



1           5.       SW was involved in a motor vehicle accident on April 11, 2011 and went to  
2 an urgent care facility, where she obtained an x-ray and was prescribed Percocet. SW  
3 returned to Respondent the following day complaining of neck pain and a buttock abscess.  
4 Respondent's physical examination showed restricted range of motion of the cervical spine  
5 and tenderness to palpation of the cervical and lumbar areas. Respondent noted that  
6 Ativan was helping, and with respect to the Percocet prescription it was noted that SW  
7 wanted to avoid Tylenol. SW's TSH test results were reviewed and reported as low (0.37)  
8 with a notation to repeat in six weeks.

9           6.       On May 5, 2011, SW was diagnosed by Respondent with "sub clinical  
10 hyperthyroidism." On May 13, 2011, SW was seen again by Respondent and reported  
11 severe neck pain and spasm. Respondent prescribed oxycodone 10 mg and Ativan, and  
12 ordered an MRI scan of the cervical and thoracic spine to be performed on July 22, 2011;  
13 however, SW did not complete the appointment. SW was reportedly involved in a second  
14 motor vehicle accident on November 28, 2011. On December 28, 2011, Respondent noted  
15 that SW was unable to go to physical therapy and unable to obtain the MRI due to her  
16 insurance deductible.

17           7.       On April 3, 2012, the medical record indicated that SW had lost her job and  
18 insurance. On June 8, 2012, Respondent noted that he discussed referring SW to a pain  
19 specialist and would obtain an MRI when SW was able to afford the costs. Respondent  
20 also noted that SW was reluctant due to a fear of needles and medical procedures. SW  
21 was reportedly involved in a third motor vehicle accident on September 28, 2012. In  
22 November 2012, Respondent noted that he discussed the need for alternative therapies  
23 and to consider decreasing the opiate medication.

24           8.       On February 27, 2013, SW reported a fall resulting in a frontal hematoma  
25 without loss of consciousness. SW also reported that she was having problems focusing

1 and thought she may have a history of Attention Deficit Disorder, though this was  
2 unconfirmed. SW filled out a questionnaire, and Respondent prescribed Adderall 20 mg.  
3 Respondent also prescribed a two month supply of oxycodone immediate release tablets  
4 at an increased dose of 15 mg twice a day.

5 9. On July 16, 2013, Respondent noted that he had spoken to SW's mother  
6 about concerns relating to SW's medication abuse. Respondent also noted that Xanax and  
7 Adderall had been discontinued. Respondent then diagnosed SW with "opiate  
8 dependence/abuse" and noted that he had a long conversation with SW and her mother  
9 about her options. Respondent's plan was to discontinue her medications and monitor  
10 withdrawal symptoms with Clonidine and Trazadone. Respondent also suggested that SW  
11 be referred for an evaluation at a clinical rehabilitation program and decreased SW's  
12 oxycodone to 10 mg three times a day and clonazepam to 1 mg once a day.

13 10. On August 8, 2013, Respondent decreased SW's oxycodone to 5 mg three  
14 times a day and prescribed Lorazepam 1 mg as needed. On September 10, 2013,  
15 Respondent noted that SW had some improvement. Respondent identified tachycardia as  
16 a concern, but did not perform tests to monitor the issue. Respondent discontinued SW's  
17 Lorazepam. On October 11, 2013, SW had her final visit with Respondent and requested  
18 medication for muscle spasm and tightness. Respondent prescribed Soma 350 mg as  
19 needed.

20 11. The standard of care required Respondent to properly assess a patient for  
21 risk of dependency/addiction, provide appropriate diagnostics or non-drug therapy, and  
22 critically re-assess the plan of care in light of new or worsening symptoms. Respondent  
23 deviated from this standard of care by failing to properly assess SW for risk of  
24 dependency/addiction, failing to provide appropriate diagnostics or non-drug therapy, and  
25 failing to critically re-assess the plan of care in light of new or worsening symptoms.



1 decreased EP's oxycodone from three times a day to twice a day as EP stated that it  
2 caused grogginess.

3 16. On EP's May 1, 2014 visit, Respondent noted that he was unable to obtain  
4 records from EP's prior treating provider. On May 27, 2014, Respondent noted opiate  
5 dependence as an active problem in his assessment. Respondent failed to document an  
6 action plan for this issue.

7 17. Patient MS is a 64 year old male with a prior history of hypertension and  
8 reactive airway disease. On May 11, 2010, MS was involved in a car-motorcycle accident  
9 and sustained an "open book" pelvic fracture and displaced sacral fracture, requiring  
10 multiple corrective surgeries. MS's course was complicated by a MRSA infection of the  
11 sacrum requiring surgical debridement and prolonged IV antibiotics. At the time of MS's  
12 discharge to a rehabilitation facility, he was ambulating with a walker and had a left foot  
13 drop from an L5-S1 radiculopathy vs. plexopathy which required bracing. MS was  
14 discharged home on August 7, 2010.

15 18. MS established care with Respondent on August 17, 2010 and Respondent  
16 continued MS on the medications started in the hospital, which were MsContin 75 mg by  
17 mouth twice a day, Percocet 7/325 up to four times per day as needed, Neurontin 300 mg  
18 by mouth three times a day and Temazepam 30 mg by mouth at bedtime.

19 19. On September 28, 2010, Respondent decreased MS's MsContin to 60 mg  
20 twice a day. On September 30, 2010, a pelvic CT revealed nonunion of MS's sacral  
21 fracture. Further operative intervention was considered by not undertaken. Respondent  
22 increased MS's MsContin back to 75 mg twice a day on October 26, 2010. On November  
23 18, 2010, MS described his pain as 1-3 out of 10 and notes state that MS was doing his  
24 own activities of daily living. Respondent decreased MS's Percocet and prescribed  
25

1 Oxycontin 30 mg by mouth every four to six hours as needed. On December 20, 2010,  
2 Respondent saw MS in follow-up, and described MS as pain free with medication.

3 20. Respondent documented monthly visits with MS through November 26,  
4 2014. Respondent treated MS for worsening blood pressure and asthma symptoms at  
5 several visits. MS's pain was described as two out of ten in multiple notes. No changes  
6 were made in MS's pain medications during that time.

7 21. The standard of care required Respondent to make diligent attempts to  
8 obtain prior records to document the injury and medical course. Respondent deviated  
9 from this standard of care by failing to obtain EP's prior medical records from the hospital.

10 22. The standard of care required Respondent to have the patient sign a pain  
11 contract. Respondent deviated from the standard of care by failing to have patients EP  
12 and MS enter into pain contracts.

13 23. The standard of care required Respondent to periodically review the patient's  
14 CSPMP profile. Respondent deviated from this standard of care by failing to periodically  
15 review the CSPMP database regarding patient MS.

16 24. The standard of care required Respondent to perform random urine drug  
17 testing to assure medication compliance and to rule out use of other controlled  
18 substances. Respondent deviated from this standard of care by failing to perform random  
19 urine drug testing of both patients EP and MS to assure medication compliance and to rule  
20 out the use of other controlled substances.

21 25. The standard of care required Respondent to attempt to wean addictive  
22 medications. Respondent deviated from this standard of care by failing to make ongoing  
23 attempts to wean addictive medications for both patients EP and MS.

24 26. There was the potential for patient harm in that ongoing use of high potency  
25 narcotics risks addiction.

1 **CONCLUSIONS OF LAW**

2 a. The Board possesses jurisdiction over the subject matter hereof and over  
3 Respondent.

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

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

10  
11 **ORDER**

12 IT IS HEREBY ORDERED THAT:

13 1. Respondent is issued a Letter of Reprimand.

14 2. Respondent is placed on Probation for a period of 6 months with the  
15 following terms and conditions:

16 a. **Continuing Medical Education**

17 Respondent shall within 6 months of the effective date of this Order obtain no less  
18 than 15 hours of Board staff pre-approved Category I Continuing Medical Education  
19 ("CME") in an intensive, in-person course regarding controlled substance prescribing.  
20 Respondent shall within **thirty days** of the effective date of this Order submit his request  
21 for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall  
22 provide Board staff with satisfactory proof of attendance. The CME hours shall be in  
23 addition to the hours required for the biennial renewal of medical licensure. The Probation  
24 shall terminate upon Respondent's proof of successful completion of the CME.

1                   **b. Obey All Laws**

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

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

7                   DATED AND EFFECTIVE this 4<sup>th</sup> day of October, 2016.

8  
9                   ARIZONA MEDICAL BOARD

10                  By Patricia E. McSorley  
11                   Patricia E. McSorley  
12                   Executive Director

13                                   **CONSENT TO ENTRY OF ORDER**

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

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

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

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

25                   5.     All admissions made by Respondent are solely for final disposition of this  
matter and any subsequent related administrative proceedings or civil litigation involving

1 the Board and Respondent. Therefore, said admissions by Respondent are not intended  
 2 or made for any other use, such as in the context of another state or federal government  
 3 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
 4 any other state or federal court.

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

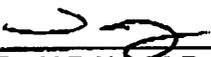
10 7. This Order is a public record that will be publicly disseminated as a formal  
 11 disciplinary action of the Board and will be reported to the National Practitioner's Data  
 12 Bank and on the Board's web site as a disciplinary action.

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

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

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

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

23  
 24   
 25 TAPAN B. JADAV, M.D.

DATED: 8/31/16

1 EXECUTED COPY of the foregoing mailed  
this 4<sup>th</sup> day of October, 2016 to:

2  
3 Tapan B. Jadav, M.D.  
4 Address of Record

5 ORIGINAL of the foregoing filed  
this 4<sup>th</sup> day of October, 2016 with:

6 Arizona Medical Board  
7 9545 E. Doubletree Ranch Road  
8 Scottsdale, AZ 85258

9 Mary Butler  
Board staff

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