

1 5. Respondent's care of L.J. included prescribing the following controlled
2 substances: alprazolam at the second visit and every subsequent visit; carisoprodol at
3 L.J.'s third visit; and oxycodone at L.J.'s fourth visit and every subsequent visit.

4 6. Concerns regarding Respondent's management of L.J.'s care with controlled
5 substances were raised when L.J. was admitted into a behavioral health treatment
6 program.

7 7. Respondent did not follow many aspects of the Board's guidelines
8 concerning the use of opioid analgesics in the treatment of chronic pain in the office setting
9 and the Federation of State Medical Boards' clinical practice guidelines.

10 8. The standard of care requires a physician to conduct a complete history and
11 physical examination with appropriate investigations to include diagnostic imaging and
12 laboratory studies for chronic pain patients. Respondent deviated from the standard of
13 care in his treatment of L.J. by failing to complete an adequate history and physical
14 examination, by failing to timely and appropriately obtain diagnostic imaging, and by failing
15 to order appropriate laboratory studies for the L.J.

16 9. The standard of care requires a physician to obtain past medical records
17 concerning chronic pain patients. Respondent deviated from the standard of care by
18 failing to obtain L.J.'s past medical records.

19 10. The standard of care requires a physician to articulate a treatment plan to
20 include pharmacologic, physical, behavioral, and surgical treatment options. Respondent
21 deviated from the standard of care by failing to articulate a treatment plan for L.J. to
22 include pharmacologic, physical, behavioral, and surgical treatment options.

23 11. The standard of care requires a physician to rationally justify escalating
24 doses of multiple controlled substances. Respondent deviated from the standard of care

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1 by failing to rationally justify escalating doses of multiple controlled substances prescribed
2 to L.J.

3 12. Actual harm occurred to L.J. in that she either developed a new medical
4 condition of combined opioid (oxycodone) and non-opioid (alprazolam and carisoprodol)
5 drug-dependence; or, she had that medical condition at the time she was initially seen and
6 cared for, but it remained undiagnosed and unaddressed.

7 13. The Board's investigation of case no. MD-14-1000A also included a review of
8 Respondent's care and treatment of patients L.K., S.G., J.P., K.S. and J.S.

9 14. L.K. was a patient of Respondent from July of 2012 through November of
10 2015. Respondent prescribed L.K. Vicodin, Naproxen, Percocet, Soma, Xanax, and
11 oxycodone.

12 15. S.G. was a patient of Respondent from October of 2011 through July of
13 2015. Respondent prescribed S.G. alprazolam, Soma, Trazodone, and oxycodone (with
14 an increase in oxycodone occurring in 2012 after a motor vehicle accident).

15 16. J.P. was a patient of Respondent from June of 2011 through November of
16 2014 until he left the clinic after declining to take a drug test. Respondent prescribed J.P.
17 OxyContin, oxycodone, and Soma. J.P. was noted to routinely come in early for 30 day
18 supplies of the medications.

19 17. K.S. was a patient of Respondent from February of 2012 through November
20 3, 2015. Respondent prescribed K.S. linosopril, Soma, clonazepam, oxycodone,
21 omeprazole and Phenergan. K.S. routinely came in early for a 30 day supply of her
22 medications. In February of 2013, K.S. reported to Respondent that her purse was stolen
23 and Respondent refilled all of K.S.'s medications. In March of 2013, Respondent added
24 Dilaudid to K.S.'s medications without documenting a rationale for the additional
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1 medication. K.S.'s medical records contain a drug screen which showed a positive finding
2 of amphetamines that Respondent never addressed.

3 18. J.S. was a patient of Respondent from October of 2012 through March of
4 2015 until she was referred for pain management (and subsequently admitted for
5 treatment with use of buprenorphine). Respondent prescribed J.S. Vicodin, Naproxen,
6 alprazolam, citalopram, Soma, oxycodone, Percocet, and ranitidine. In April of 2013,
7 Respondent's office informed J.S. that she would no longer be prescribed narcotics
8 because she was receiving Percocet from another provider. Respondent, however,
9 continued to prescribe J.S. Vicodin, Soma, Percocet, alprazolam and oxycodone despite
10 the warning and with no justification.

11 19. The standard of care requires a physician to perform adequate evaluations of
12 a patient at the initial visit and every subsequent visit which includes a complete and
13 detailed medical history, obtaining medical records from previous providers, a detailed
14 evaluation of the patient's areas of concern, and providing treatment plans to resolve the
15 conditions presented. Respondent deviated from the standard of care in his treatment of
16 L.K., S.G., J.P., K.S. and J.S. by failing to perform adequate evaluations at the patients'
17 initial and subsequent visits. Respondent failed to obtain complete and detailed medical
18 histories on the all of the patients, failed to obtain the patients' medical records from
19 previous providers, failed to perform a detailed evaluation of the patients' areas of concern
20 and failed to provide treatment plans to the patients to resolve the patients' conditions.

21 20. The standard of care requires a physician to recognize the dangers and
22 severe side effects of the drug treatment that is being prescribed and the possibility, in the
23 case of controlled substances, of drug diversion, severe addiction, and even death.
24 Respondent deviated from the standard of care in his treatment of L.K., S.G., J.P., K.S.
25 and J.S. by failing to discuss with the patients treatment options other than changing or

1 increasing the amount of highly addicting drugs. There was no apparent concern by
2 Respondent over the patients requesting early medication refills and changing narcotic
3 medications almost on demand of the patients. Additionally, Respondent failed to
4 recognize the serious addiction risks and other side effects associated with oxycodone,
5 alprazolam, Soma, and hydrocodone. Respondent prescribed the patients large quantities
6 of these medications on a regular basis without documented reasoning and discussion.

7 21. Respondent is required to maintain adequate medical records on every
8 patient which include evaluation findings, detailed patient histories, progress notes from
9 every visit, diagnoses and justifications for treatment, and cautionary warnings.
10 Respondent's medical records for patients L.J., L.K., S.G., J.P., K.S. and J.S. do not
11 contain detailed evaluations or justification for Respondent's ongoing pain management.
12 Nearly all of the progress notes for each patient described the same examination and were
13 repetitive. The records do not contain documentation of discussions advising the patients
14 of the serious dangers and side effects associated with controlled substances.

15 22. Actual harm occurred to L.K., S.G., J.P., K.S. and J.S. in that they all
16 experienced unreasonable delays in adequate treatment for their various problems by
17 years of addiction to pain medications at extremely high doses. Some suffered with
18 depression and fatigue from the side effects of the medications prescribed by Respondent.

19 23. For L.K., S.G., J.P., K.S. and J.S., there was the potential for harm in that
20 severe drug addiction or death from an accidental or intentional overdose could have
21 occurred, the patients could have inflicted injury on themselves or others. There was also
22 a potential for drug diversion in that many of the medications Respondent prescribed in
23 large quantities to the patients are popular street drugs.

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1 **Case No. MD-15-0748A**

2 24. The Board initiated case number MD-15-0748A after receiving a complaint
3 regarding Respondent's care and treatment of a 36 year-old female patient ("A.S.")
4 alleging inappropriate prescribing.

5 25. A.S. first presented to Respondent on October 24, 2011. A.S. reported that
6 she had a previous surgery for a fibular fracture in May 2011 and was taking Vicodin and
7 ibuprofen for pain, Adderall for Attention Deficit Disorder ("ADD"), Ambien and trazadone
8 for sleep, and Phenergan for nausea.

9 26. A.S. was noted to be under the care of a mental health provider although
10 Respondent did not obtain any medical records to confirm this.

11 27. Respondent continued to see A.S. on a regular basis for refills of Vicodin,
12 which A.S. obtained early. On July 3, 2012, A.S. was evaluated by a physician assistant in
13 Respondent's office. The physician assistant noted that Vicodin was "not helping" at a
14 dose of 2 every 8 hours and prescribed A.S. Percocet. The same day, A.S. also saw
15 Respondent and he refilled her Percocet. A.S. was noted to be taking Ambien, citalopram,
16 and Ativan. Respondent continued to see A.S. monthly for refills of Percocet (120 to 150),
17 which she frequently received early. Respondent also changed A.S.'s medication to
18 clonazepam and Zofran during this time.

19 28. Respondent saw A.S. on April 2, 2013 and noted that she was doing well on
20 Percocet. Respondent switched A.S.'s medication from Percocet to oxycodone without
21 documenting an explanation in A.S.'s medical records. Respondent's chart notes for the
22 subsequent 11 visits are the same and state that A.S. was doing well on Percocet while
23 Respondent prescribed a high amount of oxycodone at each visit without a documented
24 explanation.

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1 29. At A.S.'s January 3, 2014 visit, Respondent noted that she was overweight
2 and prescribed phentermine. This was not discussed or treated again. A.S. continued
3 seeing Respondent monthly (usually about every 27 days) for refills of oxycodone.

4 30. A.S.'s last visit with Respondent was on April 27, 2015. Respondent noted
5 that A.S. complained of multiple stressors, including the loss of custody of her son
6 following an apparent suicide of her daughter, and that she was sad, upset and crying.
7 Respondent's examination notes state that A.S. appeared to be tired with anxious mood
8 and affect. Respondent documented diagnoses were anxiety, ADD, hypertension, joint and
9 ankle pain, and insomnia. Respondent prescribed A.S. Adderall (at A.S.'s request because
10 she was starting a new job), Phenergan, oxycodone, and lorazepam.

11 31. On May 6, 2015, A.S. was found deceased in her home. An autopsy found
12 the cause of death as acute oxycodone intoxication and the manner of death
13 undetermined.

14 32. The standard of care requires a physician to document complete physical
15 and mental health examinations prior to the initiation of controlled substances. Respondent
16 deviated from the standard of care by failing to document complete physical and mental
17 health examinations prior to initially prescribing controlled substances to A.S.

18 33. The standard of care requires a physician to refer a patient with psychiatric
19 complaints to appropriate mental health professionals. Respondent deviated from the
20 standard of care by failing to refer A.S. to mental health professionals although he noted
21 A.S. as being anxious and complaining of multiple stressors.

22 34. The standard of care requires a physician to appropriately monitor a patient's
23 controlled substance use with regard to possible abuse/dependence. Respondent deviated
24 from the standard of care by failing to appropriately monitor A.S.'s controlled substance
25 use with regard to possible abuse/dependence. Respondent continued to prescribe A.S.

1 addicting, depressing, and mind altering drugs for an extended period of time without any
2 documentation as to the long term resolution with monthly refills of progressively larger
3 and more potent pain medications.

4 35. The standard of care requires a physician to counsel a patient regarding the
5 risks and benefits of using controlled substances. Respondent deviated from the standard
6 of care by failing to counsel A.S. regarding the risks and benefits of using controlled
7 substances which Respondent prescribed for over 3½ years.

8 36. Respondent is required to maintain adequate medical records on every
9 patient. Respondent's charting for A.S. is inaccurate because Respondent continued to
10 describe A.S. as being on Percocet after he switched her to oxycodone and also failed to
11 document an explanation for the switch to oxycodone.

12 37. Actual harm occurred in that A.S. died from acute oxycodone intoxication.

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14 **CONCLUSIONS OF LAW**

15 a. The Board possesses jurisdiction over the subject matter hereof and over
16 Respondent.

17 b. The conduct and circumstances described above constitute unprofessional
18 conduct pursuant to A.R.S. § 32-1401(27)(e)("Failing or refusing to maintain adequate
19 records on a patient.").

20 c. The conduct and circumstances described above constitute unprofessional
21 conduct pursuant to A.R.S. § 32-1401(27)(q)("Any conduct or practice that is or might be
22 harmful or dangerous to the health of the patient or the public.").

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1 **ORDER**

2 IT IS HEREBY ORDERED THAT:

3 1. Respondent is issued a Decree of Censure.

4 2. Respondent is placed on Probation for a period of 5 year(s) with the
5 following terms and conditions:

6 a. **Continuing Medical Education**

7 Respondent shall within 6 months of the effective date of this Order obtain no
8 less than 15 hours of Board staff pre-approved Category I Continuing Medical Education
9 ("CME") in an intensive, in-person course regarding prescribing of controlled substances.
10 Respondent shall within thirty days of the effective date of this Order submit his request for
11 CME to the Board for pre-approval. Upon completion of the CME, Respondent shall
12 provide Board staff with satisfactory proof of attendance. The CME hours shall be in
13 addition to the hours required for the biennial renewal of medical licensure.

14 b. **Practice Restriction**

15 Respondent is prohibited from prescribing, administering, or dispensing any
16 controlled substances for a period of 5 years. Board staff or its agents shall conduct
17 periodic/quarterly chart reviews to monitor Respondent's compliance with this Board
18 Order.

19 c. **Obey All Laws**

20 Respondent shall obey all state, federal and local laws, all rules governing
21 the practice of medicine in Arizona, and remain in full compliance with any court ordered
22 criminal probation, payments and other orders.

23 d. **Tolling**

24 In the event Respondent should leave Arizona to reside or practice outside
25 the State or for any reason should Respondent stop practicing medicine in Arizona,

1 Respondent shall notify the Executive Director in writing within ten days of departure and
2 return or the dates of non-practice within Arizona. Non-practice is defined as any period of
3 time exceeding thirty days during which Respondent is not engaging in the practice of
4 medicine. Periods of temporary or permanent residence or practice outside Arizona or of
5 non-practice within Arizona, will not apply to the reduction of the probationary period.

6 **e. Probation Termination**

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8 Prior to the termination of Probation, Respondent must submit a written
9 request to the Board for release from the terms of this Order. Respondent's request for
10 release will be placed on the next pending Board agenda, provided a complete submission
11 is received by Board staff no less than 14 days prior to the Board meeting. Respondent's
12 request for release must provide the Board with evidence establishing that he has
13 successfully satisfied all of the terms and conditions of this Order. The Board has the sole
14 discretion to determine whether all of the terms and conditions of this Order have been
15 met or whether to take any other action that is consistent with its statutory and regulatory
16 authority.

17 3. The Board retains jurisdiction and may initiate new action against
18 Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(r).

19 DATED AND EFFECTIVE this 16th day of September, 2016.

20 ARIZONA MEDICAL BOARD

21
22 By Patricia E. McSorley
23 Patricia E. McSorley
24 Executive Director
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1 **CONSENT TO ENTRY OF ORDER**

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

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

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

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

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

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

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

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

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

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

13 11. ***Respondent has read and understands the conditions of probation.***

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15 Robert K. Truesdale, M.D.
16 ROBERT K. TRUESDALE, M.D.

DATED: 07/28/16

17
18 EXECUTED COPY of the foregoing mailed
19 this 16th day of September, 2016 to:

20 Robert K. Truesdale, M.D.
21 Address of Record

22 ORIGINAL of the foregoing filed
23 this 16th day of September, 2016 with:

24 Arizona Medical Board
25 9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Baker
Board staff