing a brief and limited initial evaluation without identifying an objective pain generator or pain syndrome.

24. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing extremely high doses of opiates for musculoskeletal pain.

25. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by continuing to prescribe oxycodone IR 30mg to PG in the face of multiple aberrant behaviors without changing the treatment plan or increasing monitoring for abuse.

26. The Board established by clear and convincing evidence that PG was never adequately evaluated for drug dependency and the public was placed at risk due to diversion of her medications. Additionally, there was potential for overdose with respiratory depression, aspiration, neurologic damage, and death.

AT

27. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by performing a brief and inadequate history without a pain generator or pain syndrome documented.

28. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing opiates without any justification.

29. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to consider the increased risk of overdose and death when sedatives were prescribed.

30. The Board established by clear and convincing evidence Respondent deviated from the standard of care by ignoring AT's aberrant behaviors and by failing to discontinue prescribing or modify the treatment plan and increase monitoring.

31. The Board established by clear and convincing evidence that AT abused medications that were not medically indicated. Respondent's conduct placed AT at risk of complications of opiates including impaired function, mood, endocrinologic, and immune disorders. The public was placed at risk in that AT,

who was a bus driver, was prescribed opiates and sedatives with no consideration of driving impairment. Further, the public was placed at risk due to possible diversion of easily abused and highly sought after drugs.

FS

32. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to adequately assess FS to determine if opioids were clinically indicated.

33. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing a potentially fatal opioid dose to a patient presumed to be opioid naïve.

34. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by initiating and escalating opioids and benzodiazepine without investigating and/or adequately addressing red flags for opioid abuse and/or addiction.

35. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing escalating doses of combined opioid and benzodiazepine with essentially no diagnostic work-up to identify indications commensurate with the significant associated risks.

36. The Board established by clear and convincing evidence that Respondent's conduct placed FS at risk of respiratory depression, accidental overdose, and death. Additionally, Respondent's conduct may have perpetuated drug seeking, abuse, addiction, and/or diversion.

ME

37. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to recognize the significant risk of continued narcotic and benzodiazepine in a patient with

documented severe pulmonary impairment, hypoventilation, hypoxemia, and oxygen dependence.

38. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to adequately assess ME's subjective complaints in order to determine if opioids were clinically indicated.

39. The Board established by clear and convincing evidence that Respondent's conduct resulted in perpetuation of ME's hypoventilation, hypoxemia, and oxygen dependence. Further, ME was exposed to all of the medical risks associated with long-term opioid use in a setting absent objective pathology to warrant such treatment given her hypoxemia and hypoventilation.

CD

40. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to adequately assess CD in order to determine if opioids were clinically indicated.

41. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by initiating and escalating opioids without addressing red flags for aberrant drug-seeking behavior.

42. The Board established by clear and convincing evidence that, as a result of Respondent's conduct, CD was exposed to the entirety of medical risks associated with long-term opioid use in a setting absent objective pathology to warrant such treatment.

DB

43. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to adequately assess DB to determine if opioids were clinically necessary.

44. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by prescribing an initial opioid dosage of nearly 70mg morphine equivalent daily to a presumed opioid naïve patient.

45. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by initiating and escalating opioids without adequately reviewing, monitoring, and addressing red flags for aberrant drug-seeking behavior.

46. The Board established by clear and convincing evidence that Respondent's conduct perpetuated addiction and/or diversion in providing narcotic prescriptions to a patient with minimal objective findings who demonstrated commonly recognized red flags for aberrant drug-seeking behavior. Additionally, DB was exposed to the entirety of medical risks associated with long-term opioid use in a setting absent objective pathology to warrant such treatment.

III. RECOMMENDED ORDER

The State requests that the Board **REJECT** the ALJ's Recommended Order and instead **ADOPT** the following:

ORDER

Based on the foregoing, it is ORDERED that on the effective date of the Board's final order in this matter, the Board revoke License No. 11382 for the practice of allopathic medicine in Arizona previously issued to Respondent David Alan Ruben, M.D.

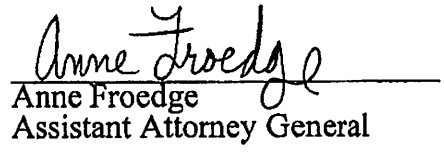
In addition to the above-provided disciplinary penalty, Respondent is assessed the costs of the hearing pursuant to A.R.S. § 32-1451(M). Payment of those costs shall be paid to the Board no later than 30 days following the effective date of the Order, unless such deadline is extended by the Board or the Board's designee.

IV. CONCLUSION

The State is requesting that the Board accept, modify and reject the ALJ's Findings of Fact, Conclusions of Law and Order in accordance with this Motion and as supported by the appropriate citations to the record

DATED this 25th day of November, 2015.

Mark Brnovich
Attorney General



Anne Froedge
Assistant Attorney General

ORIGINAL filed this 25 day of November, 2015 with:

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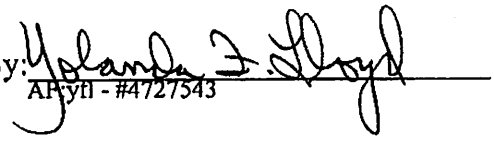
By: 
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