

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-04-0186A  
MD-04-0925A

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

(Decree of Censure and Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting  
8 on October 6, 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

14 **FINDINGS OF FACT**

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 **CASE NO. MD-04-0186A**

20 3. The Board initiated case number MD-04-0186A after receiving a complaint  
21 from the Arizona Board of Psychologist's Examiners ("Psychology Board") involving  
22 Respondent's psychiatric evaluation of a party in a child custody dispute that went to trial.  
23 Respondent conducted a psychiatric evaluation, a custody evaluation and made custody  
24 recommendations. The Superior Court also asked another physician to do a custody  
25 evaluation. This physician raised serious concerns about the quality of Respondent's  
evaluation as it related to his custody recommendations. This physician noted

1 Respondent failed to consider domestic violence findings made by the Court and also  
2 made his recommendations based solely upon his interview with the father and did not  
3 interview the mother or child. The Court also opined on the issue of custody and found  
4 Respondent's disregard of the domestic violence history quite unusual. The Court  
5 concluded the Respondent failed to consider important relevant information in arriving at  
6 an unbiased and objective opinion.

7 4. Respondent testified he was asked to do a psychiatric evaluation of the  
8 patient, not a custody evaluation. Respondent noted because the patient was involved in  
9 a hostile divorce proceeding he was told he might be asked to testify and was  
10 subpoenaed to testify. Respondent testified his Court testimony was that he had  
11 conducted a psychiatric evaluation, not a custody evaluation. Respondent testified he  
12 found no treatable psychiatric illness in the patient. Respondent testified his testimony  
13 before the Court that there was nothing psychiatrically that would make it inappropriate to  
14 say the patient should be separated from or not have contact with his daughter.

15 5. Respondent was asked who contacted him to do the evaluation and what  
16 he believed was the purpose of the evaluation. Respondent testified the patient's  
17 mother, who was a patient of his, referred the patient to him and asked him to do a  
18 psychiatric evaluation to determine whether or not the patient was mentally healthy.  
19 Respondent was asked how he obtained the voluminous amount of records he reviewed.  
20 Respondent testified the patient brought him a box with copies of the records.  
21 Respondent was asked his understanding of where the records in the box came from.  
22 Respondent testified the records were copies of all sorts of records of the difficulties the  
23 patient was having in going through a hostile divorce. Respondent noted some of the  
24 records were police reports that had been dismissed as having no real foundation for  
25 follow-up and other things of that sort.

1           6.     The Board noted Respondent's recommendation in his report where he  
2 concluded "[a]ppropriately, therefore, the considered recommendation of this clinician is  
3 for a fully normal and equal joint custody by father and mother with unrestricted normal  
4 grandparenting, access by all grandparents." Respondent was asked how he made this  
5 recommendation in light of the domestic violence and the restrictions that had been  
6 placed on the father with regard to visitation with his daughter. Respondent testified his  
7 recommendation was made solely on the basis of the psychiatric health of the patient, not  
8 of the parenting situation. Respondent testified his report was added data that the patient  
9 had no definable psychiatric problem needing treatment. Respondent was asked how he  
10 justified leaving out this rather important information in coming up with a recommendation  
11 for full and normal joint and equal custody in a report that was to be impartial.  
12 Respondent testified it was because he was not making a recommendation for custody,  
13 but simply giving his opinion based on the psychiatric health of the patient and the sole  
14 question he was answering was whether or not the patient should be involved in  
15 parenting.

16           7.     Respondent was asked if it was his testimony that the history of domestic  
17 violence and the history of the Court's restriction of visitation by the patient had  
18 absolutely no relationship to the psychiatric evaluation he performed. Respondent stated  
19 that was not his testimony. Respondent testified there was a pattern that made him  
20 highly suspicious there was more going on in terms of the patient being set up for an  
21 order of protection type of situation and as a consequence he made the recommendation  
22 to the Court that maybe the estranged wife ought to be evaluated also in a symmetrical  
23 type of situation.

24           8.     Respondent was asked if he disclosed his long-standing physician-patient  
25 relationship with the child's grandmother (the patient's mother). Respondent testified he

1 had. Respondent testified in retrospect he should have put in the report that it was based  
2 solely on the psychiatric evaluation of the patient, but he did talk numerous times in the  
3 report about the patient's mother being in treatment for depression and post-traumatic  
4 stress after the death of the patient's father. Respondent was asked if it ever appeared  
5 to him that there would be possible red flags of bias in his report when in his  
6 recommendations he did not take into consideration that the Court had restricted the  
7 patient's contact with the child and recommended the grandmother and patient have  
8 unrestricted privileges and custody. Respondent testified that based on psychiatric  
9 evaluations there would be no specific red flags for that type of situation that he was  
10 aware of and any additional situation that he was not aware of was the Court's duty to  
11 determine. Respondent again testified his evaluation was just a psychiatric evaluation.

12 9. Respondent was asked if at any time he observed the interaction of either  
13 parent with the child. Respondent testified he had not because he did not do a parenting  
14 evaluation, but a determination of the mental health of the patient. Respondent was  
15 asked if he was saying domestic violence does not come into the realm of a psychiatric  
16 evaluation. Respondent testified he was not. Respondent was asked if he considered  
17 domestic violence when doing a psychiatric evaluation and coming up with  
18 recommendations. Respondent testified he did. Respondent was asked how he  
19 considered the evidence of domestic violence in this case. Respondent testified the best  
20 evidence he had in the information was that there was a lot more than a one-sided  
21 situation. Respondent was asked to elaborate. Respondent testified the pattern was  
22 such that accusations would be made and the police would find nothing and dismiss the  
23 accusations. Respondent noted the fact that the patient was not allowed to live with the  
24 child's mother from the start even before they had the child and, if the Board notes the  
25 history of that situation that the patient was being manipulated from the start, and the

1 child's mother was living with her parents for ninety to ninety-five percent of the time the  
2 parties were married. Respondent testified the patient was being controlled and  
3 manipulated by his estranged wife.

4 10. Respondent was asked if he came to his conclusions about the patient  
5 being manipulated by his wife and the other items based on hearsay from the patient or  
6 on reviewing the documents, but not on a face-to-face examination of the wife.  
7 Respondent testified he could not say whether the wife was sick, but there ought to have  
8 been an evaluation and that is basically what he was saying in his report. The Board  
9 noted that Respondent's report stated the wife was manipulating the patient, that the  
10 patient was being set-up, but Respondent never examined her in order to do a psychiatric  
11 examination. Respondent was asked if he ever met with the wife. Respondent testified  
12 he was not intending to do anything other than the psychiatric evaluation of the patient  
13 and had not seen the patient since. Respondent testified he did the best he could based  
14 on the information he had at hand and he did it as fully as possible and there was no  
15 psychiatric illness to directly deal with there.

16 11. The Board noted Respondent's report seems to indicate that he is  
17 recommending to the Court that there be joint custody, but his testimony is that he was  
18 only evaluating the patient to determine whether the patient had a psychiatric illness.  
19 The Board noted that his report does not say he is only evaluating the patient for this  
20 purpose and makes a recommendation about custody. Respondent testified there was  
21 no reason to deny the child the appropriate parenting of the patient. Respondent testified  
22 he might have phrased his report differently in terms of the recommendations, but the  
23 recommendations are not his actual diagnosis and the summary of the report in terms of  
24 diagnosis is there.

25

1           12.    Respondent noted his report said the patient was "evaluated on an out-  
2 patient basis for reasons associated with a custody dispute during a hostile divorce  
3 proceeding in which his mental health status has been called into question regarding  
4 parenting and the safety of his child when in his presence." Respondent testified this  
5 meant he was not doing any sort of parenting evaluation directly, but merely the  
6 psychiatric evaluation to determine whether the patient had something that was treatable  
7 that ought to be treated that might have affected his parenting situation. Respondent was  
8 asked why he did not just say this outright rather than make an elaborate  
9 recommendation that supersedes everything else he said. The Board noted Respondent  
10 could simply have said "this patient has no mental illness that I can identify" and left it at  
11 that. Respondent testified part of the problem was that the patient's mother (also his  
12 patient) was being kept away from her grandchild because of a diagnosis of depression.  
13 And, knowing that, he phrased the report the way he did because the effect was to say  
14 that any mental illness whatsoever makes someone unfit to be a parent and that is clearly  
15 not the case and should not be the case. Respondent testified this was the gist of the  
16 questioning when he testified in Court. Respondent was asked what he would do if he  
17 was faced with a similar situation again, specifically, what would he put in his report.  
18 Respondent testified he would amplify more and say that there is no psychiatric illness  
19 and that anything else in terms of custody and parenting was for other people to  
20 determine.

21           13.    The Board noted Respondent ignored some very relevant data in preparing  
22 his report and there was a compartmentalization between his recommendations and the  
23 body of his report. The Board also noted that when a physician conducts an independent  
24 medical examination all issues must be known and discussed whether they help or hurt  
25 the person who is the subject of the report. The Board noted Respondent ignored most

1 of the data, except that which was disparaging to the wife and cleared the patient  
2 completely by ignoring any domestic violence. The Board determined that Respondent,  
3 by ignoring relevant data, made false statements in his medical report.

4 14. The standard of care required Respondent to evaluate the patient based on  
5 all available data and conduct an appropriate evaluation prior to making any  
6 recommendation.

7 15. Respondent deviated from the standard of care because he ignored  
8 relevant data when evaluating the patient and made a custody recommendation without  
9 conducting an appropriate evaluation.

10 16. There was potential harm to the public because the Court may have acted  
11 on Respondent's recommendation and inappropriately placed the child.

12 **Case No. MD-04-0925A**

13 17. The Board initiated case number MD-04-0925A after receiving a complaint  
14 regarding Respondent's care and treatment of a fifty-two year-old male patient ("GL").  
15 GL self-referred to Respondent, his insurance plan's contract psychiatrist, in February  
16 1999. GL's family physician had started him on Ritalin SR 20mg daily and Ritalin  
17 immediate release ("IR") 20 mg three times a day along with Wellbutrin SR 150 mg twice  
18 a day. At GL's initial visit Respondent increased the Ritalin SR 20 mg t.i.d. and continued  
19 the Ritalin IR. Respondent recommended GL continue the Wellbutrin SR. There is no  
20 record of Respondent updating GL's family physician of the treatment plan and its results.

21 18. For the next several months GL continued to receive refills of both forms of  
22 Ritalin from his family physician and Respondent. Both physicians were unaware that GL  
23 was receiving medication from the other. GL saw Respondent monthly for thirty minutes.  
24 During GL's visits his progress was assessed and his prescriptions renewed.  
25 Respondent's notes one month after GL's initial visit reflect Ritalin SR 20 mg t.i.d. and an

1 increase in Ritalin IR to 20 mg t.i.d. Thereafter Respondent saw GL every two to four  
2 months. In January 2000 Respondent discontinued GL's Ritalin and prescribed  
3 Dexedrine LA 15 mg b.i.d. Respondent saw GL five months later when GL complained of  
4 being irritable. Respondent discontinued the Dexedrine and restarted both forms of  
5 Ritalin t.i.d. Three months later Respondent saw GL and added Paxil 20 mg daily.  
6 Respondent started GL on Temazepam 30 mg at bedtime for sleeping difficulties.

7 19. In November 2000 Respondent started GL on Dexedrine Spansule 10 mg  
8 t.i.d. and Dexedrine 5 mg t.i.d. and increased the Temazepam to 60 mg at bedtime. In  
9 January 2001 Respondent increased the Dexedrine Spansule to 15 mg t.i.d. with  
10 Dextrstat 10 mg t.i.d. The Temazepam was continued at 60 mg at bedtime and GL was  
11 no longer on Paxil. GL renewed his psychostimulant prescriptions at the same pharmacy  
12 every month even though his office visit's with Respondent progressively decreased.  
13 Respondent did not see GL from March 2002 until October 2002. Respondent's progress  
14 notes do not contain blood pressure readings, laboratory tests, EKG, medical consults or  
15 second opinion requests. Respondent's October 2002 office note reflects GL may need  
16 a higher dose of Adderall XR and he prescribed 30 mg three times a day. Prior to this  
17 visit the pharmacy dispensed 120 Adderall monthly and from November 2002 through  
18 May 2003 the pharmacy dispensed 360 Ritalin monthly.

19 20. In July 2003 GL was in a car accident and was taken to the emergency  
20 department at Banner Desert Samaritan Medical Center ("Desert Samaritan"). The  
21 emergency physician noted GL had no negative medical history and was not on any  
22 medication. On August 12, 2003 GL was in physical distress and was referred to Desert  
23 Samaritan. Respondent's progress notes of a visit at this time indicate GL acknowledged  
24 he was getting Adderall and maybe Ritalin from at least one other physician. The  
25 pharmacy printouts do not reflect this, but they do reflect 90 Adderall XR capsules

1 monthly prescribed by Respondent until the last prescription fill in March 2004. GL's  
2 family physician's notes reflect a September 11, 2003 phone call from Respondent  
3 wherein Respondent described GL as a "hypermetabolizer" and said GL had been getting  
4 medications from more than one physician. After the August 12, 2003 emergency room  
5 visit where it was suspected GL was having acute dystonia he was referred to another  
6 physician ("Physician"). Physician and later another physician followed GL's care and  
7 each independently came to the conclusion that he was having movement disorder  
8 induced by the long period of time he was taking psychostimulants before he came to  
9 their attention. GL was referred to Barrow Neurological Clinic where it was determined  
10 his tardive dyskinesia was slowly reversing and would eventually diminish over the  
11 subsequent months. It was also determined that if the tardive dyskinesia was present for  
12 another six months it would likely persist. GL was advised to be off all medication except  
13 for Klonopin and to be reassessed with neuropsychological testing to see if deficits in his  
14 initial testing improved.

15         21. Respondent testified he was treating GL for Attention Deficit Hyperactivity  
16 Disorder ("ADHD") when he got a call from another physician who was also prescribing  
17 Adderall for ADHD. Respondent indicated both he and the other doctor were shocked  
18 that they were both prescribing Adderall. Respondent testified he immediately called the  
19 Drug Enforcement Administration ("DEA") to let them know about GL. Respondent noted  
20 he was not sure how to go about all the various things, but he felt that when a patient was  
21 doctor shopping and apparently getting prescriptions from several different physicians it  
22 was not appropriate. Respondent testified DEA agents subsequently came to his office  
23 when he was not there and his staff gave them GL's chart. Respondent testified his staff  
24 was so intimidated they did not keep copies of the chart or get a receipt from the agents.  
25 Respondent testified he then got a request for GL's chart. Respondent testified he called

1 the DEA in Mesa and kept getting directed back and forth between Mesa and downtown.  
2 Respondent testified the records were eventually returned and he forwarded the records  
3 as requested. Respondent testified he saw GL once briefly after speaking with the other  
4 physician and told him he could not prescribe any more medications and that he had  
5 notified the DEA. Respondent testified he wished GL well, but told him he was not going  
6 to prescribe to him anymore.

7 22. Respondent was asked if GL had any co-morbid diagnoses. Respondent  
8 testified GL had Dysthymia, a mild low-level long-term depression and/or anxiety.  
9 Respondent testified GL denied using other substances at that time, although he  
10 admitted to using significant amounts of alcohol when he was in college. Respondent  
11 testified treatment with Adderall was standard for ADHD. Respondent was asked about  
12 his prescribing Dexedrine, a psychostimulant, at the same time he prescribed Adderall.  
13 Respondent testified he combined them to extend GL's day. Respondent was asked  
14 about Adderall being extended release, which would last for ten or twelve plus hours, and  
15 his prescribing it to be taken three times daily. Respondent testified sometimes with  
16 rapid metabolizers he has to prescribe this way. The Board noted the recommendations  
17 for Adderall are to give it first thing in the morning so it lasts during the day and that GL  
18 was getting it three times a day, so instead of getting 30 milligrams per day he was  
19 getting up to 240 milligrams. Respondent agreed, but noted GL metabolized rapidly.

20 23. Respondent was asked about the prescription for Diazepam to assist GL to  
21 sleep, specifically whether Respondent thought there was any relation to GL getting 240  
22 milligrams of Adderall XR and his difficulty sleeping. Respondent testified GL had  
23 problems with sleep long before he was on the medications and some patients actually  
24 need twenty-four hour coverage with the stimulants because they actually sleep better.  
25 Respondent was asked the usual dose of Diazepam. Respondent testified it was thirty,

1 but in psychiatry it goes up to ninety. Respondent was asked if it was counterproductive  
2 to give GL 240 mg of Adderall extended per day and then give him 90 milligrams of  
3 Diazepam to sleep. Respondent testified there were cases where it could be, but almost  
4 all ADHD people have a tendency to have a slipped sleep schedule so they often require  
5 sleep medications.

6 24. Respondent was asked to list a few of the side effects he considered  
7 important in patients who are on psychostimulants. Respondent testified the side effects  
8 are very individual with patients, but one of the things that happens with people who are  
9 on psychostimulants, some of them long term (rarely ADHD people), is they can get  
10 paranoid and so forth, have tremors... Respondent testified sometimes when people are  
11 in that category they go out and supplement with other things and so forth and that is  
12 what it sounds like was happening with GL—that he was going outside Respondent's  
13 purview and getting additional medications that Respondent did not know about.  
14 Respondent was asked if there were other medical complications. Respondent testified  
15 there can be associated dopaminergic difficulties and pseudoparkinsonism. Respondent  
16 was asked whether high blood pressure was a complication. Respondent testified it was.  
17 The Board noted it had difficulty finding any vital signs for GL in Respondent's records.  
18 Respondent testified that for those things GL was supposed to be being followed up  
19 regularly by the primary care physician.

20 25. Respondent was asked if it was his testimony that it was not his practice to  
21 take vital signs in patients when prescribing psychostimulants. Respondent testified  
22 psychiatrists refer patients to primary care doctors for these things. Respondent was  
23 asked if he got any feedback that GL was going to his primary care physician and what  
24 his vital signs were. Respondent testified he relied on GL's verbal history. Respondent  
25 was asked about GL's presentation in the emergency room of Desert Samaritan because

1 of a transient ischemic episode ("TIA"). Respondent testified this was just before he got  
2 the call that another physician was prescribing to GL and was the first indication there  
3 were some major problems in that way. The Board noted shortly around that time or just  
4 before that GL developed some dyskinesias. Respondent was asked if despite that TIA,  
5 the hypertension, and dyskinesia he continued to prescribe psychostimulants in large  
6 doses to GL. Respondent testified at that particular time he was trying to get GL into  
7 more formal care. Respondent was asked what was "more formal care" considering GL  
8 had a primary care physician and Respondent was his psychiatrist. Respondent testified  
9 he and the primary care physician were talking about getting GL down and off all  
10 psychostimulants. Respondent testified he believed this was one of the primary impetus  
11 for GL trying to get prescriptions from another doctor.

12 26. Respondent was asked if he had any ideas about how he would improve  
13 his records as they were almost illegible. Respondent testified he is working on ways of  
14 resolving that. Respondent noted whenever his records have been reviewed by people  
15 who are trying to see what is in them they are amazed that he has more information in his  
16 records than most doctors. The Board noted Respondent may have a lot of information  
17 in his records, but it is not retrievable by anyone other than Respondent. Respondent  
18 was asked if his records contain a medication sheet where he lists the medications so he  
19 can look at it and see how often the patient is getting medications and how much he is  
20 getting. Respondent testified he was instituting that practice, but is not part of the  
21 records before the Board. Respondent testified he will be very happy when the DEA  
22 institutes its new computer system that puts every prescription into a central database  
23 and allows physicians to access all of a patient's prescriptions.

24 27. Respondent was asked how he defined or diagnosed a "rapid metabolizer"  
25 as he described GL. Respondent testified that among other things it has to do with the

1 particular response situation. Respondent testified it is an individual situation for patients  
2 and some need huge amounts in order to get the benefits and others need very small  
3 amounts. Respondent was asked what kind of symptoms GL was exhibiting that  
4 indicated he needed higher and higher doses of Adderall. Respondent testified it had to  
5 do with his attention span and how he was functioning. Respondent testified GL did not  
6 tell him about everything that was going on and he only learned of the TIA when GL's  
7 wife came in with him. Respondent testified he observes a patient to see if the patient  
8 can keep his focus when talking to him and tracks where the patient is looking, and  
9 whether he changes the subject regularly. Respondent testified he can get an evaluation  
10 of whether the medicine is doing better or not so good relative to what the patient is  
11 taking, as long as the patient is truthful about what he is taking. Respondent was asked if  
12 the symptoms of a rapid metabolizer and too low a dose of drug could be confused with  
13 too much drug. In other words, was GL's lack of attention the result of too much drug.  
14 Respondent testified there are occasions where that might be the case, but that would  
15 generally be coincident with additional symptoms.

16 28. Respondent was asked if he ever considered giving GL a "drug holiday."  
17 Respondent testified he had and that was one of the arguments for his continuing to treat  
18 GL, but he never got the chance to even deal with that. Respondent was asked how,  
19 during the three to four years he treated GL, he was unable to do a drug holiday.  
20 Respondent testified there was one point where GL was on a drug holiday, but his  
21 understanding was that GL lost his job because of it.

22 29. In response to a query from the Board, the Board's Medical Consultant  
23 clarified that the pharmacy survey indicates Respondent continued to prescribe Adderall  
24 to GL for five or six months after Respondent was aware of the involvement of another  
25

1 physician in GL's care. The Medical Consultant also clarified there is no rule prohibiting  
2 Respondent, as a psychiatrist, from checking a patient's vital signs.

3 30. The standard of care required Respondent to conduct a careful history and  
4 physical examination, to provide close monitoring and follow-up of a patient on  
5 medication that has serious side effects, and to properly prescribe amphetamines.

6 31. Respondent deviated from the standard of care because he did not conduct  
7 a careful history and physical examination of GL, because he did not provide close  
8 monitoring and follow-up of a patient on medication that has serious side effects and  
9 because he excessively prescribed amphetamines.

10 32. GL was harmed because he suffered a movement disorder as a result of  
11 the amphetamines prescribed by Respondent.

12 33. Respondent was required to maintain adequate medical records.  
13 "Adequate medical records" are legible medical records containing, at a minimum,  
14 sufficient information to identify the patient; support the diagnosis, justify the treatment,  
15 accurately document the results, indicate advice and precautionary warnings provided to  
16 the patient and provide sufficient information for another practitioner to assume continuity  
17 of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2).  
18 Respondent's records were not adequate medical records.

19  
20 **CONCLUSIONS OF LAW**

21 1. The Arizona Medical Board possesses jurisdiction over the subject matter  
22 hereof and over Respondent.

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



