BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

JEFF CRAWFORD, M.D.

Holder of License No. 18695
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-17-0137A

INTERIM FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER
FOR SUMMARY SUSPENSION OF
LICENSE

INTRODUCTION

The above-captioned matter came for discussion before the Arizona Medical Board ("Board") at its January 4, 2018 meeting, where it had been placed on the agenda to consider possible summary action against Jeff Crawford, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending a formal hearing or other Board action. A.R.S. § 32-1451(D).

INTERIM 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 18695 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-17-0137A after receiving a complaint regarding Respondent's care and treatment of a 58 year-old male patient ("CE") alleging excessive prescribing of opioids.

4. CE began treatment with Respondent in 2006. Respondent prescribed multiple opioid medications for CE between June of 2010 and May 12, 2017 including oxycodone, hydromorphone, fentanyl patches, and morphine sulfate ER, as well as concurrent prescriptions for benzodiazepines and carisoprodol. Prescription records note
multiple early refills for opioid medications prescribed by Respondent during this time period.

5. On May 12, 2017, Respondent prescribed CE oxycodone 20 mg, quantity 120, oxycodone 15 mg, quantity 300, oxycodone 30 mg, quantity 300, and hydromorphone 4 mg, quantity 60. The total daily morphine equivalent ("MED") for that date is 827 mg. Additionally, Respondent concurrently prescribed CE alprazolam 1 mg twice a day and clonazepam 1 mg four times a day during this time period and carisoprodol 350 mg four times a day.

6. A Medical Consultant ("MC") who reviewed Respondent's care of CE noted multiple deviations from the standard of care including failure to establish a legitimate purpose requiring controlled substance medications, prescribing inappropriate dosages and quantities of controlled substances, failure to appropriately monitor CE for aberrant medication usage and failure to document any improvement in pain and function.

7. Patient CE was at risk of potential harm including addiction, adverse medication reactions, overdosing and death versus diversion to others creating similar problems.

8. During the Board's consideration of the above captioned matter on December 6, 2017, Board staff presented the foregoing and related Board staff's concern regarding Respondent's approach to the investigation process. Board staff noted that Respondent failed to respond to no less than ten written or telephonic attempts to contact him, and failed to provide a written narrative as requested by the Board.

9. Respondent provided Board staff with medical records related to CE, but only after Board staff sent a formal request for a staff interview and subpoena for medical records. Respondent was offered an opportunity to enter into an interim consent agreement for a practice restriction, and did not respond. Respondent was provided
notice for the Board’s December 6, 2017 Board meeting, and did not appear for the meeting.

10. Based on the evidence presented, the Board voted unanimously to summarily restrict Respondent’s license, prohibiting him from prescribing controlled substances in the State of Arizona pending the outcome of a formal hearing in the matter. The Board’s Summary Restriction Order was sent to all of Respondent’s addresses of record and emailed to Respondent on December 7, 2017.

11. Board staff subsequently received a complaint alleging that Respondent continued to prescribe controlled substances in violation of the Board’s December 6, 2017 Summary Restriction Order. Board staff obtained Respondent’s Controlled Substance Prescription Monitoring Program (“CSPMP”) profile report, which indicated that Respondent had violated the Summary Restriction Order by issuing prescriptions for controlled substances to patients between December 7, 2017 and December 22, 2017. Based on the CSPMP data, Board staff issued subpoenas to the various pharmacies identified on the report.

12. On December 22, 2017 Board staff contacted Respondent, who admitted to prescribing controlled substances in violation of the Board’s Summary Restriction Order. During the conversation, Board staff verbally advised Respondent that the Summary Restriction Order required him to cease issuing controlled substance prescriptions. Respondent was subsequently notified in writing that he was in violation of the Board’s Summary Restriction Order.

13. During the Board’s consideration of the above captioned matter on January 4, 2018, Board staff presented the foregoing as well as responses received to date from the pharmacies subpoenaed on December 22, 2017. The responses substantiated that Respondent has issued at least 41 prescriptions to various patients since the effective
date of the Board's Summary Restriction Order. Additionally, Board staff reported that an
additional CSPMP report had been obtained, showing that Respondent continued to
violate the Summary Restriction Order by writing prescriptions for controlled substances
through January 2, 2018. Based on the evidence presented, the Board voted to summarily
suspend Respondent's license and refer the matter to the Office of Administrative
Hearings with a recommendation that Respondent's license be revoked.

INTERIM 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(27)(e) ("Failing or refusing to maintain adequate records on
a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct
pursuant to A.R.S. § 32-1401(27)(q) ("Any conduct or practice that is or might be harmful
or dangerous to the health of the patient or the public.").

4. The conduct and circumstances described above constitute unprofessional conduct
pursuant to A.R.S. § 32-1401(27)(dd) ("Failing to furnish information in a timely manner to
the board or the board's investigators or representatives if legally requested by the
board.").

5. The conduct and circumstances described above constitute unprofessional conduct
pursuant to A.R.S. § 32-1401(27)(r) ("Violating a formal order, probation, consent
agreement or stipulation issued or entered into by the board or its executive director under
this chapter.").

6. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public
health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).
ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above,

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 18695, is summarily suspended. Respondent is prohibited from practicing medicine in the State of Arizona and is prohibited from prescribing any form of treatment including prescription medications or injections of any kind.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against Respondent. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this Order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced within sixty days from the date of the issuance of this Order, unless stipulated and agreed otherwise by Respondent. A.R.S. § 32-1451(D).

4. This Order supersedes the Board's December 7, 2017 Summary Restriction Order.

DATED AND EFFECTIVE this ___ day of January, 2018.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Executive Director
EXECUTED COPY of the foregoing mailed this 4th day of January, 2018 to:

Jeff Crawford, M.D.
Address of Record

ORIGINAl of the foregoing filed this 4th day of January, 2018 with:

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

[Signature]
Board staff