

1 .BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **KENNETH M. FISHER, M.D.**

4 Holder of License No. 12762
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-15-1067A
MD-15-1170A

**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR DECREE
OF CENSURE AND PROBATION**

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 February 14, 2018. Kenneth M. Fisher, M.D. ("Respondent"), appeared with legal counsel,
9 Calvin L. Raup, Esq., before the Board for a Formal Interview pursuant to the authority
10 vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue 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 FACT¹**

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

16 2. Respondent is the holder of license number 12762 for the practice of
17 allopathic medicine in the State of Arizona.

18 **MD-15-1067A**

19 3. The Board initiated case number MD-15-1067A after receiving a complaint
20 regarding Respondent's care and treatment of a 32 year-old male patient ("RR") alleging
21 inappropriate prescribing.

22 4. RR began seeing Respondent in 2009. Respondent's records show that
23 Respondent required RR to sign a pain contract and an Agreement for Treatment with
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¹ Respondent originally appeared for a Formal Interview in this matter on April 5, 2017, and the Board voted to issue Findings of Fact, Conclusions of Law and Order for Decree of Censure with Probation and Practice

1 Suboxone, and documented a discussion of the risks and benefits of benzodiazepines and
2 Suboxone. Respondent's records show that RR had previously been diagnosed with
3 sciatica, fatigue, thoracic sprain, and opioid/sedative-hypnotic dependence. In 2012, RR
4 was hospitalized for a multi-drug overdose and completed a detoxification program at that
5 time.

6 5. Between 2013 and 2015, RR received multiple prescriptions from
7 Respondent including buprenorphine, alprazolam, zolpidem, clonazepam, diazepam,
8 modafinil, and armodafinil. Other medications were listed in Respondent's visit notes
9 including trazadone, gabapentin, and Celexa.

10 6. During this time, RR called Respondent on multiple occasions requesting
11 early refills on the buprenorphine and multiple benzodiazepines. Respondent documented
12 that RR was warned about benzodiazepine addiction, that RR cycled his medications and
13 did not take two on the same night, and that RR wished to switch benzodiazepines each
14 month. Respondent also documented that RR admitted to holding onto his last prescription
15 so he could take more due to stress. Regarding these prescriptions, Respondent wrote on
16 December 23, 2014 that he acknowledged that many of their conversations were not
17 recorded in the medical record because RR called after hours or over the weekend.

18 7. Respondent saw RR frequently during this period, with appointments ranging
19 from weekly to monthly, and his notes over this time make reference to additional
20 diagnoses including chronic fatigue syndrome, obsessive-compulsive disorder, anxiety
21 disorder, and post-traumatic stress disorder.

22 8. In January of 2013, when Respondent began prescribing diazepam, he
23 documented that RR was seeing a psychiatrist and therapist who agreed with the low dose
24 Valium. However, in September of 2013, Respondent documented that RR's therapist had
25 never seen him, and in November of 2013, he wrote that RR had not seen his counselor

1 yet. There is no evidence in the medical record to reflect any ongoing communication
2 between Respondent and any mental health professional regarding the patient.

3 9. During January 2, 2013 – October 29, 2015, Respondent wrote a total of 169
4 prescriptions and refills for schedule II, III, and IV controlled substance medications for RR.
5 The Controlled Substance Prescription Monitoring Program (“CSPMP”) record also shows
6 that during this time period, there were multiple episodes where RR was filling
7 prescriptions for the opiate, the stimulant, and up to three different benzodiazepines
8 simultaneously.

9 10. The standard of care required Respondent to discuss the risks, benefits,
10 interactions, precautions, or alternatives with the patient regarding the prescribed
11 medications, and to document evidence of formal evaluation, differential diagnoses, or
12 specific diagnoses to justify the prescribing, and to review the patient’s medication at each
13 visit while considering drug interactions or duplication of treatment. Respondent deviated
14 from this standard of care by prescribing multiple controlled substances without
15 appropriate evaluation or diagnosis, and without appropriate follow-up monitoring.

16 11. The standard of care required Respondent to utilize appropriate precautions
17 regarding prescribing benzodiazepines for a patient with RR’s presentation. Additionally,
18 benzodiazepines are not recommended in cases where there is evidence or history of
19 substance abuse. Finally, the use of benzodiazepines concurrent with buprenorphine
20 therapy is relatively contraindicated. Respondent deviated from this standard of care by
21 prescribing benzodiazepines for inappropriate diagnoses, including anxiety; by prescribing
22 multiple benzodiazepines simultaneously; by prescribing long term benzodiazepines; by
23 prescribing benzodiazepines for a patient with known polysubstance abuse and addiction
24 to opiates and benzodiazepines; and by continuing to prescribe benzodiazepines
25 concurrently with buprenorphine.

1 12. The standard of care for prescribing buprenorphine requires the prescribing
2 physician to establish an appropriate diagnosis and to utilize appropriate patient contracts.
3 The standard of care also requires a physician ensure that the therapy continues to be
4 appropriate, to monitor compliance with urine drug screens and to coordinate care with a
5 patient's mental health care providers. Respondent deviated from the standard of care by
6 failing to appropriately monitor RR's compliance with the treatment, and failing to
7 coordinate care with RR's other providers.

8 13. The standard of care required Respondent to coordinate the patient's care
9 with other treating providers. Respondent deviated from this standard of care by failing to
10 coordinate care with RR's mental health providers.

11 14. Actual harm occurred to the patient in that RR was admitted to the hospital in
12 August of 2015 for issues related to multi-drug addiction.

13 15. There was the potential for patient harm in that RR could have died.

14 **MD-15-1170A**

15 16. The Board initiated case number MD-15-1170A after receiving a complaint
16 regarding Respondent's care and treatment of a 55 year-old female patient ("AG") alleging
17 failure to properly prescribe medication.

18 17. In September of 2011, AG first presented to Respondent with the diagnosis
19 of opioid/sedative-hypnotic dependence. She also described frequent migraine
20 headaches. AG was given a prescription for Suboxone at that time and the medical record
21 states that she was attending AA meetings 4-5 times weekly. AG signed an initial Patient
22 Contract and Agreement for Treatment with Suboxone, and Respondent reviewed a
23 Suboxone protocol with the patient.

24 18. In 2011, Respondent's medical record notes also stated that Bipolar Disorder
25 was added to AG's list of diagnoses, and references that AG was taking Effexor and

1 Trazadone. In late 2011, Respondent began prescribing Fioricet for AG's headaches. AG
2 continued on Suboxone.

3 19. In November, 2011 Respondent prescribed Tylenol with codeine to AG for
4 dental pain and documented that AG weaned off of Suboxone; however, Respondent did
5 not document a treatment plan regarding a weaning process.

6 20. In 2013, the diagnoses of Anxiety and Depression appear in Respondent's
7 notes, and there are references in the record that AG continued to see a counselor and/or
8 attend AA meetings. During this time, Respondent continued to prescribe Fioricet and
9 Suboxone. In April of 2013, AG was hospitalized for an alleged suicide attempt involving
10 the ingestion of large doses of Fioricet. During her hospital stay, AG's psychiatrist called
11 twice requesting to speak to Respondent, but there is no documentation that Respondent
12 ever spoke to the psychiatrist regarding AG.

13 21. For the remainder of 2013, and for the first six months of 2014, there is no
14 mention of Suboxone therapy in Respondent's notes. During this period, Respondent saw
15 AG multiple times for headaches and fibromyalgia. AG received prescriptions for Vicodin,
16 Soma, Dilaudid, Percocet, and Ambien at various visits.

17 22. On June 10, 2014, AG saw Respondent for what he documented as her
18 looking to restart Suboxone and admitting to self-medicating, and having to increase her
19 dosage of prescribed medications to avoid withdrawal symptoms. Respondent restarted
20 Suboxone therapy at that time and recommended that AG re-establish with a behavioral
21 health professional, as he stated that AG had been abandoned in psychiatric therapy.

22 23. In October of 2014, Respondent documented that AG stopped her
23 psychiatric medications. Respondent subsequently started prescribing alprazolam and
24 restarted AG's prescriptions for Fioricet and Soma.

25 24. AG continued to see Respondent regularly into 2015 and prescriptions for
alprazolam, Ambien, Soma, and Suboxone continued despite AG being diagnosed with

1 obstructive sleep apnea in March of 2015. The last recorded visit with AG was August 14,
2 2015, and the final prescription written by Respondent for AG was dated August 4, 2015,
3 at which time a urine drug screen was performed.

4 25. The standard of care required Respondent to discuss the risks, benefits,
5 interactions, precautions, or alternatives with the patient regarding the prescribed
6 medications, and to document evidence of formal evaluation, differential diagnoses, or
7 specific diagnoses to justify the prescribing, and to review the patient's medication at each
8 visit while considering drug interactions or duplication of treatment. Respondent deviated
9 from this standard of care by prescribing multiple controlled substances without first
10 discussing the risks, benefits, interactions, precautions, or alternatives with little evidence
11 of formal evaluation, differential diagnoses, or specific diagnoses to justify the prescribing,
12 and without reviewing AG's medication at each visit, no consideration of drug interactions
13 or duplication of treatment.

14 26. The standard of care required Respondent to prescribe medications in such
15 a manner that does not increase the patient's chance of overdose and death, to
16 discontinue prescribing a medication in a patient with history of overdose from that
17 medication, and to discontinue prescribing multiple sedative-hypnotics in a patient
18 diagnosed with obstructive sleep apnea as to avoid placing the patient at a significantly
19 higher risk of hypoxia and death. Respondent deviated from this standard of care by
20 prescribing multiple sedative-hypnotics simultaneously with Suboxone, significantly
21 increasing the chances of overdose and death, by prescribing Fiorinal despite history of
22 hospitalization for Fiorinal overdose, and by continuing to prescribe multiple sedative-
23 hypnotics after AG was diagnosed with obstructive sleep apnea, another significant risk of
24 hypoxia and death.

25 27. The standard of care for outpatient Suboxone therapy required Respondent
to utilize this therapy in conjunction with psychological counseling, to perform monthly

1 urine drug screens and establish linkage and communication with the patient's mental
2 health providers. A treatment must be discussed and documented, including discussion of
3 disqualifying behaviors, and the patient should be re-evaluated on a regular basis as to the
4 patient's progress or appropriateness in the program. Respondent deviated from this
5 standard of care by inappropriately treating AG as an outpatient for Suboxone therapy
6 given her previous suicide attempt and prescription drug overdose, her use of multiple
7 controlled substances, and lack of consistent psychiatric follow up, lack of re-evaluation as
8 to progress or appropriateness in the program, and lack of routine urine drug screens.

9 28. The standard of care required Respondent to coordinate the patient's care
10 with other providers involved in the patient's treatment. Respondent deviated from this
11 standard of care by failing to coordinate care with AG's other providers.

12 29. Actual patient harm occurred in that Respondent's prescribing practices, and
13 lack of care coordination interfered with the patient's recovery and contributed to ongoing
14 drug-dependency behavior.

15 30. There was the potential for patient harm in that the prescribing of multiple
16 sedative-hypnotic medications (in addition to Suboxone and other opiates) in the face of a
17 previous drug-related overdose, and with a diagnosis of obstructive sleep apnea, placed
18 this patient at high risk of death, disability, and drug dependence.

19 31. During a Formal Interview on this matter, Respondent testified that his use of
20 opioid medication therapy has been significantly reduced, and that to the best of his
21 recollection, he has not prescribed any Schedule II medications to a new patient in a year,
22 except for terminally ill cancer patients. Respondent testified that for all patients he utilizes
23 pain contracts and urine drug screens, conducts his treatment in conjunction with outside
24 consultation, and that he has been in the process of weaning his patients off opioids.
25 Respondent testified that he is no longer treating AG and RR.

1 32. Respondent also testified that he continues to provide care to HIV/AIDS
2 patients, Suboxone maintenance therapy, and hormone replacement therapies to patients
3 undergoing gender conversion.

4 33. Respondent also testified that in the last few years, he has obtained a
5 significant amount of additional continuing medical education ("CME") in controlled
6 substance prescribing, and is working on becoming Board certified in addiction medicine.

7 34. During deliberations, Board members commented that Respondent's
8 ongoing education and changes in practice were mitigating. The Board also took notice of
9 the prescribing limitations included in the recently passed Opioid Epidemic Act. Board
10 members also discussed the underserved patient population to whom Respondent
11 provides care to determine the appropriate disposition of the case. The Board agreed that
12 Respondent's hormone replacement therapy patients were not at issue in these cases,
13 and ultimately determined that chart reviews performed by a Board approved monitoring
14 company with a focus on controlled substance prescribing would best ensure that
15 Respondent has incorporated his CME and new prescribing standards into his practice.
16 Board members discussed an appropriate length of probation, and noted that in the event
17 that Respondent had not remediated the concerns evidenced by these cases by the end of
18 the probationary term, additional probation may be warranted.

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1 **CONCLUSIONS OF LAW**

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

4 2. The conduct and circumstances described above constitute unprofessional
5 conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate
6 records on a patient.").

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

10 4. The conduct and circumstances described above constitute unprofessional
11 conduct pursuant to A.R.S. § 32-1401(27)(ll) ("Conduct that the board determines is gross
12 negligence, repeated negligence or negligence resulting in harm to or the death of a
13 patient.").

14 **ORDER**

15 IT IS HEREBY ORDERED THAT:

- 16 1. Respondent is issued a Decree of Censure.
17 2. Respondent is placed on Probation for a period of 2 years with the following terms
18 and conditions:

19 **a. Chart Reviews**

20 Within 30 days of the effective date of this Order, Respondent shall enter into a
21 contract with a Board-approved monitoring company to perform periodic chart reviews at
22 Respondent's expense. The chart reviews shall involve current patients' charts for care
23 rendered after February, 2018 and shall focus on Respondent's controlled substance
24 prescribing practices. Based upon the chart review, the Board retains jurisdiction to take
25 additional disciplinary or remedial action.

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 ordered
4 criminal 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 3. Prior to the termination of Probation, Respondent must submit a written request to
14 the Board for release from the terms of this Order. Respondent's request for release will
15 be placed on the next pending Board agenda, provided a complete submission is received
16 by Board staff no less than 30 days prior to the Board meeting. Respondent's request for
17 release must provide the Board with evidence establishing that he has successfully
18 satisfied all of the terms and conditions of this Order. The Board has the sole discretion to
19 determine whether all of the terms and conditions of this Order have been met or whether
20 to take any other action that is consistent with its statutory and regulatory authority,
21 including continuing the probation.

22 4. The Board retains jurisdiction and may initiate new action based upon any violation
23 of this Order.

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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. R4-16-103. Service of this order is effective five (5) days after
7 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
8 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

11 DATED AND EFFECTIVE this 18th day of April, 2018.

12 ARIZONA MEDICAL BOARD

13 By Patricia E. McSorley
14 Patricia E. McSorley
15 Executive Director

16 EXECUTED COPY of the foregoing mailed
17 this 18th day of April, 2018 to:

18 Calvin J. Raup, Esq.
19 Biltmore Pavilion, Suite A-114
20 2525 E Arizona Biltmore Circle
21 Phoenix, AZ 85016
22 Attorney for Respondent

23 ORIGINAL of the foregoing filed
24 this 18th day of April, 2018 with:

25 Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Mary Bobey
Board Staff