

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of
3 **DAVID ALAN RUBEN, M.D.,**
4 Holder of License No. 11382
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No.15A-11382-MDX

**AMENDED FINDINGS OF FACTS
CONCLUSIONS OF LAW, AND ORDER
(Decree of Censure, Practice
Restriction, and Probation)**

7 This matter was considered by the Arizona Medical Board ("Board") on December
8 1, 2015 and February 4, 2016. David Alan Ruben, M.D., ("Respondent") appeared before
9 the Board; Assistant Attorney General Anne Froedge, represented the State. Christopher
10 Munns with the Solicitor General's Section of the Attorney General's Office, was available
11 to provide independent legal advice to the Board. At its meeting on December 1, 2015, the
12 Board adopted Findings of Fact, Conclusions of Law and an Order for discipline against
13 Respondent's license. Respondent subsequently filed a Petition for Rehearing or Review
14 ("Petition") which the Board considered at its regularly scheduled meeting on February 6,
15 2016 along with the Response Brief submitted by the State. After due consideration of
16 Respondent's Petition, the Board voted to issue an Amended Findings of Fact,
17 Conclusions of Law and Order as stated herein.

18 **FINDINGS OF FACT**
19 **PROCEDURE**

- 20 1. Dr. Ruben is the holder of Board-issued License No. 11382 for the practice of
21 allopathic medicine in the State of Arizona.
- 22 2. The Board referred this matter to the Office of Administrative Hearings ("the
23 OAH"), an independent state agency, for an evidentiary hearing.
- 24 3. On January 30, 2015, the Board issued a Complaint and Notice of Hearing
25 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

1 substances to seven patients, MB, PG, AT, FS, ME, DB, and CD (Case No. MD-13-0500A);
2 (3) During the Board's investigation of the complaint involving patient MB, Dr. Ruben had
3 given MB the consultant's report; (4) In a separate matter involving inappropriate
4 prescribing, the Drug Enforcement Administration ("DEA") had disciplined Dr. Ruben by
5 suspending his DEA certificate for a period of one year, effective July 26, 2013; and (5) Dr.
6 Ruben had failed to respond appropriately to patient SE's complaint filed with the Board that
7 Dr. Ruben had failed to provide her medical records at her request.

8 4. Based on the alleged facts, the Board's Complaint and Notice of Hearing
9 charged Respondent with having committed unprofessional conduct as defined by A.R.S. §
10 32-1401(27)(a), (e), (p), (q), (s) (specifically A.R.S. §§ 32-1451.01 and 32-3206), and A.R.S.
11 § 32-1401(27)(dd), and provided notice of a hearing in the OAH.

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

20 6. The Board submitted 53 exhibits and presented the testimony of three
21 witnesses: (1) Danielle ("Elle") Steger, the Board's Chief Investigator in its Physician Health
22 Program; (2) Rob Ashby, M.D., the Board's expert on the care that Dr. Ruben rendered to
23 patients GM, MB, PG, and AT; and (3) Carol Peairs, M.D., the Board's expert on the care
24 that Dr. Ruben rendered to patients FS, ME, DB, and CD. Dr. Peairs and Dr. Ashby
25 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

1 of Dr. Ruben's patients whose care was at issue; (4) JJ, AT's significant other (Tr. III at 502);
2 (5) Scott Christopher Forrer, M.D., one of Dr. Ruben's expert witnesses; (6) MB, another of
3 Dr. Ruben's patients whose care and behavior was at issue; (7) Michael Richard Gray,
4 M.D., who also testified as an expert on Dr. Ruben's behalf; (8) CD, another of Dr. Ruben's
5 patients whose care was at issue; and (9) himself. Neither Dr. Forrer nor Dr. Gray provided
6 written reports detailing the bases for their opinions in this case.

7 HEARING EVIDENCE

8 Evidence of Divergent Opinions in the Medical Profession on the Treatment of 9 Chronic Pain Patients and the Experts' Qualifications

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

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

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

25 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.

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- 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

1 thousands of chronic pain patients on an outpatient basis since June, 1989, and that she
2 follows patients long-term. (Tr. VIII at 1320-1321). Dr. Peairs has been recognized as an
3 expert on both a state and national level regarding opioid prescribing for chronic pain. (Id at
4 1324-1326) For example, out of 41,000 members, the American Society of
5 Anesthesiologists chose Dr. Peairs to provide a national webinar for education of physicians
6 on opioid prescribing for chronic pain. (Id. at 1325). Additionally, the Mayo Clinic and the
7 University of Arizona, College of Medicine invited Dr. Peairs to speak to residents and
8 physician faculty on responsible opioid prescribing for chronic pain. (Id. 1324) Dr. Peairs
9 advised the Arizona Medical Board on developing the Guidelines for treatment of chronic
10 pain with opioids. She testified that "those guidelines specifically say they are for the
11 purpose of reassuring doctors that as long as they prescribe according to current standards
12 of care, that they do not have to fear disciplinary action." (Id.)

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

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

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

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

5 18. Dr. Ashby started his practice in 1984, as an anesthesiologist, but could not
6 continue in that specialty because he had a problem with alcohol and became addicted to
7 opioids to treat a back injury that he suffered as a child. Dr. Ashby spent seven months at
8 Talbott-Marsh Treatment Center to start his recovery. Dr. Ashby has been sober since April
9 21, 1994. Although Dr. Ashby became employed as an emergency room physician, he
10 became frustrated. Dr. Ashby subsequently went to work with Michael Sucher, Ph.D. at
11 Community Bridges treating patients with addictions.

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

22 20. Dr. Ashby testified that there are studies that show that opioid medications do
23 not effectively treat chronic pain, especially considering the risks of opioid treatment, and
24 that other alternative treatments should be considered. Dr. Ashby acknowledged that a
25 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

1 of Addiction Medicine, and American Board of Pain Management. Dr. Ruben is certified by
2 the American Board of Child and Adolescent Psychiatry and the American Board of
3 Psychiatry and Neurology.

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

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

18 24. On rebuttal, Ms. Steger testified that she was born in Tucson and that her
19 whole family lives there. Ms. Steger testified that according to the Board's website, there
20 are many pain management specialists in Tucson and that only five chronic pain specialists
21 in Tucson had their licenses revoked or suspended. Ms. Steger testified that when she
22 called to see if any pain management specialists were taking new patients, most informed
23 her that they would accept her as a patient if she had a referral from her primary care
24 provider, even if she did not have insurance. Ms. Steger testified Dr. Ruben's office was 2.8
25 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)

26 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,

1 he is familiar with the standard of care for treating chronic pain. Dr. Forrer testified that
2 although most of his patients have pain complaints, he stopped prescribing opioids to treat
3 their chronic pain in 2008 or 2009, because he feared harassment from the Board. Dr.
4 Forrer expressed extreme bias against the Arizona Medical Board. For example, he
5 testified that he did not believe the Board acted in good faith in this case and he referred to
6 use of its experts as "sham peer-reviewed." ((Vol. IV 667)

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

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

14 28. Dr. Gray completed his residency at the Cook County, Illinois hospital between
15 1974 and 1978. After practicing internal medicine for 3 or 4 years, he entered occupational
16 medicine, with an emphasis on toxicology. Dr. Gray is certified by the American Board of
17 Preventative Medicine, the American Board of Toxicology, and the American Board of
18 Emergency Medicine.

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

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

3 31. Dr. Gray has held leadership positions in various organizations, has been
4 involved in peer review, has spent six years on the Board of Health for Cochise County, has
5 spent 6 years as the appointee of two different Arizona governors on the Medical Directions
6 Committee, which was formed to establish written protocol for first responders, and in the
7 early 1990's, worked with undocumented agricultural workers.

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

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

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

19 GM

20 34. Dr. Ruben first saw GM, a 28-year-old male, on May 11, 2009. GM reported
21 that he swam three times a week, had been married for a year, had a two-month-old child,
22 and was employed as a mechanical engineer. Dr. Ruben's treatment note indicates that he
23 contacted the previous provider and was informed that although GM had several incidents of
24 lost medications, he was otherwise compliant, that his opiate dose was between 90 and 180
25 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."

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

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

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

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

24 40. Dr. Gray testified that Dr. Ruben's initial assessment of GM was reasonably
25 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.

1 41. Dr. Gray testified that Dr. Ruben had adequately identified the source of GM's
2 pain and noted that according to his medical record, he had injured his left ankle on April 7,
3 2008, which was consistent with GM's reported pain. Although the injury occurred more
4 than a year before Dr. Ruben's initial assessment, Dr. Gray testified that without surgical
5 intervention, there is no reason to believe the condition changed. Dr. Gray acknowledged
6 that the October 6, 2008 and April 12, 2009 studies of GM's left knee were read as normal
7 but that the radiologist did not secure the prior study. Dr. Gray testified that osteoarthritis
8 results from wear and tear on joints and it is well-known to practitioners that the condition
9 may require pain medication. Although x-rays are one piece of evidence, Dr. Gray testified
10 that a physician must integrate his practice and interact with the patient.

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

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

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

25 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

1 improved. Dr. Ruben prescribed Xanax .25 mg twice a day for GM's reported panic attacks
2 and 30 mg Oxycodone 6 times a day #180.

3 47. Dr. Ashby testified that Oxycodone and Xanax are synergistic and increase
4 the risk of overdose or death. Most deaths from opioids result when they are taken with a
5 sedative like alcohol or benzodiazepine like Xanax. Dr. Ashby testified that a physician
6 should get an informed consent if he prescribed such drug combinations and should
7 document in his notes that he warned the patient about the risks.

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

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

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

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

24 A UDS for GM on July 7, 2009, was positive for benzodiazepines, opiates, and Oxycodone.
25 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

1 standard. Instead, GM presented with management problems and Dr. Ruben appropriately
2 responded to these concerns when he increased his monitoring of GM on July 7, 2009, to
3 every two weeks.

4 53. On August 18, 2009, Dr. Ruben returned to monthly monitoring of GM and
5 continued the prescriptions for .25 Xanax twice a day and 30 mg Oxycodone six times a day
6 #180.

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

13 55. On October 27, 2009, Dr. Ruben again saw GM and continued him on 30 mg
14 Oxycodone eight times a day because the higher dose was helpful in treating GM's pain and
15 .25 mg Xanax to four times a day because GM's anxiety had increased due to marital
16 problems.

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

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

23 58. GM was seen by Dr. Slaski on January 9, 2010, Dr. Skinner on January 18,
24 2010, Dr. Slaski February 16, 2010, Dr. Skinner on March 15, 2010, Dr. Slaski on April 10,
25 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.

1 61. Between July 13, 2010, and July 26, 2010, GM was admitted to Palo Verde
2 Behavioral Health Hospital. The admission note stated that GM had previously been
3 involved in O'Reilly, a drug treatment program, and that he had multiple previous
4 hospitalizations for depression and pain medication use. When GM was discharged, he was
5 given a prescription for five days' of Oxycodone and advised to follow up with Dr. Ruben.
6 His discharge diagnoses were major depressive disorder, unipolar without psychosis, opiate
7 dependence, and opiate withdrawal. Among his assets was a pain management team. The
8 treatment modalities were to resume medications and check pain medications.

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

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

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

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

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

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

23 68. On November 29, 2010, Dr. Slaski saw GM early for medication. GM stated
24 that he was flying to Tokyo for work. Dr. Slaski noted that GM had cut back on his pain
25 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

1 day. Dr. Ashby's report criticized this prescription because the note included "no reason
2 listed [and] no discussion of risk or benefits."

3 71. On February 25, 2011, a nurse practitioner treated GM. She noted that he
4 reported that he had been involved in a motor vehicle accident, that he had gone to the
5 emergency room for his pain, that he had taken an extra two Oxycodone for his pain, and
6 that he had been prescribed additional pain medication in the emergency room. The nurse
7 practitioner prescribed Oxycodone 30 mg eight times a day and a cervical x-ray.

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

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

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

20 75. On July 22, 2011, a nurse practitioner saw GM and noted that he was at the
21 cutoff for pain medications because the pharmacy did not accept the prescriptions for pain
22 medications from the emergency room. The nurse practitioner increased GM's Oxycodone
23 30 mg prescription to #300.

24 76. The CSPMP pharmacy survey for August 19, 2011, showed multiple
25 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.

1 78. On August 22, 2011, Dr. Ruben saw GM. Dr. Ruben's note stated GM
2 "acknowledges and avoids beer and meat" and that GM's "opiate dose has been raised over
3 the last year by other practitioners and we discussed the problem with higher doses and
4 need to continue to pursue physical medicine and medicine specific for gout as well [as] anti
5 inflammatory meds with his PCP for better pain relief." Dr. Ruben's plan included adding
6 Abilify 2.5 mg for anxiety and that GM would begin to decrease his Oxycodone dose.
7 Despite this plan, Dr. Ruben did not decrease GM's Oxycodone and prescribed Oxycodone
8 30 mg 10 times a day #300, but did not prescribe Xanax.

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

11 [GM] lost his prescription and his credit card. He has made a police report
12 which we verified with them. He had a similar problem when his car was
13 broken into when he began with us in 2009 and several instances reported by
14 his previous physician. We went over again keeping prescriptions and
15 medication secure and his responsibility for this. He has a safe at home to
16 keep his medicine in and will keep us informed on a weekly basis of his
17 progress. These events occur when stress in his life overwhelms him. He has
18 lost his job and marital problems as well as his chronic pain. He was told that
19 he must resume psychiatric treatment immediately for us to continue his care.

20
21 I do not see the benefit of following through with discharge at this point. The
22 patient has a history of PTSD and difficulty with life stressors. I do not believe
23 [he] is abusing his medication and do believe his chronic pain is debilitating.
24 The need here is to require follow through on his part for psychiatric care. If
25 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.

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

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

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

5 83. On September 22, 2011, a nurse practitioner saw GM. She noted that he had
6 been admitted to Palo Verde Behavioral Health Hospital on September 9, 2011, and
7 discharged on September 20, 2011, after he had lost his job and his wife asked for a
8 separation. The nurse practitioner lowered GM's Oxycodone 30 mg dose to 4-5 times a day
9 #70, continued Xanax 1 mg #120, and added Zoloft.

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

17 85. On October 27, 2011, and November 17, 2011, the nurse practitioner saw
18 GM. On October 27, 2011, GM's UDS was positive for benzodiazepines and Oxycodone.
19 On November 17, 2011, the nurse practitioner prescribed Oxycodone 30 mg prescription to
20 4-5 times a day #255 to GM.

21 86. On December 19, 2011, the nurse practitioner again saw GM and noted that
22 he reported that on November 20, 2011, he had fallen when he was carrying bags from a
23 hotel in San Diego, was diagnosed with a broken right calcareous, and was wearing a splint
24 with a boot. The nurse practitioner prescribed Oxycodone 30 mg 4 times a day and at
25 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:

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

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

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

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

17 92. GM was seen by the nurse practitioner on April 26, 2012, May 24, 2012, June
18 22, 2012, and July 16, 2012. The July 16, 2012 note stated that GM's divorce had gone
19 through and that he had been robbed at a Circle K the week before.

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

24 94. Between September 18, 2012, and September 28, 2012, GM was hospitalized
25 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

1 every 3 hours and alprazolam 2 mg once to twice a day. He started all
2 treatment approximately a year ago.

3 The discharge diagnoses were adjustment disorder with depression and anxiety,
4 generalized anxiety disorder with recurrent depression, opiate dependence, and nicotine
5 dependence. GM was not given Xanax or Oxycodone while he was in the hospital. The
6 discharge plan was that GM would start taking gabapentin and Tramadol, and continue
7 taking Oxycodone after his discharge.

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

10 96. The last time Dr. Ruben or anyone else in his office saw GM was on February
11 21, 2013. Dr. Ruben's final note states in relevant part as follows:

12 The patient was again hospitalized on 9 28 12 and has been following up in
13 care since that time. He continues to experience anxiety at times and
14 sadness over the loss of his marriage. He is doing well at work and his activity
15 level has increase[d] with healing of his fractured foot and rehabilitation.
16 Tramadol has been added and helped reduce his pain level and allowed
17 significant reduction in his opiate medications over the last year. Anxiety is
18 also less with a reduction in Alprazolam to 1 mg per day. Sleep, appetite,
19 energy ok, pain 6/10.

20 He continues with less frequent gout flare ups, better controlled with
21 medication. He has pain in his L elbow, from his L calcaneal fx and primarily
22 in his knee.

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

25 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.

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

7 99. Dr. Gray testified that the earliest hospitalizations referred to the records
8 occurred before Dr. Ruben started treating GM. Dr. Ashby disputed this testimony and
9 stated that the first hospitalization occurred after GM had been in treatment with Dr. Ruben.
10 (1263-1264) Dr. Gray noted that Dr. Ruben did not see changes in GM's behavior and that
11 the comments on the medical records from the hospitals were made by others. Dr. Gray
12 testified that Dr. Ruben initially increased GM's Oxycodone dose due to Dr. Ruben's belief
13 that GM needed more to manage his pain. Dr. Gray testified that the problem with opioid
14 tolerance is that over time, a patient's liver produces enzymes that destroy the drug, so
15 doses must escalate to achieve the same effect. Dr. Gray explained escalating doses result
16 from physiology, not from the patient's character. Dr. Gray testified that when pain
17 generators are resolved, people often go off their pain medication with no or minimal
18 withdrawal, but if the patient continues to experience pain, he needs his pain medication.

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

22 101. Dr. Gray acknowledged that GM exhibited multiple behaviors that could be
23 considered red flags, such as frequent lost or stolen medications and early refills. Dr. Gray
24 testified that although such red flags must be addressed, the concept for even a high-risk
25 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.

1 Ruben noted that new voice recognition technology allows dictation after the visit to be
2 transcribed contemporaneously.

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

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

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

16 **MB**

17 107. MB was a 31-year-old male who established care with Dr. Ruben on July 30,
18 2012, for complaints of low back, bilateral elbow, wrist, knee, ankle, and jaw pain.

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

24 109. MB testified that he did not go to University Medical Center for an overdose
25 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

1 Clonazepam by CODAC. MB reported that he had a history of substance abuse, that he
2 was self-medicating, that his current dose of pain medication was too low, and that he was
3 on AHCCCS.

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

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

10 113. The Board submitted a court order in Pinal County Superior Court Case No.
11 201301711 dated March 30, 2004, sentencing MB to probation after his guilty plea to
12 possession of marijuana for sale, a class 4 felony.

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

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

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

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

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

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

4 120. Dr. Ashby's report noted that radiology revealed osteoarthritic changes to
5 "ankle" and right knee and that MB had tripartite right patella, otherwise both unremarkable,
6 and that a lumbar spine x-ray was normal. Dr. Ashby testified that MB's medical records did
7 not provide objective evidence of a pain generator that justified prescribing opioids to
8 manage his pain.

9 121. Dr. Ruben's July 30, 2012 note reflected that on the straight leg raise, MB's
10 right knee was tender with post-edema and limited range of motion, his left ankle showed
11 tenderness posterior and anterior, and had decreased range of motion in all planes. Dr.
12 Ruben diagnosed MB with anxiety with panic and chronic pain and prescribed Oxycodone
13 15 mg #105. Dr. Ruben also noted in the margin that MB reported that he was over-sedated
14 on morphine.

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

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

23 124. Dr. Ruben testified that MB had a history of being on Oxycodone 30 mg ten
24 times a day and that Dr. Ruben prescribed dose of 15 mg Oxycodone 3-4 times a day was a
25 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.

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

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

11 129. On January 18, 2013, Dr. Ruben noted that MB's pain was a little worse at
12 7/10, that he was sleeping only 4 hours a night, but that he was building low-riders and
13 doing metal fabrication. Dr. Ruben stated "[h]e will continue the oxycodone 30 mg five times
14 a day."

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

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

20 132. Dr. Gray testified that Dr. Ruben complied with the standard of care in his
21 treatment of MB and that MB benefitted from Dr. Ruben's treatment. Dr. Gray noted that
22 although Dr. Ruben did not explain why he increased MB's Oxycodone dose on January 18,
23 2013, the notes stated that "[m]edication education was done and informed consent was
24 obtained." Dr. Gray noted that at the next visit on March 18, 2013, MB reported that he was
25 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

1 Clonazepam. Dr. Ruben testified that Clonazepam could be stopped abruptly without
2 causing withdrawal and that Xanax is slower acting.

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

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

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

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

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

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

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

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

4 142. Dr. Ruben testified that he did not believe that MB was better off, even though
5 he was not taking opioids, because he was in pain. Dr. Ruben testified that MB was a
6 reliable informant and the CSPMPs showed that he only took the medications that were
7 prescribed to him. Unfortunately, there was no one in the community that he could refer MB
8 to for treatment of his chronic pain.

9 **PG**

10 143. PG was a 27-year-old female who established care with Dr. Ruben on August
11 15, 2011. PG complained of back, neck, and shoulder pain that resulted from a motor
12 vehicle accident in December 2010, as well as migraines and carpal tunnel syndrome. At
13 the time, Dr. Ruben's notes reflect that PG was being treated by two different providers and
14 on July 14, 2011, had been given #180 30 mg Oxycodone and #90 of 15 mg Oxycodone, as
15 well as #90 350 mg Soma. PG reported that in June 2011, she had a stolen prescription
16 and had some police documentation of that. PG reported getting about six hours of
17 disrupted sleep per night and that she cared for her five children during the day. PG denied
18 a history of depression, chemical dependency, or legal issues. PG had not undergone any
19 physical therapy. PG reported that pain from her migraine was sharp and constant and that
20 she had headaches every other day. PG rated her pain as 7/10. Dr. Ruben reported that
21 his physical examination of PG was normal, except that straight leg raising was positive on
22 the right and PG had spasms and tenderness in the trapezius muscles, dorsally bilaterally
23 but more on the right than on the left.

24 144. Records were obtained from a previous provider that showed diagnoses of
25 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

1 treat her pain, that PG understood the need for a pain contract going forward, and that he
2 would contact PG's two previous providers and inform them that he would be the only
3 prescriber and that he would continue Soma and add Depakote to prevent headache pain.
4 He would see PG again in a month.

5 146. Dr. Ashby testified that PG's previous records and tests that were performed
6 after she started treatment with Dr. Ruben did not show a pain generator and that although
7 Dr. Ruben ordered physical therapy for PG, there is no evidence that she ever obtained
8 physical therapy. Dr. Ashby testified that the fact that PG had obtained 225 mg Oxycodone
9 immediate release from two different physicians was concerning.

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

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

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

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

24 151. Dr. Ruben next saw PG on April 13, 2012, and prescribed 30 mg Oxycodone
25 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

1 treatment is surgery or epidural steroids. Dr. Ashby testified that there is no evidence that a
2 disk bulge can be effectively treated with opioids.

3 154. Dr. Ruben testified that a positive result on straight leg raise test is usually
4 indicative of a problem with the spinal cord. If pain travels down the leg, it indicates
5 impingement of the nerve where it exits the spinal column, which was confirmed on the April
6 7, 2011 MRI. Dr. Ruben testified that PG suffered from degenerative disk disease. The
7 March 13, 2012 EMG that diagnosed PG's carpal tunnel disease provided more objective
8 evidence of a pain generator.

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

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

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

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

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

24 160. Dr. Ashby testified that it was concerning that a chronic pain patient would not
25 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."

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

4 163. Dr. Ruben testified that he does not telegraph to a patient that he plans to do a
5 pill count, because patients can always purchase replacement drugs on the street. Dr.
6 Ruben testified that his handwritten note indicated that PG had brought in a photograph of
7 the floor safe that she had installed. Dr. Ruben testified that it is better to wait until the dust
8 settles to perform a pill count.

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

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

17 166. On November 12, 2012, Dr. Ruben's office note stated that PG's husband was
18 in jail and charged with murder and that four of her five children were hyperactive. Dr.
19 Ruben prescribed 30 mg Oxycodone eight times a day and noted that PG had run out of
20 medication a little early due to increased pain, so he would give her a refill now. The note
21 also stated that PG preferred Soma to the Flexeril, and so he prescribed Soma. The record
22 included a handwritten note that the pain contract was renewed and that the "pill count 10-
23 15 was accurate. Allegation discussed and denied."

24 167. Dr. Ashby testified that Dr. Ruben was rewarding PG by giving her an early
25 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

1 note indicated that PG now had a safe in the home and that she would be very careful about
2 keeping her medication safe, secure, and away from her children.

3 169. Dr. Ashby testified that taking Adderall that was not prescribed was illegal
4 because it was a stimulant. Dr. Ashby testified that he has no tolerance for drug diversion
5 because it compromises the safety of the community. By allowing the other patient to
6 borrow pain medication, PG committed a felony. Dr. Ashby opined that Dr. Ruben should
7 have refused to write further prescriptions for Oxycodone for PG.

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

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

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

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

22 174. On January 31, 2013, Dr. Ruben again saw PG and gave her a 2-month
23 supply of her medication. Dr. Ruben noted that PG's headaches were improved and that
24 her anxiety was under control. Although she was still receiving 30 mg Oxycodone seven
25 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

1 variety of issues. Dr. Ruben testified that the reason for his handwritten note that he was
2 making recommendations for social services, since there was an open CPS case and he
3 was trying to help PG organize her life.

4 177. Dr. Ruben testified that by April 4, 2013, PG's pain had improved to 6 out of
5 10 and that she was able to work at home and care for her children, whom she had gotten
6 back from CPS. Dr. Ruben testified that although PG's behavior included some red flags,
7 he was able to increase his monitoring of her, and her condition improved. Dr. Ruben
8 explained that sometimes, if a provider increases requirements, the patient may not return
9 or may give up treatment altogether and self-medicate. Dr. Ruben testified that his goal is to
10 get patients where they are functional on the lowest possible dose of an opioid.

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

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

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

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

22 AT

23 182. AT is a 52-year-old man who established care with Dr. Ruben on October 28,
24 2010, while he was employed as a bus driver, for shoulder, mid-thoracic, and hip pain. AT
25 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

1 stated that is not the standard of care and makes continuity of care difficult. A controlled
2 substance database would have been useful, but was not done.

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

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

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

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

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

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

24 190. Dr. Ruben testified that many pain patients with musculoskeletal pain do not
25 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.

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

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

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

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

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

20 197. Dr. Ruben testified that the Soma was not continued after December 9, 2011,
21 and that AT was prescribed Flexeril. Dr. Ruben testified that he observed AT at every visit
22 to gauge how his medications were affecting him. Dr. Ruben testified that Soma and
23 Flexeril were administered at night, so the patient can sleep, and at the doses that he
24 prescribed would wear off by morning. Dr. Ruben testified that his job is to treat patients by
25 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
(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)

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

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

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

14 201. Dr. Ruben saw AT on February 9, 2012, March 8, 2012, April 5, 2012, May 7,
15 2012, June 17, 2012, and July 5, 2012. At each visit, Dr. Ruben noted that AT's condition
16 was stable and renewed the prescriptions for 30 mg Oxycodone six times a day and Flexeril.

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

18 203. Dr. Ruben saw AT on December 10, 2012, January 10, 2013, and March 13,
19 2013. Dr. Ruben continued prescribing the same medications. Dr. Ruben performed
20 regular UDSs on AT, all of which confirmed the presence of the prescribed substances.

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

24 205. AT testified that his pain took away the joy of living. AT testified that physical
25 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.

1 **FS**

2 207. FS is a 28-year-old male who was seen for initial evaluation by Dr. Ruben on
3 April 10, 2012. FS complained of diffuse pain over his back and knees and Dr. Ruben noted
4 that FS had suffered different injuries over time. FS reported that he had received
5 Oxycodone 5 mg from another physician several years ago, and that he currently takes non-
6 prescription medication and Oxycodone three to seven times a day. FS rated his pain as
8/10 and described it as sharp.

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

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

14 210. A CSPMP that Dr. Ruben obtained on April 10, 2012, showed that FS had
15 been prescribed Oxycodone-Acetaminophen 5 - 325 #16 on March 7, 2012, and that he had
16 not been prescribed Xanax or Adderall in the past twelve months. The CSPMP also
17 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.

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

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

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

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

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

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

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

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

24 219. On April 10, 2012, FS signed a pain contract that included a provision that if
25 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.

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

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

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

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

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

25 225. 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.

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

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

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

12 229. On November 12, 2012, FS was seen by Dr. Ruben. Dr. Ruben noted that FS
13 was working in day labor, sometimes shoveling, which Dr. Ruben noted was "bad for his
14 back." FS reported that his pain was 9/10, that he slept four hours a day, but that his mood
15 was okay. FS reported that Amitriptyline made him groggy. Dr. Ruben increased the Xanax
16 to .5 mg t.i.d., and continued to prescribe Oxycodone 30 mg five times a day and Naproxen
17 500 mg b.i.d.

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

21 231. On December 10, 2012, FS was seen by Dr. Ruben. It was noted that a
22 prescription had been altered at the pharmacy. FS stated that another patient of Dr.
23 Ruben's had taken the prescription, but that FS had spoken to the pharmacist, who said he
24 would fill the prescription after determining the correct amount. Dr. Ruben stated that "we
25 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

1 clear evidence that FS was responsible, he resolved to investigate the matter further. Dr.
2 Ruben testified that the circumstances had to be considered as a whole: If he cannot
3 substantiate each incident as a violation of the pain contract, he gives the patient the benefit
4 of a doubt. Dr. Ruben testified that if the patient is abusing or diverting medication, the
5 incidents will continue. Dr. Ruben testified that as long as numerous repeated questionable
6 incidents do not occur, if the patient is benefitting from his care, he will continue to prescribe
7 medication to the patient. Dr. Ruben testified that he believes it is unethical to fire a patient
8 because people with chronic pain, especially if they are younger, may have abused drugs in
9 the past. Dr. Ruben testified that his goal is to help his patients get back on track. Dr.
10 Ruben pointed out that FS's last UDS was consistent with the drugs that were prescribed.

11 233. There are two handwritten notes on the bottom of the December 10, 2012
12 typed office note: "December 27, 2012, fill oxycodone eight times a day number (illegible)"
13 and "January 14, 2012, oxycodone 30 mg x 6 per day will decrease 20 (illegible)."

14 According to the medication sheet, on December 10, 2012, FX received a prescription for 30
15 mg Oxycodone five times a day #40, and on December 18, 2012, received a prescription for
16 30 mg Oxycodone eight times a day #40.

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

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

26 236. Dr. Ruben testified that FS had been prescribed Oxycodone by a nurse
27 practitioner in another doctor's office. He contacted the doctor's office and was told that
28 there was no record of FS having been seen on this date. Dr. Ruben testified that he went
29 to see the doctor personally and the doctor stated that he had never written the prescription.

1 Dr. Ruben testified that he contacted the pharmacy board, but there was no way to follow-up
2 on the inquiry and that he wrote a note in FS's chart.

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

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

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

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

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

27 242. Dr. Peairs testified that Dr. Ruben had ignored numerous red flags for opioid
28 abuse or addiction, including the prescription for Suboxone three months prior to
29 establishing care, the presence of non-prescribed controlled substances on the UDS, the
30 misrepresentation of the current opioid and benzodiazepine usage, the report of stolen

1 narcotic medicine, CSPMP documentation of the simultaneous acquisition of a large
2 quantity of narcotic outside the licensee's practice, CSPMP evidence that suggested an
3 altered prescription in October 2012, and documented evidence of an altered prescription in
4 November 2012.

5 243. Dr. Peairs testified that Dr. Ruben had exposed FS to an unreasonable risk of
6 harm because Dr. Ruben had perpetuated FS's drug abuse and diversion, as evidenced by
7 a reported theft of medication, an altered prescription, and filling two prescriptions for
8 Oxycodone within days. Dr. Peairs testified that the combination of a benzodiazepine and
9 escalating doses of Oxycodone exposed FS to a risk of death. Dr. Peairs testified that the
10 risks to FS outweighed the benefits of Dr. Ruben's treatment.

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

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

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

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

25 **ME**

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

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

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

11 251. Dr. Ruben testified that ME had a history of degenerative disk disease,
12 radiculopathy, spinal stenosis, and nerve impingements that caused pain. His March 20,
13 2006 examination also identified spasms on both sides of her spine. Dr. Ruben testified that
14 ME had objectively verifiable pain generators.

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

21 253. Dr. Ruben testified that an October 31, 2007 ultrasound noted slight scattered
22 focal atherosclerotic changes in ME's main arterial segments of her lower extremities. Dr.
23 Ruben testified that arteries getting clogged up could decrease pulses in ME's lower
24 extremities and that the body tries to get rid of plaque by inflammation, which can cause
25 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.

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

4 255. On August 29, 2006, Amitab Puri performed a sleep study on ME and found
5 significant hypoventilation with saturation to 86% during both REM and non-REM sleep, but
6 no obstructive sleep apnea. The impressions were obesity, based on ME's BMI of 30.9, and
7 hypoventilation as a consequence of narcotic use. Dr. Puri's recommendations included the
8 following:

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

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

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

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

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

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

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

8 Since then, after discussion with you, I have learned, that the patient had
9 ciliary dysmotility syndrome. She had suffered a closed head injury in the past
10 and suffered from a post concussive syndrome. And on your discussion with
11 Dr. Locher, pulmonologist, had emphysema [COPD]. She had an established
12 diagnosis of respiratory failure, hypoxic and had been on oxygen for several
13 years prior to this sleep study.

14 Her hypoxia, then certainly could be related to multifactorial reasons.
15 Respiratory disorder such as emphysema, will cause V/Q mismatch, and are a
16 known cause of hypoxia. She was also noted to have a body mass index of
17 31, this could have been a confounding feature too. Narcotics could add to
18 this hypoxia.

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

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

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

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

5 263. Dr. Ruben saw ME on March 2, 2012, January 18, 2013, February 25, 2013,
6 March 22, 2013, and April 19, 2013. During that time, she was on Oxycodone 30 mg 5
7 times a day and Valium 5 mg 4 times a day. Intermittently, she was also given Methadone
8 10 mg 6 times a day or Dilaudid 4 mg 3 times a day.

9 264. On January 18, 2013, Dr. Ruben noted that ME's sleep was six hours and that
10 she was breeding dogs, living by herself, and "doing okay." On February 25, 2013, ME's
11 sleep was okay, except when she work up with pain and she needed to lose weight, but did
12 not seem motivated, but her mood was okay and her mental status was stable. By April 19,
13 2013, ME was doing "pretty good; she [was] much more mobile, walks better and feels
14 better. Being off the methadone and substituting the Dilaudid helped."

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

20 266. Dr. Peairs testified that although Dr. Locher's 2004 CT scan showed disk
21 degeneration, Dr. Ruben had failed to update that information through physical examination,
22 imaging, or any other means. Dr. Ruben did not know the degree of disease progression or
23 whether ME's condition could have been improved by treatment of her back condition. Dr.
24 Peairs testified that Dr. Ruben fell below the standard of care by not considering alternatives
25 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

1 perpetuated ME's oxygen dependence and testified that people with respiratory conditions
2 are routinely treated with pain medications.

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

5
6 **CD**

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

9 INITIAL EXAMINATION

10 [CD] is a 42-year-old-male. He injured his right knee in 2003 in a motor
11 vehicle accident. This has caused him continued pain and discomfort. He
12 injured his left hip about a year ago and he now also has pain in his upper
13 back which causes him to have decreased mobility of his neck. It is pinching
14 and sharp; it varies but is constant. It causes him daily headaches. The
15 headaches are daily; sometimes they are mild but are pounding on the left
16 side. They do not often cause nausea or vomiting. Sometimes the pain goes
17 from his neck and down to his left waist. It is unclear if the pain is from the left
18 hip and goes up but he has difficulty standing for more than 15 to 20 minutes.
19 He cannot do his machine operating at work as he cannot turn his head;
20 bending and flexing is difficult.

21 He sleeps three to four hours at night. His appetite is up and down. His
22 energy is low and he is irritable at home. He denies chemical dependency or
23 legal problems. He has hypertension and asthma but does not take
24 medication. He denies any weakness or numbness but there is spasm in his
25 neck.

26 He has tried massage which has been of no help. He has not had a TENS
27 unit or acupuncture. He had some physical therapy which was of some help.
28 He has taken Excedrin and Vicodin which have not helped much. He took
29 oxycodone 30 mg t.i.d. for a short time which was helpful. Flexeril made him
30 tired.

31

32 PHYSICAL EXAMINATION

33 He is well developed, well nourished. His gait is okay. He can do tandem but
34 was unable to do a squat. Flexion and rotation of the trunk were intact. Upper
35 and lower hip flexion were intact; sensation of the upper and lower extremities

1 is intact. Reflexes are 1:4 patellar bilaterally. Straight leg raising was
2 basically negative. He has some tenderness in the areas of his left his left hip
3 anteriorly, the right knee and also the left trapezius and cervical paraspinals.
4 He had decreased rotation to the left of his head and decreased flexion. Grip
5 is 3:4, biceps/triceps strength is 2:4, range of motion is okay. Hip flexion
6 shows pain on the left.

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

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

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

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

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

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

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

32 277. On December 13, 2012, CD completed a self-report, stating that he had no
33 insurance, that his pain had increased slightly and that he experienced new pain since the

1 last visit, that he had undergone physical therapy, but it did not help, and that his pain
2 medication was not sufficient to manage his pain.

3 278. Dr. Ruben's file contains radiology studies of CD's cervical and thoracic spine
4 taken by El-Rio Community Health Center taken on December 13, 2012, that were negative.
5 A study taken of DB's lumbosacral spine showed spondylitis involving the pars of L5 on the
6 left, mild degree of anterior spondylolisthesis of L5 over S1 of approximately 5 mm, but no
7 other significant abnormalities. Dr. Ruben's file also contains reports from 2002 and 2003 of
8 a broken right clavicle and effusion in the right knee, but no fracture.

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

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

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

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

20 283. The last time that Dr. Ruben saw CD was on February 21, 2013. Dr. Ruben
21 noted that CD's lower back pain and hip pain continued, that he had hurt his back more in
22 November when he was on the job on a forklift, and that he had to stop working that day, but
23 that he had not made a claim for the injury. Dr. Ruben noted that CD reported that the pain
24 continued to be significantly different than it was before, that he has not worked since the
25 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.

1 Medication education was again reviewed and informed consent was
2 reaffirmed.

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

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

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

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

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

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

289. 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.

1 Ruben sent CD to physical therapy, it made his pain worse. On Dr. Ruben's suggestion, CD
2 still uses a Pilate's ball, although he did not think that it helped. CD testified that in the
3 informed consent that he signed, he obtained information about drugs.

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

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

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

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

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

DB

26 296. DB is a 37-year-old man who established care with Dr. Ruben on March 18,
27 2013. DB is MB's brother. In November 2012, DB had been in a motor vehicle accident in
28 which he had re-injured his right knee and hit his head, requiring suturing over his eyebrow.
29 DB reported that after the accident, he started having 3-4 migraines per week, twice as

1 many as before the accident, with light sensitivity, nausea, and vomiting. DB reported that
2 the migraines started when he was involved in another accident 20 years earlier, in which he
3 had lost consciousness and which had resulted in scarring of his right lateral head. DB
4 reported that he was dazed and confused after the most recent accident, and Dr. Ruben
5 opined that DB "obviously had a brain contusion."

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

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

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

23 300. Dr. Ruben diagnosed DB with swelling and arthritic changes in both hands
24 and perhaps the right big toe, increased migraine headaches with nausea and vomiting, and
25 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."

1 302. A CSPMP that Dr. Ruben obtained for DB on March 18, 2013, showed that
2 Compass Behavioral Health Care had prescribed Suboxone 2 mg #11 on December 18,
3 2012, December 26, 2012, and January 3, 2013, and Suboxone 2 mg #14 June 21, 2012,
4 and that University of Arizona Medical Center had prescribed Oxycodone 5 mg #28 on
5 November 28, 2012, and Oxycodone-Acetaminophen #20 on November 18, 2012. There
6 were no prescriptions for benzodiazepines.

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

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

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

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

23 307. Dr. Ruben testified that in both his handwritten and typewritten notes for
24 March 18, 2013, DB had denied his own or family members' aberrant behaviors or
25 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

1 proximal interphalangeal joint of the 4th finger of the left hand and arthritic changes of the
2 first metacarpophalangeal joint of the right hand, which could be posttraumatic, but no
3 evidence for erosive arthritic process. A November 12, 2012 CT scan of DB's head and
4 cervical spine showed postsurgical changes related to prior right frontal craniotomy and mild
5 multilevel degenerative changes of the cervical spine, without significant central canal
6 stenosis. A January 11, 2013 x-ray of DB's right knee showed no acute fracture, an
7 intramedullary rod fixation for a proximal femoral fracture, and a small right knee joint
8 effusion and soft tissue edema about the right knee.

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

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

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

16 313. On April 18, 2013, Dr. Ruben prescribed Oxycodone 30 mg 2-3 times a day
17 #80 to DB.

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

23 315. Dr. Ruben testified that he increased DB's Oxycodone dose to what he
24 reported to having taken before because the lesser dose did not adequately control DB's
25 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.

1 317. Dr. Peairs' report noted that Dr. Ruben also departed from the standard of
2 care by failing to investigate and/or adequate address numerous red flags that MB
3 presented, including his self-report of using his mother's Oxycodone, the presence of non-
4 prescribed Methadone on the initial UDS, the presence of marijuana on the initial UDS, the
5 presence of non-prescribed benzodiazepines on the second UDS.

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

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

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

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

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

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

22 323. Dr. Ruben testified that he drafted the response to Dr. Ashby's criticism based
23 on a transcription of MB's comments. MB's signed letter refers to Dr. Ashby by name in the
24 first and third line. Dr. Ruben testified that when MB signed the response, the first three
25 lines, the second sentence, and the sixth sentence were 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

1 325. On or about April 1, 2009, the Board and Dr. Ruben entered into a Consent
2 Agreement for a Letter of Reprimand and Probation to resolve one Board case, under which
3 Dr. Ruben agreed to complete 15-20 hours continuing medical education in pain
4 management, to be placed on probation for a term of one year, and during that time, to allow
5 Board staff or its agents to conduct periodic chart reviews. The factual bases for the April 1,
6 2009 Consent Agreement were Dr. Ruben's care of a single chronic pain patient between
7 November 17, 2006, and October 19, 2007.

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

14 327. On or about June 10, 2010, the Board and Dr. Ruben entered into a Consent
15 Agreement for an Order for Decree of Censure, Practice Restriction, and Probation to
16 resolve five Board cases, under which Dr. Ruben agreed to accept a decree of censure, to
17 not prescribe opioids for a period of one year, which would commence after the 60 days that
18 the Board allowed Dr. Ruben to terminate care of patients that required opioids to allow
19 them to find other providers, to complete a PACE prescribing course, to be placed on
20 probation for a term of two years, and to enter into a contract with Affiliated Monitors to
21 provide quarterly chart reviews during the probationary term. The factual bases for the June
22 10, 2010 Consent Agreement were Dr. Ruben's care of nine chronic pain patients between
23 2005 and 2009.

24 328. Dr. Ruben agreed not to contest the validity of the Findings of Fact and
25 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."

1 329. Over the Board's objection for lack of relevance to the current case, Dr. Ruben
2 submitted affidavits or letters of commendation from eight other providers that were written
3 in 2010. Dr. Ruben also submitted other physicians' positive reviews of the charts of the ten
4 patients whose care was at issue in the April 1, 2009 Consent Agreement and the June 10,
5 2010 Consent Agreement and affidavits or positive reviews from 23 patients, some of whose
6 care had been at issue in the April 1, 2009 Consent Agreement or the June 10, 2010
7 Consent Agreement.

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

10 330. On or about June 26, 2013, federal Drug Enforcement Administration's
11 ("DEA's") Administrator Michelle M. Leonhart issued a decision suspending Dr. Ruben's
12 DEA certificate for one year. The genesis of the DEA's complaint was that between April 9,
13 2008, and June 6, 2008, two cooperating sources, posing as patients, had visited Dr.
14 Ruben's office and the had prescribed Schedule II controlled substances to them without a
15 physical examination.

16 331. A hearing had been held before federal Administrative Law Judge ("ALJ")
17 Timothy D. Wing between January 10, 2012, and January 12, 2012. ALJ Wing found that
18 the DEA did not establish that Dr. Ruben had improperly written prescriptions for the federal
19 agents masquerading as patients. ALJ Wing found that the Findings of Fact alleged in the
20 April 1, 2009 Consent Agreement and June 10, 2010 Consent Agreement showed that Dr.
21 Ruben lacked a legitimate purpose in prescribing controlled substances to numerous
22 patients, potentially furnishing cause to sanction his DEA certificate, but that Dr. Ruben had
23 "credibly accepted responsibility for his past misconduct and demonstrated that he has
24 implemented various corrective measures to ensure that his practice is consistent with the
25 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

1 DEA certificate under the federal Controlled Substances Act, 21 U.S.C. § 824(a)(4), and
2 principles of collateral estoppel . Administrator Leonhart therefore required that Dr. Ruben's
3 DEA certificate be suspended for a period of one year based on the repeated acts of
4 unprofessional conduct that formed the basis of the June 10, 2010 Consent Agreement. Dr.
5 Ruben has appealed Administrator Leonhart's decision and his appeal is presently pending
6 before the Ninth Circuit Court of Appeals.

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

16 **CONCLUSIONS OF LAW**

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

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

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

27 3. Although Dr. Ruben has appealed the DEA's suspension of his DEA
28 certificate, unless and until Administrator Leonhart's decision finding cause to suspend his
29 certificate under the federal Controlled Substances Act is reversed on appeal, the decision
30 is conclusive. Therefore, the Board has established by clear and convincing evidence that

1 Dr. Ruben committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(a) and
2 (p).

3 4. The same conduct that Administrator Leonhart cited as bases to suspend Dr.
4 Ruben's DEA certificate for one year, to wit, the Board's June 10, 2010 consent
5 agreement, had already resulted in Dr. Ruben's agreement to not prescribe opioids for one
6 year over a different time period. There is no evidence that Dr. Ruben failed to comply
7 with this term or any of the other terms of the April 1, 2009 consent agreement and June
8 10, 2010 consent agreement. Administrator Leonhart's decision did not find that Dr.
9 Ruben committed any new acts that constituted unprofessional conduct as defined in
10 Arizona law or in violation of federal statute.

11 **FAILING OR REFUSING TO FURNISH ADEQUATE RECORDS ON A PATIENT**

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

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

7. Deleted.

**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

1 the public.” The Arizona Court of Appeals has acknowledged that this definition is broad in
2 the context of medical treatment:

3 Many appropriate forms of medical treatment entail potential harm. There is
4 some potential for harm in most prescription medication; and some forms of
5 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.

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

9 9. The evidence submitted at hearing demonstrated that chronic pain
10 management involves patients’ psychological as well as physical characteristics. Because
11 different patients may experience and react differently to similar radiological or other
12 objective indicia of a pain generator, a substantial minority of allopathic physicians believe
13 that chronic pain management standards of care may be found at the interstices among
14 psychiatric, neurological, anesthetic, and addiction practices. Moreover, the location of the
15 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.

16 10. Dr. Pears testified that “you can say someone has subjective pain without a
17 pain generator. However, it is the objective identifiable cause that you are treating with
18 opioids.” (Tr. VIII at 1348) She further testified that it is below the standard of care of any
19 respectable minority of any pain treating physicians in the state of Arizona to prescribe
20 opioids when they cannot locate an objective pain generator such as an abnormal x-ray.
21 (Tr. VIII at 1349) Dr. Ashby testified that he is not aware of any physicians who believe you
22 can use opioids even if you cannot find an objective cause of the pain, such as an
23 abnormal x-ray or other objective test. (Tr. VIII at 1372) Dr. Ashby also testified that “the
24 pain generator is a pathologic condition that should explain the pain involved. And so the
25 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)

1 increased with the medications that were prescribed. Respondent's prescribing high
2 doses of opiates to GM placed GM at high risk for overdose and death.

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5 **MB**

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

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

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

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

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

PG

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

1 **FS**

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

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

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

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

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

20 **ME**

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

25 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-

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

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5 **CD**

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

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

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

15 **DB**

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

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

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

25 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.

1 **ORDER**

2 Based on the foregoing, IT IS HEREBY ORDERED THAT:

3 1. Respondent is issued a Decree of Censure.

4 2. Practice Restriction

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

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

8 3. Probation

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

10 a. Obey All Laws

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

13 b. Tolling

14 In the event Respondent should leave Arizona to reside or practice outside the State or for
15 any reason should Respondent stop practicing medicine in Arizona, Respondent shall
16 notify the Executive Director in writing within ten days of departure and return or the dates
17 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.

18 4. This Order is the final disposition of case numbers MD-13-0315A and MD-
19 13-0500A.

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

22 **RIGHT TO APPEAL TO SUPERIOR COURT**

23 Respondent is hereby notified that he has exhausted his administrative remedies.
24 Respondent is advised that an appeal to Superior Court in Maricopa County may be taken
25 from this decision pursuant to title 12, chapter 7, article 6 of Arizona Revised Statutes.

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DATED this 9th day of February, 2016.

THE ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this
9th day of February, 2016 with:

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

Executed copy of the foregoing
mailed by U.S. Mail this
9th day of February, 2016 to:

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