BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MICHAEL S. SNYDER, M.D.** Holder of License No. 17687 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-02-0622 **CONSENT AGREEMENT FOR PROBATION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Michael S. Snyder, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. Respondent understands that by entering into this Consent Agreement, he voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

3. Respondent acknowledges and understands that this Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are 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.

5. Respondent acknowledges and agrees that, although the Consent Agreement has not yet been accepted by the Board and issued by the Executive Director, upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. Respondent further understands that this Consent Agreement, once approved and signed, is a public record that may be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

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

Michael S. Snyder, M.D.

DATED: 11/26/03

FINDINGS OF FACT

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

2. Respondent is the holder of license number 17687 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0622 after Board Staff ("Staff") discovered during a pharmacy survey regarding another physician that Respondent prescribed excessive amounts of controlled substances from July 2001 through September 2002.

PATIENT W.M.

4. A 49 year-old male patient ("W.M.") presented to Respondent for pain treatment because of pain in his neck, shoulder, upper back, lumbar area and hips. W.M. further reported pain in both knees and occasional foot pain with loss of strength in his upper and lower extremities. W.M. was reluctant to undergo diagnostic testing because of his refusal to consider surgical intervention.

5. W.M. was noted to have diagnoses of depression, sleep apnea, and probable cervical herniations versus other causes of cervical root irritation with probable lumbar disc injuries, probable sciatica and osteoarthritis. (The medical records were not clear whether Respondent or another physician made these diagnoses.)

6. Respondent provided W.M. with prescriptions for opioids for his complaints of unrelenting pain. W. M. stated that he typically takes 10-12 mg of opioid medication on a daily basis and each tablet consists of 4 mg. The prescription read, "may use up to every four hours as need for pain."

7. The pharmacy survey indicates that between September 26, 2001, and

August 26, 2002, Respondent prescribed 1,645 tablets of opioid medication to W.M. The ratio breakdown of the pharmacy survey reflects that over the course of 11 months, Respondent prescribed W.M. approximately 5 opioid tablets per day for pain management.

8. Respondent is required to maintain adequate records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

9. Respondent's records did not detail a proper evaluation of W.M. during the initial examination or after each new report of pain or during appropriate intervals during treatment.

10. The standard of care required Respondent to properly evaluate W.M. during an initial evaluation, after each new report of pain, and at appropriate intervals during treatment. The standard of care also requires Respondent to recognize and fully document medication indication for the use of opioid medications and a treatment plan developed with certain therapeutic endpoints that include pain relief, improved physical functioning, appropriate diagnostic studies, referral to specialists, and analysis of appropriate candidacy for opioid therapy. Additionally, the standard of care required Respondent to obtain an informed consent and a signed pain management contract.

11. Respondent's conduct was unreasonable given the standard of care because he failed to properly evaluate the patient during an initial evaluation, after each new report of pain, and at appropriate intervals during treatment. Respondent also failed to recognize and fully document medication indication for the use of opioid medications and a treatment plan developed with certain therapeutic endpoints that include pain relief, improved physical functioning, appropriate diagnostic studies, referral to specialists, and

analysis of appropriate candidacy for opioid therapy. Respondent also failed to obtain an informed consent and a signed pain management contract and to maintain records to support any diagnosis for which pain medications were prescribed.

12. W.M. was potentially harmed because he was treated for "probable" diagnoses without supporting diagnostic testing, making it impossible to assess and evaluate the need for further medical treatment and therapies for the diagnosed conditions. As a result, W.M. could have had serious medical conditions that went untreated.

PATIENT A.G.

13. On or about August 8, 2001, a 38 year-old male patient ("A.G.") presented to Respondent with complaints of arthritis pain involving his neck, shoulders, lower back and hips. In addition, A.G. was just finishing a series of treatment for hepatitis type C. A.G. is currently in remission.

14. Respondent provided medical care to A.G. on a pro bono basis because A.G. is medically indigent. Respondent stated that he has an affinity toward A.G. since they both have disability arthritis. Respondent provided A.G. with prescriptions for opioids after a rheumatologist's prescriptions for morphine sulfate failed to provide A.G. with any relief.

15. The pharmacy survey concerning Respondent's prescribing practices for A.G. indicates that between July 10, 2001, and August 31, 2002, Respondent prescribed 6,700 tablets and/or caplets of opioid medication to A.G. The ratio breakdown of the pharmacy survey reflects that over the course of 13½ months, Respondent prescribed that W.M. take approximately 18 opioid tablets and/or caplets per day for pain management.

16. Respondent is required to maintain adequate records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the

treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

17. Respondent's records did not detail a proper evaluation of A.G. during the initial examination or after each new report of pain or during appropriate intervals during treatment.

18. The standard of care required Respondent to properly evaluate the patient during an initial evaluation, after each new report of pain, and at appropriate intervals during treatment. The standard of care also required that Respondent recognize and fully document medication indication for the use of opioid medications and a treatment plan developed with certain therapeutic endpoints that include pain relief, improved physical functioning, appropriate diagnostic studies, referral to specialists, and analysis of appropriate candidacy for opioid therapy. Additionally, the standard of care required Respondent to obtain an informed consent and a signed pain management contract.

19. Respondent's conduct was unreasonable given the standard of care because his records on A.G failed to provide any continuing diagnostic studies to support the diagnosis for which pain medications were being prescribed. Additionally, Respondent failed to meet the accepted standard of care because he did not recognize and fully document medication indication for the use of opioid medications and a treatment plan developed with certain therapeutic endpoints that include pain relief, improved physical functioning, appropriate diagnostic studies, referral to specialists, and analysis of appropriate candidacy for opioid therapy. Additionally, Respondent failed to meet the standard of care because he did not obtain an informed consent and a signed pain management contract.

20. A.G. was potentially harmed because he was treated for "probable"

diagnoses without supporting diagnostic testing, making it impossible to assess and evaluate the need for further medical treatment and therapies for the diagnosed conditions. As a result, A.G. could have had serious medical conditions that went untreated.

PATIENT C.F.

21. This 54 year-old male patient ("C.F.") is Respondent's attorney and lives in Respondent's home. C.F. has been diagnosed with non-Hodgkin's lymphoma with metastasis. Respondent provides C.F. with prescriptions for opioid medication to help him with the effects of the cancer and chemotherapy treatment given by his oncologist.

22. Respondent admitted that he had stopped keeping records on C.F. and relies entirely upon C.F.'s own diary for documentation.

23. The pharmacy survey indicates that between July 6, 2001, and September 14, 2002, Respondent prescribed 19,255 tablets of opioid medication to C.F. The ratio breakdown of the pharmacy survey reflects that over the course of 14 months, Respondent prescribed that C.F. take 45 opioid tablets per day for pain management.

24. Respondent is required to maintain adequate records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment.

25. Respondent's records did not detail a proper evaluation of C.F. during the initial examination or after each new report of pain or during appropriate intervals during treatment.

26. The standard of care required Respondent to properly evaluate C.F. during an initial evaluation, after each new report of pain, and at appropriate intervals during

treatment. Respondent must recognize and fully document medication indication for the use of opioid medications and a treatment plan developed with certain therapeutic endpoints that include pain relief, improved physical functioning, appropriate diagnostic studies, referral to specialists, and analysis of appropriate candidacy for opioid therapy. Additionally, the standard of care required Respondent to obtain an informed consent and a signed pain management contract.

27. Respondent's conduct was unreasonable given the standard of care because he stopped keeping records on C.F. and relied entirely on the patient's own diary for documentation. Additionally, Respondent failed to meet the accepted standard of care because he did not recognize and fully document medication indication for the use of opioid medications and a treatment plan developed with certain therapeutic endpoints that include pain relief, improved physical functioning, appropriate diagnostic studies, referral to specialists, and analysis of appropriate candidacy for opioid therapy. Additionally, Respondent failed to meet the standard of care because he did not obtain an informed consent or have C.F. sign a pain management contract.

28. C.F. was potentially harmed because he was treated for "probable" diagnoses without supporting diagnostic testing, making it impossible to assess and evaluate the need for further medical treatment and therapies for the diagnosed conditions. As a result, C.F. could have had serious medical conditions that went untreated.

CONCLUSIONS OF LAW

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

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(q) - ("[a]ny conduct or practice that is or might

be harmful or dangerous to the health of the patient or the public.")

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(e) - ("[f]ailing or refusing to maintain adequate records on a patient.")

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is placed on probation for 1 year with the following terms and conditions:

A. Continuing Medical Education (CME)

Respondent shall, within 1 year of the effective date of this Order, obtain 20 hours of Board Staff pre-approved Category I Continuing Medical Education (CME) in pain management and provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license.

2. This Order is the final disposition of case number MD-02-0622.

DATED AND EFFECTIVE this 14th day of JANUARY, 2004.

(SEAL)

ARIZONA MEDICAL BOARD

By Barry A. Cassidy
BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 14th day of January, 2004 with:

Arizona Medical Board
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. . .

EXECUTED COPY of the foregoing mailed this 14 day of January, 2004 to:

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Attorney for Michael S. Snyder, M.D.

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EXECUTED COPY of the foregoing hand-delivered this 14th day of January, 2004, to:

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