.BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOHN J. SEARS, M.D.** Holder of License No. 27392 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-16-0589A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION**

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 13, 2018. John J. Sears, M.D. ("Respondent"), appeared with legal counsel, Scott Hergenroether, Esq., before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue 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 number 27392 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-16-0589A after receiving a complaint regarding Respondent's care and treatment of a 37 year-old male patient ("CP") alleging inappropriate prescribing and failure to properly treat the patient.

Patient CP

4. In December of 2011, CP established care with Respondent as his primary care physician. CP had previously been followed by other medical providers at Respondent's clinic, and had been referred to an orthopedic clinic for foot pain. CP had a history of left foot surgery in 2010 for repair of bunion deformity after which he complained of persistent aching and burning sensations in both feet. CP underwent evaluations from

his foot surgeon, pain specialist, and a neurologist. These specialists found no evidence of a peripheral neuropathy, but MRI scanning showed a possible nerve root compression in the lumbo-sacral spine and CP was offered therapeutic injections, which he declined. At the time of his initial evaluation by Respondent, CP also had a documented history of anxiety and ADHD, for which CP was being seen by behavioral health professionals and treated with prescriptions for both a benzodiazepine and amphetamine.

5. At his initial visit with Respondent, CP complained of ongoing pain in his feet and back, and Respondent prescribed hydromorphone for pain at that time. Two weeks later at a follow up appointment, Respondent prescribed CP a long-acting morphine product in addition to continuing the hydromorphone. As part of initiating long-term opiate pain treatment in this patient, Respondent discussed and entered into a pain contract with CP, performed a urine drug screen, and he reviewed the Controlled Substance Prescription Monitoring Program ("CSPMP") database.

6. Respondent continued to prescribe hydromorphone and morphine to CP over the next five years, with most prescriptions refilled without in-person visits by the patient. Throughout this period, CP continued to concurrently see psychiatry and behavioral health professionals and their updates were entered into his medical record, reflecting the ongoing diagnoses of ADHD, PTSD, anxiety, and depression as well as the ongoing prescribing of Xanax and amphetamine.

7. On May 11, 2015, CP requested replacement medications, claiming that the previous prescriptions were stolen. Respondent requested that CP provide a police report of the theft, and issued replacement prescriptions. On November 17, 2015, Respondent notified CP in writing that if he could not attend in-person appointments more than twice a year, Respondent would not continue to write prescriptions. On December 8, 2015, refills of both prescriptions were filled by phone order by Respondent.

8. On both December 9 and 10, 2015, CP presented to an emergency room with complaints of withdrawal symptoms from pain medications and expressed a desire for substance abuse rehabilitation, but left after declining the offered treatment. CP's mother contacted Respondent after the second failed admission and notified him regarding her concerns that CP was abusing his prescribed medications.

9. On December 11, 2015 Respondent saw CP at his office noting a presenting complaint of "Report of injection drug abuse," and an assessment and plan of "Drug Abuse. No more prescriptions for controlled substances." Respondent notified CP in writing that he was terminating the physician-patient relationship for violation of the pain contract. On December 23, 2015, Respondent again saw CP, and restarted prescriptions for hydromorphone and morphine, noting in the record that he did not believe the mother's report of substance abuse.

10. During the course of the Board's investigation, three additional patients' charts were obtained for a quality of care review of Respondent's current patients with long-term opiate use of over two years.

Patient JH

11. This is a 51 year-old male who established care with Respondent for chronic pain management for spinal stenosis status-post five back surgeries. Respondent prescribed JH a pain management regimen of morphine ER 200mg #60/month, morphine 30mg #180/month, and fentanyl patch 100mcg #15/month since December of 2014.

12. From December 9, 2014 through September 28, 2016, JH had two office visits even though he was receiving medications on a monthly basis. JH had an emergency room visit in December of 2015 and a documented phone call regarding possible sleep apnea. JH was next seen by Respondent in September of 2016 and then again in February of 2017 at which time Respondent documented a discussion regarding

reduction of his pain medication. JH was also receiving clonazepam from another provider during Respondent's treatment.

Patient JD

13. This is a 49 year-old male to whom Respondent provided chronic pain management due to back problems. Respondent prescribed JD a regimen of morphine 30mg #240/month, morphine ER 100mg #90/month, and gabapentin 100mg tab #60/month from October 2, 2015 to December 28, 2016.

14. Between 2014 and 2016, JD averaged three visits per year while receiving monthly telephonic refills for medications prescribed by Respondent.

Patient RB

15. This is a 60 year-old male to whom Respondent provided chronic pain management due to polyarthritis. Respondent prescribed RB a regimen of morphine ER 100mg #90/month (from January 28, 2013 to January 25, 2017 aside from period in May 11, 2016 to January 25, 2017 when he was on 200mg bid), morphine 30mg #240/month (from April 20, 2016 to January 25, 2017; he was on #210 from March 13, 2014 to April 20, 2016), and baclofen 10mg #90/month (from September 9, 2015 to August 16, 2016). RB's insurer sent Respondent multiple letters warning of excessive drug utilization.

16. On May 20, 2016, RB's chart included a noted diagnosis of (accidental) drug overdose due to cutting one of his 200mg tablets in half. RB was found to have methamphetamines and barbiturates in his urine drug screen on January 19, 2017 and as a result was discharged as a pain management patient on February 9, 2017.

Deviations from the Standard of Care

17. The standard of care requires a physician to perform an adequate patient assessment prior to initiating treatment with long-term opiate pain medications, and to monitor the patient's condition during the ongoing treatment of chronic pain with opiates.

Respondent deviated from the standard of care by starting CP on long-term opiate pain medications without an adequate patient assessment, and continued without adequate monitoring of the patient's condition.

18. The standard of care requires a physician to consider and/or address the patient's concurrent psychiatric conditions and prescribed benzodiazepines and amphetamine, and coordinate care with the patient's other treating providers. Respondent deviated from the standard of care by failing to consider or address CP's concurrent psychiatric conditions and prescribed benzodiazepines and amphetamines, and by failing to coordinate care with the patient's treating providers.

19. The standard of care requires a physician to investigate concerns relating to the possible abuse of prescribed opiates. Respondent deviated from the standard of care by failing to appropriately investigate concerns regarding possible abuse of prescribed opiates by CP.

20. The standard of care requires a physician to demonstrate respect for patients and their families, and should avoid conduct that may negatively affect patient care. Respondent deviated from the standard of care by using poor professional judgment and treating the patient's mother with unnecessary disrespect.

21. The standard of care for a patient on chronic pain management requires a physician to see the patient on a regular basis to verify compliance, assess symptoms and side effects, and identify opportunities to minimize medicine load. With regard to Patients JH, JD and RB, Respondent deviated from the standard of care by failing to utilize the opportunities to reduce pain medication amounts when the patients were stable.

22. The standard of care for a patient on chronic pain management requires a physician to see the patient in the office on a monthly, bimonthly, or even quarterly basis for evaluation when refills of medication are given. With regard to Patients JH, JD and RB,

Respondent deviated from the standard of care by providing monthly pain medication refills to patients JH, JD, and RB without requiring regular follow up.

23. With regard to CP, There was actual patient harm in that CP developed a physical dependence on opiates, evidenced by his withdrawal symptoms when not taking the drugs. CP developed a tolerance to opiates, evidence by requiring dosage increases of both morphine and hydrocodone.

24. With regard to patients JH, JD and RB, all three patients developed a dependence on the opioid medications and needed to take them on a monthly basis.

25. With regard to CP, he was at risk for potential harm in that CP may have also developed an addiction to opiates. By not addressing these behaviors and not adequately investigating the concerns of the ER physician or the patient's mother, and by refusing to communicate with the patient's family, Respondent put this patient at risk for ongoing problems associated with addiction such as physical deterioration and worsening mental health.

26. With regard to JH, this patient was identified by another provider with potential sleep apnea which is an affliction that can potentially lead to the affected person to stop breathing. High doses of pain medications are also associated with depression of respiratory drive. Respondent's failure to timely address this finding put the patient at risk of respiratory depression and death.

27. Patient RB was at risk for abuse and diversion of medications.

Procedural History

28. On December 6, 2017, the Board met to consider summary action against Respondent, based on the above findings. Respondent appeared with counsel, and after review of the case and deliberation with counsel, the Board determined not to take any action at the time, provided the Respondent promptly schedule and complete a Board-

approved intensive, in-person continuing medical education ("CME") course in controlled substance prescribing.

29. On January 20-21, 2018, Respondent completed a Board-approved course in Opioids, Pain Management and Addiction for a total of 21 hours.

30. During a Formal Interview on this matter, Respondent testified that since completing the CME, he has established a practice of seeing his patients a minimum of every 90 days, and utilizes a new pain management contract that requires any patient taking more than 90 daily morphine equivalent dose ("MED") to consult with a pain management specialist. Respondent testified that obtaining consultations and in-person patient visits can be challenging due to the lack of qualified providers in his geographic area. Respondent also testified that his practice instituted electronic medical records ("EMR") in 2013 and electronic prescribing approximately a year and a half ago. Respondent stated that he had a steep learning curve with instituting EMR.

31. Respondent testified that he has changed his practice, and is encouraging his patients to taper their doses as much as possible, or to eliminate the use of opioids all together. Respondent stated that he has had difficulty coordinating care with psychiatrists caring for his patients, but that there are a few providers who will speak with him about shared patients. In response to an inquiry about how to identify a patient who may be misusing opioids, Respondent testified that he would review the CSPMP, check for early refills, and examine patient demeanor to look for signs of abuse or diversion. Respondent testified that he has instituted urine drug screens for patients receiving opioids.

32. During that same Formal Interview, Board members commented that while his testimony regarding recent practice changes was positive and mitigated the need to restrict his practice, probation with chart reviews for care provided after completion of the

CME would provide reassurance that Respondent had fully incorporated his recent CME into his practice.

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.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on Probation for a period of 1 year with the following terms and conditions:

a. Chart Reviews

Within 30 days of the effective date of this Order, Respondent shall enter into a contract with a Board-approved monitoring company to perform periodic chart reviews at Respondent's expense. The chart reviews shall involve current patients' charts for care rendered after January, 2018. Based upon the chart review, the Board retains jurisdiction to take additional disciplinary or remedial action. After two consecutive favorable chart reviews, Respondent may petition the Board for termination of probation as stated herein.

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

c. Tolling

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

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

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he/she 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 AND EFFECTIVE this 17th day of April, 2018.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

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

James. E. Ledbetter
Ledbetter Law Firm, PLC
1003 N Main Street
Cottonwood, AZ 85326
Attorney for Respondent

ORIGINAL of the foregoing filed
this 17th day of April, 2018 with:

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

Mary Babey
Board staff