BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **UNEN D. HSU, M.D.** Holder of License No. **8373** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0847A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Decree of Censure and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on August 8, 2007. Unen D. Hsu, M.D., ("Respondent") appeared before the Board with legal counsel James R. Taylor for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

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 No. 8373 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0847A after receiving a complaint regarding Respondent's care and treatment of a twenty-nine year-old female patient ("HM"). HM came under Respondent's care on October 6, 2004 for heroin addiction. At the initial visit, Respondent documented HM's seven year history of heroin use, that she required four injections of heroin per day, and had last injected herself with heroin that morning. Respondent performed a cursory physical examination and obtained a sparse and inadequate history for the work-up of an active heroin abuser. Respondent did not test HM for HIV or hepatitis and did not refer her to an addiction medicine specialist. Respondent told Board Staff that at the first visit HM told him she had been kicked out of a methadone clinic, but Respondent did not document this and did not

attempt to obtain records from the methadone clinic. At the first visit Respondent prescribed clonidine and methadone for the purpose of treating HM's heroin addiction and recommended a two-week follow-up visit.

4. Respondent's medical records indicate that on November 3, 2005 HM was treated in an emergency department as a result of an auto accident caused when she apparently fell asleep at the wheel. Respondent's original medical records indicate HM's last heroin dose was 2-3 days earlier.

5. Over the following two years Respondent continued to regularly prescribe methadone for "maintenance treatment" of heroin addiction and prescribed benzodiazepine for "anxiety and depression." Although Respondent indicated in his medical record and during an interview with Board Staff that he was aware ongoing heroin use was an issue with HM in the early months when he began prescribing methadone, he instituted, continued and escalated the methadone dosage. On multiple occasions HM presented to Respondent with abscess, cellulitis, drainage and/or swelling of the extremities or abdomen, yet Respondent did not consider the possibility that this represented ongoing heroin use.

6. On five occasions HM reported lost or stolen medication, but Respondent did not believe these incidents were suggestive of drug abuse. On each occasion Respondent replaced the prescription and did not perform a urine drug screen. On multiple occasions HM returned for early refill of methadone and/or benzodiazepines and, on each occasion, Respondent provided the early refill. Respondent did not perform urine drug screens or investigate the reason for HM's non-compliance. On twelve dates Respondent prescribed methadone and/or benzodiazepines to HM, a known heroin addict, without an associated office visit.

7. On July 24, 2006 Respondent admitted HM to the hospital for treatment of multiple subcutaneous abscesses. HM required a central venous line because of poor venous access. A physician with any knowledge of addiction medicine would have been suspicious of "skin

popping" (subcutaneous or intramuscular injection of heroin) in a known heroin addict with no venous access and multiple subcutaneous abscesses. On July 17, 2006 and September 12, 2006 HM presented to Respondent with a history of incarceration and withdrawal from methadone. At each visit Respondent refilled HM's medications, but did not ask why HM had been incarcerated. The complainant informed the Board HM had been incarcerated for illegal drug use and is known to be involved in prostitution. At the September 12, 2006 visit Respondent documented HM's medications had been confiscated while in prison and wrote "continue the same." During a review of his records with Board Staff, Respondent acknowledged prescribing methadone and benzodiazepine without documenting the prescriptions in HM's record or merely documenting "continue the same" without further explanation or specifics.

8. On October 6, 2006 HM was hospitalized for an overdose of Xanax and, during the hospitalization, admitted to taking 60 Xanax because she was "trying to kill [her]self." HM was discharged on October 8, 2006. On October 9, 2006 HM returned to Respondent and he documented she had been hospitalized for an overdose of Xanax (benzodiazepine) and was being treated at a methadone clinic. Yet, Respondent prescribed methadone without requesting the records from the hospital or methadone clinic. On October 12, 2006 HM was found asleep in a parking lot. Emergency medical services reported she had taken 50 Xanax and had been seen the previous week for the same thing. HM was hospitalized again and required intubation and mechanical ventilation because of respiratory failure and witnessed aspiration. HM's drug screen was positive for benzodiazepine, methadone, opiates and tricyclics. HM was seen by a cardiologist for hypertension, bradycardia, and borderline prolonged QT interval. On October 15, 2006 HM was transferred directly from the hospital to Behavioral Health for inpatient psychiatric treatment.

9. On October 19, 2006 HM was discharged from Behavioral Health against medical advice and took a taxi directly to Respondent's office. Respondent documented in HM's record

that she had been hospitalized for psychiatric care. Despite knowing HM was enrolled in a methadone program and had been hospitalized for benzodiazepine overdose ten days earlier, Respondent again prescribed methadone, benzodiazepine (Lorazepam) and Seroquel. Respondent did not contact the psychiatrist or obtain the hospital records to confirm HM's story that while she was in the hospital the psychiatrist had prescribed these same medications. Respondent maintained he prescribed the methadone on October 9 and 19, 2006 because HM could not get to the methadone clinic. Respondent could not explain how HM could get to his office, but not the methadone clinic.

10. On October 21, 2006 HM was again brought to the emergency department ("ED") by ambulance with altered mental status and report of another methadone and benzodiazepine overdose. The ED physician noted both bottles of the most recently prescribed methadone and benzodiazepine were empty and described HM as intoxicated, belligerent and uncooperative. HM had to be restrained. HM required a femoral line because of absence of peripheral venous access. After HM was medically stabilized during hospitalization she was transferred directly to inpatient Behavioral Health on October 23, 2006 for psychiatric care. HM gave Behavioral Health a history of heroin use six months earlier and occasional cocaine use. HM requested and was granted discharge on October 26, 2006.

11. After discharge, HM went to Respondent's office and requested a methadone prescription. Respondent was not in the office – he was at the Board's offices for an interview with Board Staff (including a Medical Consultant). During the interview HM paged Respondent requesting her medications. Respondent informed Board Staff he believed it appropriate to refill HM's prescriptions because it was the only way to prevent HM from returning to heroin use. Respondent did, however, inform Board Staff he would defer to their recommendation regarding whether or not to continue prescribing methadone to HM. At the conclusion of the interview

Respondent signed an Interim Consent Agreement for Practice Restriction prohibiting him from prescribing controlled substances while the investigation was pending.

12. Respondent's primary area of practice is diabetes and endocrine issues. Respondent has no training in treating addiction and could not produce any proof of having taken continuing medical education in this area. Respondent is not affiliated with a licensed opioid treatment program and his office has not been designated as a medication-dispensing unit for treatment of addiction. Respondent was aware that HM's pharmacy would not fill a prescription for methadone for the treatment of addiction, therefore, he purposefully falsified the prescriptions to include "for chronic pain" as the reason for the methadone. Until meeting with Board Staff in October 2006, Respondent was unaware it is illegal to give methadone to heroin addicts outside of an approved program.

13. The standard of care requires a physician to adhere to federal and State regulations for prescribing controlled substances.

14. Respondent deviated from the standard of care by treating HM for heroin addiction with methadone maintenance for two years through his office practice despite State and federal guidelines that expressly prohibit such treatment in any setting other than a licensed Opioid Treatment Program.

15. The standard of care requires a physician to write accurate, not fraudulent, prescriptions.

16. Respondent deviated from the standard of care when he circumvented State and federal guidelines governing take-home methadone for treatment of addiction by falsifying the written prescriptions as "for chronic pain."

17. The standard of care requires a physician be aware of the significant characteristics, complications, vulnerable patient populations, and drug interaction associated with medications prescribed and to prescribe and monitor accordingly.

18. Respondent deviated from the standard of care by prescribing methadone and benzodiazepine with inadequate knowledge of the effects of the medications, particularly in heroin addicts, and by continuously prescribing this potentially lethal and addictive combination to HM, a heroin addict.

19. The standard of care requires a physician treating a specific disease provide the patient with at least the minimum basic care (testing for HIV and hepatitis, referral to an addictionologist or methadone clinic) and monitoring (obtain urine screen, recognize multiple subcutaneous abscess and scarring of the abdomen and forearm as signs of self-administration of heroin) for the problem or refer the patient to a specialist who can provide adequate care.

20. Respondent deviated from the standard of care by failing to provide even the minimum basic care to HM, a patient with known intravenous drug abuse, and by failing to recognize, test, or examine HM for signs of ongoing illicit drug use.

21. The standard of care when prescribing potentially addictive substances requires a physician closely monitor for, recognize and follow-up on problems suggestive of non-compliance and aberrant drug-related disorders, particularly when prescribing to an individual with a known history of heroin addiction.

22. Respondent deviated from the standard of care by continuing to prescribe methadone for home use and benzodiazepine to HM even when she reported she was actively using heroin and when he was in possession of hospital records documenting her ongoing drug abuse; by failing to recognize obvious red flags from ongoing drug abuse, including repeated early depletion of medication, repeated reports of lost and stolen prescriptions, recurrent abscesses of the extremities and abdomen, two incarcerations, emergency room reports of injury, hospitalization for benzodiazepine overdose, and self-report of recent psychiatric hospitalization; by failing to address obvious red flags with ongoing urine screens; and by repeatedly granting early refills without investigating the cause of early depletion of controlled substances.

23. The standard of care requires a physician exercise appropriate decision-making, render appropriate treatment, and implement referrals when there is evidence of ongoing substance abuse.

24. Respondent deviated from the standard of care by failing to refer HM to an addiction medicine specialist, psychiatrist, or methadone clinic; by continuing to prescribe to HM despite her self-report of continuing heroin use; by continuing to prescribe despite having hospital records wherein the treating physician obtained a history of recent heroin use; by continuing to prescribe methadone to HM even after he was aware she was attending a methadone clinic; and by continuing to prescribe benzodiazepine to HM within days of her hospitalization for benzodiazepine overdose.

25. HM's addiction was perpetuated by Respondent's supplying her with methadone and benzodiazepine for two years without appropriate medical rationale and monitoring and in the presence of aberrant drug seeking behavior and evidence of ongoing heroin use. HM required multiple hospitalizations for prescription medication overdose, required intubation and ventilation during one of these hospitalizations for respiratory failure and aspiration and required psychiatric hospitalization on two occasions following stabilization of her overdose-related medical problems.

26. A physician is required to maintain adequate medical records. An adequate medical record means a legible record 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. A.R.S. § 32-1401(2). Respondent did not document in HM's record that she presented to him after being kicked out of a methadone clinic and did not document several prescriptions for methadone and benzodiazepine.

27. As a result of the review of HM's case, records of Respondent's chronic pain patients were randomly chosen and reviewed. The review supported that each of these patients had evidence of chronic pain generators and no aberrant drug seeking behavior was identified. In Respondent's letter of response to this review, he included a letter of support from patient JC. Based on JC's letter, his records were obtained and reviewed.

28. JC sought treatment from Respondent on December 7, 2005 for chronic pain attributed to a pelvic fracture, facial bone fractures and a spine fracture sustained in 1987 as a result of a motorcycle accident. There are x-rays documenting evidence of an old fracture of the pubic symphysis and fixation plates. JC told Respondent that his treating physician ("Dr. S") prescribed MSContin 600 mg bid and Morphine IR 30 mg prn q 2-3 hours. Respondent did not document why JC was transferring care from Dr. S. to him. Respondent made a notation to obtain Dr. S's medical records, but there is no evidence he obtained the records and/or verified the dosage and response to treatment. At the first visit Respondent assumed prescribing MSContin and Morphine solely on JC's report that this was his ongoing prescription. Respondent also prescribed Diazepam 10 mg and Soma.

29. Respondent was subsequently informed JC's insurance carrier would not authorize Morphine 30 mg #300 concurrent with the MSContin prescription. Respondent did not investigate the obvious discrepancy as to why the carrier would make a sudden reversal in policy if JC had indeed been getting these medications from Dr. S. Respondent prescribed #200 Percocet in lieu of the Morphine, but did not request or get back the written prescription for Morphine, despite the prescription's large street value. On subsequent visits Respondent replaced the Percocet with MS Elixir with multiple refills.

30. Respondent continued to prescribe MSContin and MS Elixir to JC over an eleven month period, up until the time he relinquished his prescribing privileges in the Interim Consent

Agreement for Practice Restriction signed on October 26, 2006. Respondent did not document he discussed precautions, opioid treatment, or urine drug screens with JC.

31. The Board obtained Dr. S's records for JC. The records show JC discontinued treatment with Dr. S in ***2001***, more than four years before he initially presented to Respondent; JC's pain management was assumed by the Veteran's Administration Hospital; the highest dosage of morphine ever prescribed by Dr. S was MSContin 180 mg per day and Morphine 30 mg bid; JC had a history of addiction to methamphetamine and marijuana, and a history of alcohol abuse and binge drinking; JC had multiple positive urine drug screens for methamphetamine while under Dr. S's care; JC had a diagnosis of schizoaffective/bipolar disorder and numerous psychiatric crises while under Dr. S's care; and Dr. S considered JC a high-risk patient for opioid management and noted her prescribing was dependent on JC's adherence to an opioid contract and on JC attending 12-Step groups with a sponsor.

32. When a patient with chronic, non-malignant pain presents initially for pain management, the standard of care requires a physician to evaluate the patient, review and/or obtain pertinent previous medical records, and order any indicated additional studies or consultations.

33. Respondent deviated from the standard of care by not obtaining the prior treating physician's records that would have alerted him to JC's deception and obvious aberrant drug seeking behavior.

34. JC's addictive behavior and/or prescription drug diversion were perpetuated. JC's prescription drug diversion could have perpetuated drug addiction and diversion among members of the public.

35. A physician is required to maintain adequate medical records. An adequate medical record means a legible record 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. A.R.S. § 32-1401(2). Respondent did not document why JC was transferring care from another physician and did not document discussing precautions, an opioid treatment agreement, or urine drug screens.

CONCLUSIONS OF LAW

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

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

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. § 32-1401(27)(j) ("[p]rescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes"); A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

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

IT IS HEREBY ORDERED:

1. Respondent is issued a Decree of Censure for inappropriate narcotic prescribing.

2. Respondent is placed on probation for fifteen years with the following terms and conditions:

a. Respondent's practice is restricted in that he shall not prescribe narcotics. Respondent may petition the Board within five years for termination of probation.

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

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

3. The Interim Consent Agreement for Practice Restriction dated October 26, 2006 remains in effect until the effective date of this Order.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

DATED this 12th day of October 2007.

THE ARIZONA MEDICAL BOARD

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

ORIGINAL of the foregoing filed this 12th day of October, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 12th day of October, 2007, to:

James R. Taylor
Lawless & Taylor, P.C.
4201 North 24th Street – Suite 100
Phoenix, Arizona 85016-0001

Unen D. Hsu, M.D.
Address of Record

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