

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **HOWARD L. MITCHELL, M.D.**

4 Holder of License No. **30004**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-04-0484A
MD-04-1010A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Letter of Reprimand and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting
8 on August 11, 2005. Howard L. Mitchell, M.D., ("Respondent") appeared before the
9 Board without legal counsel for a formal interview pursuant to the authority vested in the
10 Board by A.R.S. § 32-1451(H). The Board voted to issue the following findings of fact,
11 conclusions of law and order after due consideration of the facts and law applicable to
12 this matter.

13 **FINDINGS OF FACT**

- 14
- 15 1. The Board is the duly constituted authority for the regulation and control of
16 the practice of allopathic medicine in the State of Arizona.
 - 17 2. Respondent is the holder of License No. 30004 for the practice of allopathic
18 medicine in the State of Arizona.
 - 19 3. The Board initiated case number MD-04-0484A after receiving a complaint
20 regarding Respondent's care and treatment of a 26 year-old female patient (AR) and a
21 complaint regarding Respondent's care and treatment of a 34 year-old female patient
22 (MW). The complaint involving AR alleged Respondent over-prescribed controlled
23 substances to AR resulting in her having to undergo detoxification and having to present
24 to the emergency room after overdosing. The complaint involving MW also alleged
25 Respondent over-prescribed controlled substances.

1 4. The Board initiated case number MD-04-1010A after receiving a complaint
2 regarding Respondent's care and treatment of a 33 year-old female patient (FB). The
3 complaint alleged that Respondent over-prescribed controlled substances to FB even
4 after being told FB was addicted and was undergoing detoxification.

5 5. Because of the similarity of the issues in cases MD-04-0484A and MD-04-
6 1010A the Board and Respondent agreed to conduct the interview by combining
7 consideration of the cases. The Board's Medical Consultant opined that Respondent
8 over-prescribed narcotic analgesics to all three patients and that Respondent's records
9 were difficult to read and interpret. The Medical Consultant noted that it was almost
10 impossible to correlate Respondent's office notes with prescriptions and refills and he
11 needed to rely on pharmacy printouts to determine Respondent's prescribing. The
12 Medical Consultant added that during an investigative interview Respondent did not give
13 satisfactory answers to questions and seemed evasive and poorly focused on the
14 problem at hand.

15 6. Respondent testified that his patients had not filed the complaints, but their
16 family members had. Respondent stated his notes were handwritten in small writing and
17 there was a lot of information in his notes. Respondent testified his practice is a solo
18 practice in general psychiatry and probably at least two-thirds of his patients are referred
19 by other psychiatrists, neurologists, pain clinics, obstetricians and gynecologists and
20 other physicians. Respondent testified the patients are referred to him after the other
21 physician has gone as far as they feel comfortable going and these patients are the most
22 challenging patients. Respondent noted he does some pain management, not pain
23 procedures; and he is a member of the Academy of Pain Management and the American
24 Headache Society; and he obtains regular continuing medical education.

25

1 7. Respondent testified that part of the problem for his patients is that they get
2 the short shrift in treatment of their medical problems, particularly pain, from other
3 physicians because they tend to talk about their feelings rather than the facts.
4 Respondent testified he gets proactive in trying to help out in referrals and, after other
5 physicians have done what they can, the patients are referred back to him for
6 management of pain medications. Respondent testified he does not advertise as doing
7 pain management, but someone has to do the job for psychiatric patients. Respondent
8 noted he does not see many patients because he takes so much time with each patient.
9 Respondent also noted psychiatric patients are not as compliant with their medications
10 and treatment regimens. Respondent testified that as a psychiatrist he could not
11 abandon patients and "fire" patients as readily as physicians in other areas of practice
12 and he could not hold them to specific contracts like pain clinics can.

13 8. Respondent was asked if a psychiatrist was always unable to "fire" a patient
14 or did that inability only arise in certain cases. Respondent testified it was not in all
15 cases, but you have to go to more extreme measures to the extent that even if you have
16 told a patient they cannot come back, if the patient has not gotten another physician you
17 are almost forced to continue treating them until they get another physician, and
18 sometimes they do not.

19 9. Respondent was asked to list some of the common psychiatric conditions a
20 psychiatrist treats. Respondent listed depression, anxiety, and obsessive compulsive
21 disorder. Respondent was asked if he was prohibited from "firing" a patient he was
22 treating for obsessive compulsive disorder. Respondent testified he was not, but noted
23 he would be responsible if the patient were to get suicidal and commit suicide.
24 Respondent was asked to assume the patient was not depressed – was being treated
25

1 solely for obsessive compulsive disorder – and asked if he could “fire” the patient.

2 Respondent testified he could.

3 10. Respondent was asked if he believed he practiced within the standard of
4 care in regard to his prescribing practices for AR, MW, and FB. Respondent testified he
5 had and noted he would be very happy when the federal Drug Enforcement
6 Administration (“DEA”) finishes activating the system where all prescribing records will be
7 available instantly and physicians will be prescribing through a centralized computer
8 system.

9 11. Respondent was asked about his statement in a letter to the Board that he
10 was aware, or at least suspected, FB was not using all of the medications he prescribed
11 to her. Respondent testified he did believe some of the medications had been stolen.
12 The Board noted that, although Respondent’s notes were difficult to read, after reading
13 Respondent’s records and the pharmacy surveys, it appeared he continued to prescribe
14 to FB even in light of his suspicions. Respondent testified he did continue to prescribe
15 and insisted FB get a lock box for her medication. Respondent was asked how he
16 followed up on this recommendation – how did he know that the drugs were not being
17 diverted from FB in spite of the fact that he was continuing to prescribe. Respondent
18 testified FB showed him the lock box.

19 12. Respondent was asked about a letter he received from FB reporting that
20 her husband had been able to get into the lock box. Respondent testified when FB told
21 him about her husband he suggested she got a lock box with a combination instead of
22 one with a key. Respondent was asked if he still continued to prescribe narcotics to FB
23 even though he knew they were being diverted. Respondent testified he continued to
24 prescribe because he could not abandon FB with her family history of suicide with undue
25 treatment of pain. Respondent was asked what pain condition he was treating FB for

1 specifically. Respondent testified FB was bipolar type II with anxiety and panic problems
2 who had a previous diagnosis of what used to be called "reflex sympathetic dystrophy"
3 problems associated with a previous rib injury.

4 13. Respondent was asked to look at his records because the Board was
5 unable to read his writing and unable to garner this information from FB's records.
6 Respondent was asked where in his records would the Board find FB's underlying
7 medical condition that required he prescribe narcotics. Respondent testified FB came in
8 with a history of a previous suicide attempt (jumping) and after that had a history of low
9 back pain, radiculopathy. Respondent testified this information was in his records as
10 "LBP." Respondent was asked how he evaluated FB's low back pain. Respondent
11 testified he did not evaluate medical things and FB came to him with a diagnosis of low
12 back pain. Respondent was asked if FB brought him any notes from a primary care
13 physician, an orthopedic surgeon, a neurosurgeon, or any other physician verifying she
14 had low back pain. Respondent testified FB had not. Respondent testified he did refer
15 FB to a neurologist for sorting out what was going on with her. Respondent was asked if
16 he had the copy of the consult done by the neurologist. Respondent testified he did not.

17 14. Respondent was directed to his records on AR and asked to point the
18 Board to the evidence in his records of the AR's condition that required he prescribe
19 narcotics. Respondent testified AR had been in a car accident in 1995, had
20 endometriosis, and chronic chest wall pain from regional sympathetic pain syndrome
21 ("RSD"). Respondent was asked how, when he assumed the responsibility of prescribing
22 medications to treat AR for these conditions, he confirmed AR had these conditions.
23 Respondent testified AR came to him with these diagnoses as well as a diagnosis of
24 fibromyalgia. Respondent testified he referred AR out to a neurologist for evaluation of
25 her pain and other neurological deficits. Respondent was asked why he was the

1 physician prescribing narcotics for these conditions. Respondent testified that other
2 physicians do not want to treat psychiatric patients who are suicidal and when there is a
3 history of pain and suicide in the family the pain can tip the patients over the edge.

4 15. Respondent was asked where in AR's chart the Board would find the record
5 of the results of the consult with the neurologist stating AR needed large amounts of
6 narcotics to be maintained. Respondent testified he did not think he got a consultation
7 report back, but he still needed to treat AR. Respondent was asked if it was accurate to
8 say he continued to treat both FB and AR with narcotics without any record of proof of the
9 underlying diagnosis he was treating them for. Respondent testified that it was accurate.
10 Respondent was asked the applicable standard of care regarding treating patients' pain
11 with narcotics and the documentation that would be appropriate. Respondent testified the
12 standard of care would be to get, if possible, firm diagnoses from various physicians for
13 the various conditions, but sometimes that is not possible with psychiatric patients.
14 Respondent was asked if he felt he met the standard of care in his prescribing to FB and
15 AR. Respondent testified that in retrospect he would have done things differently, but he
16 still ended up with the responsibility of treating the patients and he could not abandon
17 them.

18 16. Respondent was directed to his records on MW. Respondent was asked
19 what MW's underlying medical condition was for which he was prescribing narcotics.
20 Respondent testified MW came to him with a diagnosis of cluster headaches that were
21 seasonally sensitive and a history of treatment with hydrocodone and one of the triptans
22 as well as Imitrex for her headaches. Respondent was asked if it bothered him that MW
23 had a history of using a number of illegal substances. Respondent said it did.
24 Respondent was asked why then he felt comfortable prescribing narcotics for seasonal
25 cluster headaches on a regular basis. Respondent testified he was not comfortable

1 prescribing on a regular basis and noted MW was also on long-term treatment with anti-
2 epileptics for neuropathic pain and became non-functional when taken off of opioids.

3 17. Respondent testified MW also had a history of cervical osteoarthritis and
4 problems with her upper extremities, not just headaches. Respondent was asked where
5 in the record it was documented that MW had cervical osteoarthritis. Respondent
6 testified MW did not have insurance to get some of the things he recommended and he
7 had referred her for neurological testing and a neurological consult. Respondent testified
8 he would not have continued treating, but since MW was already in his care he could not
9 abandon her.

10 18. Respondent admitted that all three patients under consideration were
11 receiving large numbers of narcotics and there is no evidence in the records to support
12 the need for long-term narcotics in terms of additional testing or consultation.
13 Respondent testified that in retrospect he should have never accepted these patients.
14 Respondent maintained that he partly met the standard of care that required he be
15 certain of the underlying condition for which he was prescribing narcotics before he
16 prescribed any narcotics.

17 19. Respondent was asked how he was qualified to practice pain management
18 – what residencies did he complete, what fellowships did he complete, what courses did
19 he complete. Respondent testified that during his residency at Maricopa Medical Center
20 he trained under an internist whose specialty is pain management. Respondent was
21 asked if it was common for psychiatrists to include pain management as part of their
22 practice. Respondent testified it was not, but there is a emerging subspecialty in
23 psychiatry in that regard. Respondent testified he completed the Psychopharmacology
24 Congress last February (12 ½ hours) and the previous course of pain management.
25 Respondent was asked if it was common for him to see patients with cluster headaches.

1 Respondent testified he sees such patients occasionally and they are typically referred by
2 neurologists.

3 20. Respondent was asked if he recognized that prescriptions in the pharmacy
4 survey indicate he prescribed twelve and sometimes eighteen Percocets a day to some
5 of the patients. Respondent testified if he had been aware a patient was taking that
6 much Percocet he would not at all have prescribed that. Respondent was reminded that
7 all of the prescriptions went out under his signature. Respondent testified that this group
8 of three patients was in some ways conning him into getting rewrites of prescriptions and
9 so forth and this is another reason he looks forward to the DEA's new prescription
10 system. Respondent was asked how, if he was maintaining adequate office records, he
11 could have been conned into writing prescriptions for a patient. Respondent testified
12 there were all sorts of excuses for things with these patients – patients conferring with
13 each other and sometimes other family members and in retrospect it was a very bad
14 situation and he has taken steps to make sure it does not happen again.

15 21. Respondent was asked if it was his testimony that his records may have
16 played a role in allowing the patients to con him. Respondent testified that he agreed to
17 the extent he did not write down all of the excuses all of the times and all of the
18 justifications for writing the prescriptions and so forth. The Board noted there was no
19 summary list of medications in any of the three patients' charts and asked if Respondent
20 used a summary list of medications in his charts. Respondent testified he had not, but
21 was instituting that practice.

22 22. Respondent was asked if he were to go on a six-month sabbatical and
23 another physician had to cover for him how would that physician decipher Respondent's
24 charts – how would that physician know what was going on with complicated patients,
25 what medications were being refilled, and how many times refills had been ordered.

1 Respondent testified these charts were not typical and he has made changes to his
2 practice to tighten things up. However, Respondent testified he is still writing out his
3 charts and not dictating them.

4 23. Respondent was asked if he knew the nature of FB's admission to the
5 hospital when she was taken to the emergency room for what her parent's thought was
6 an overdose – Tylenol toxicity. Respondent testified he had no knowledge of any records
7 that indicate FB was admitted to the hospital for Tylenol toxicity and he would not have
8 this knowledge unless FB told him or brought him the records.

9 24. Respondent was required to keep adequate medical records on his
10 patients. Adequate medical records are legible medical records that contain, at a
11 minimum, sufficient information to identify the patient, support the diagnosis, justify the
12 treatment, accurately document the results, indicate advice and cautionary warnings
13 provided to the patient and provide sufficient information for another practitioner to
14 assume continuity of the patient's care at any point during the course of treatment.
15 A.R.S. § 32-1401(2).

16 25. The standard of care required Respondent to confirm his patients'
17 underlying conditions before prescribing narcotics to treat the conditions and to prescribe
18 the proper amount of narcotics to his patients.

19 26. Respondent deviated from the standard of care because he did not confirm
20 his patients' underlying conditions before he prescribed narcotics to treat the conditions
21 and because he prescribed excessive amounts of narcotics to his patients.

22 27. AR was harmed because she had to be taken to a detoxification institution
23 and to the emergency room for overdosing. MW was potentially harmed because she
24 could have become addicted. FB was harmed because she overdosed and required
25 admission to the hospital.

1 **CONCLUSIONS OF LAW**

2 1. The Arizona Medical Board possesses jurisdiction over the subject matter
3 hereof and over Respondent.

4 2. The Board has received substantial evidence supporting the Findings of
5 Fact described above and said findings constitute unprofessional conduct or other
6 grounds for the Board to take disciplinary action.

7 3. The conduct and circumstances described above constitutes unprofessional
8 conduct pursuant to A.R.S. § 32-1401(27)(e) (“[f]ailing or refusing to maintain adequate
9 records on a patient;”) and 32-1401(27)(q) (“[a]ny conduct or practice that is or might be
10 harmful or dangerous to the health of the patient or the public.”

11 **ORDER**

12 Based upon the foregoing Findings of Fact and Conclusions of Law,

13 IT IS HEREBY ORDERED:

14 1. Respondent is issued a Letter of Reprimand for inadequate medical records
15 and excessive prescribing of narcotics.

16 2. Respondent is placed on probation for one year with the following terms
17 and conditions:

18 a. Respondent shall obtain 20 hours of Board Staff pre-approved Category I
19 Continuing Medical Education (“CME”) in recordkeeping offered by the Physician
20 Assessment and Clinical Education Program (“PACE”) and 20 hours of Board Staff pre-
21 approved Category I CME in pain management. Respondent shall provide Board Staff
22 with satisfactory proof of attendance. The CME hours shall be in addition to the hours
23 required for biennial renewal of medical license.

24 b. Respondent shall obey all federal, state, and local laws and all rules
25 governing the practice of medicine in Arizona.

1 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

2 Respondent is hereby notified that he has the right to petition for a rehearing or
3 review. The petition for rehearing or review must be filed with the Board's Executive
4 Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The
5 petition for rehearing or review must set forth legally sufficient reasons for granting a
6 rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days
7 after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not
8 filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to
9 Respondent.

10 Respondent is further notified that the filing of a motion for rehearing or review is
11 required to preserve any rights of appeal to the Superior Court.

12 DATED this 13th day of October, 2005.



THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

18 ORIGINAL of the foregoing filed this
19 13th day of October, 2005 with:

20 Arizona Medical Board
21 9545 East Doubletree Ranch Road
22 Scottsdale, Arizona 85258

23 Executed copy of the foregoing
24 mailed by U.S. Certified Mail this
25 13th day of October, 2005, to:

Howard L. Mitchell, M.D.
Address of Record