

1 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
2 any other state or federal court.

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

8 6. This Consent Agreement, once approved and signed, is a public record that
9 will be publicly disseminated as a formal action of the Board and will be reported to the
10 National Practitioner Data Bank and to the Arizona Medical Board's website.

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

14 8. Any violation of this Consent Agreement constitutes unprofessional conduct
15 pursuant to A.R.S. §32-1401(27)(r) - ("[v]iolating a formal order, probation, consent
16 agreement or stipulation issued or entered into by the board or its executive director under
17 this chapter.") and may result in disciplinary action pursuant to A.R.S. §32-1451.

18 9. Respondent has read and understands the condition(s) of probation.

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20 _____
FRANKLIN H. BAROI, M.D.

DATED: 1/31/06

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1 **FINDINGS OF FACT**

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

4 2. Respondent is the holder of license number 22605 for the practice of
5 allopathic medicine in the State of Arizona

6 3. The Board initiated case number MD-04-0639A after receiving an
7 anonymous complaint regarding Respondent's prescribing practices for multiple patients.

8 4. A review of Respondent's medical records revealed numerous
9 documentation, prescribing and evaluations of numerous patients. Specifically:

10 **Patient M.L.**

11 A. Respondent prescribed 380 Valium to M.L, a 56 year old female, over a
12 period of 38 days and a combination of Tylenol #3 and #4 in the amount of 350 in 38 days.
13 This amounted to about 10 Valium per day and 9.2 Tylenol per day.

14 B. Respondent prescribed Valium #90 to be taken one to three times a day for
15 30 days. Respondent refilled the prescription after 22 days.

16 C. Respondent prescribed APAP/codeine #100 and refilled the same
17 medication for the same amount 10 days later. This amounted to an excessive dose of 10
18 tablets a day.

19 **Patient J.D.**

20 A. Respondent prescribed J.D., a 72 year old male, Valium 10 mg one to three
21 times daily (30-60 mg per day). The recommended dosage of Valium is 2 to 10 mg two to
22 four times daily. This was an excessive amount for an elderly individual.

23 **Patient J.W.**

24 A. On December 15, 2003 J.W., a 42 year old male, presented to Respondent
25 for a follow up visit to lose weight. Respondent's records state J.W. had "seizure disorder,

1 low back pain, hypertension, among others." There is no record that a back examination
2 was performed. Under Respondent's neurological evaluation it states "confusion not
3 detected."

4 B. Respondent prescribed differing doses of Sular, Elavil, Percocet, Diovan,
5 Vistaril, Roxicet, Permax, Dilantin, Imitrex, and Bumex. However, Respondent's medical
6 records do not reflect which medications the patient was taking at what time.

7 C. Respondent's records indicate that J.W. had a history of hypertension. The
8 only lab work noted in the chart is from one year previously and the chart does not mention
9 electrolyte levels in spite of the fact that J.W. was on Bumex and potassium.

10 D. Respondent prescribed Dilantin, a seizure medication, although there is no
11 seizure history noted in the medical record. No Dilantin levels are recorded in the chart.

12 E. Respondent's office visit note of January 5, 2004 states that he prescribed
13 Micardis, an angiotensin II receptor antagonist (ARB) plus diuretic. If J.W. was still on
14 Bumex and potassium, Respondent should have ordered a kidney evaluation before
15 prescribing Micardis and the ARB.

16 F. On February 24, 2004 Respondent saw J.W. for concerns of elevated blood
17 pressure. Respondent prescribed Benicar 20/12/5 and Metoprolol for J.W.'s blood
18 pressure. The medical record does not indicate if Respondent discontinued the Micardis
19 prescribed on January 5, 2004. Additionally, the medical record does not indicate if
20 Respondent continued to prescribe Sular, Bumex and potassium in combination with the
21 Benicar.

22 G. On March 11, 2004 Respondent prescribed another ARB (Diovan). However
23 his medical records do not indicate whether the Diovan substituted the previously
24 prescribed ARBs. Respondent did not order any laboratory studies to confirm the levels of
25 ARBs.

1 H. On May 3, 2004 Respondent saw J.W. for elevated blood pressure and a
2 diagnosis of diabetes mellitus. The medical record does not reflect how Respondent came
3 to the diagnosis of diabetes, nor did Respondent note any suggested treatment for
4 diabetes. The medical record states that J.W. was placed on Ritalin, but there is no
5 documentation as to why it was introduced. The record indicates that J.W. was on Sular,
6 Diovan, Bumex and K-Dur for blood pressure.

7 **Patient C.G.**

8 A. Respondent saw C.G., a 46 year old female, on August 20, 2003 for a history
9 of pernicious anemia and edema in the lower extremities. Respondent's medical record
10 does not indicate if Respondent diagnosed the cause of C.G.'s edema and there is little
11 evidence in the chart if Respondent diagnosed anemia.

12 B. On October 16, 2003 Respondent prescribed Levsin for C.G.'s abdominal
13 pain, but there is no indication in the record of what the abdominal pain consists or why
14 C.G. was given Levsin.

15 C. Respondent also began to wean C.G. off her prescription of Soma due to
16 C.G.'s concerns that she is addicted to the medication. Respondent's plan was to wean
17 C.G. from Soma by taking one tab every six hours the first week, then after six and one-
18 half hours in week two, after seven hours in week three, seven and one-half hours in week
19 four and finally, after eight hours in week five.

20 D. Respondent also noted that C.G. suffered from severe bipolar disease and
21 myalgia, but he did not refer her to a psychiatrist for treatment.

22 E. On November 17, 2003 C.G. requested a contraceptive Depo-Provera shot.
23 Respondent started C.G. on Depo-Provera even though C.G. was unsure of the last date
24 of her period and without first conducting a pelvic or breast examination.

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1 F. On December 17, 2003 Respondent's records indicated that C.G. was taking
2 one Soma every eight hours. This contradicted his plan to wean C.G. from the drug.
3 Additionally, the records indicated that Respondent also prescribed Prevacid and Levsin,
4 although there is no evidence as to why these drugs were prescribed.

5 G. On January 7, 2004 Respondent started C.G. on Mevacor, a cholesterol
6 lowering medication, even though C.G.'s medical record listed cholesterol, triglycerides,
7 HDL and VL/DL all within the normal range.

8 H. On January 12, 2004 C.G.'s medical records reflected that she was taking
9 Soma every six hours, which is more often than she was taking it months earlier, in
10 addition to Valium twice a day.

11 **Patient T.R.**

12 A. Respondent saw T.R., a 40 year old female, in February 2004 following a fall
13 that resulted in hospitalization. T.R. suffered from multiple sclerosis and seizure disorder.

14 B. On February 20, 2004 Respondent's notes reflected a medication list
15 consisting of Baclofen, Uniretic, Duragesic patch, Depakote and Zoloft. However, the
16 record does not indicate which of these medications T.R. was actually taking.

17 C. Respondent also prescribed two thyroid medications, levothyroxine and
18 Synthroid, but his records did not indicate if T.R. was referred for appropriate laboratory
19 testing or that Respondent conducted regular thyroid monitoring.

20 D. On March 10, 2004 Respondent's notes reflect that T.R. was taking MS Elixir
21 as well as Duragesic patches. Both medications have side effects of decreased respiration
22 that can be harmful to a patient with multiple sclerosis.

23 E. On May 10, 2004 nurse's notes state that T.R. was placed on Univasc, 15
24 mg, twice a day, although there is no evidence in the record for why she was placed on
25 that medication.

1 5. It is an act of unprofessional conduct to fail or refuse to maintain adequate
2 records on a patient.

3 6. The standard of care required Respondent to prescribe medications,
4 specifically narcotics, in the usual and customary manner of recommended dosages.

5 7. Respondent deviated from the standard of care because he prescribed
6 excessive quantities of narcotics to patient M.L. and to patient J.D.

7 8. The standard of care required Respondent to appropriately record any
8 medication prescribed or discontinued.

9 9. Respondent deviated from the standard of care by failing to document
10 prescriptions at initial and at discontinuation of a particular medication.

11 10. The standard of care required Respondent to appropriately evaluate and
12 treat patients with diabetes.

13 11. Respondent deviated from the standard of care by performing an inadequate
14 evaluation of diabetes in patient J.W.

15 12. The standard of care required Respondent to provide an appropriate
16 evaluation of patients presenting with hypertension.

17 13. Respondent deviated from the standard of care by failing to provide an
18 appropriate evaluation of hypertension for patient J.W.

19 14. The standard of care required Respondent to appropriately and timely make
20 referrals to sub-specialists as needed.

21 15. Respondent deviated from the standard of care by failing to refer patient
22 C.G. to a psychiatrist for her bipolar disorder.

23 16. The standard of care required Respondent to appropriately prescribe and
24 monitor thyroid medications.

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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 order criminal
4 probation, payments and other orders.

5 C. Tolling

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

13 23. This Order is the final disposition of case number MD-04-0639A.

14 DATED AND EFFECTIVE this 9th day of February, 2006.

16
17 (SEAL)



ARIZONA MEDICAL BOARD

18
19 By 

TIMOTHY C. MILLER, J.D.
Executive Director

20
21 ORIGINAL of the foregoing filed this
22 10th day of February, 2006 with:

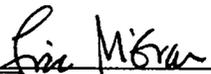
23 Arizona Medical Board
24 9545 E. Doubletree Ranch Road
25 Scottsdale, AZ 85258

1 EXECUTED COPY of the foregoing mailed
2 this 10th day of February, 2006 to:

3 Mr. Gordon Bueler
4 Bueler Jones LLP
5 1300 N. McClintock Dr., Ste. B4
6 Chandler, AZ 85226-7241

7 EXECUTED COPY of the foregoing mailed
8 this 10th day of February, 2006 to:

9 Franklin H. Baroi, M.D.
10 Address of Record

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12 _____
13 Investigational Review
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