BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of:

GREGORY J. PORTER, M.D.,

Holder of License No. 14879
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No.17A-14879-MDX

FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER
(Revocation of License)

On April 17, 2018, this matter came before the Arizona Medical Board
("Board") for consideration of Administrative Law Judge (ALJ) Diane Mihalsky's
proposed Findings of Fact, Conclusions of Law and Recommended Order.
Gregory J. Porter, M.D., ("Respondent") appeared before the Board on his own
behalf; Assistant Attorney General Anne Froedge represented the State. Assistant
Attorney General Elizabeth A. Campbell was available to provide independent
legal advice to the Board.

The Board, having considered the ALJ's Decision and the entire record in
this matter, hereby issues the following Findings of Fact, Conclusions of Law and
Order.

FINDINGS OF FACT
BACKGROUND AND PROCEDURE

1. Dr. Porter is the holder of Board-issued License No. 14879 for the
practice of allopathic medicine in the State of Arizona. The Board referred this
matter to the Office of Administrative Hearings, an independent state agency, for an
evidentiary hearing.

2. Dr. Porter treated V.C., a 60-year-old female patient, on March 2,
3. On or about August 17, 2016, the Board received a complaint from one of V.C.'s daughters that Dr. Porter's prescription of methadone to V.C. had caused her death.1 On August 22, 2016, the Board notified Dr. Porter of the complaint.2

4. On September 1, 2016, the Board notified Dr. Porter that its investigation of the complaint had been moved for further review and requested that he complete a narrative response to the complaint and provide a complete copy of V.C.'s medical records to assist in its review.3

5. On or about September 14, 2016, Dr. Porter provided a narrative response to the complaint, in relevant part as follows:

[V.C.'s] main symptom was chronic pain secondary to fibromyalgia and degenerative joint disease, manifesting mostly in her lumbar spine with occasional sciatica, there was no history of orthopedic surgery. The second main symptom was severe stress, and she denied any depression. Besides pain and anxiety the rest of the RS were negative. Her other medical problems were high blood pressure and hypothyroidism. Her medications were amlodipine 5mgs, HCTZ and Lisinopril the latter two she did not know the milligram but she thought was 25 and 10 respectively and ibuprofen 800 mgs tid. She also stated that she was prescribed levothyroxine .3 mgs and was not taking it regular because “it was too expensive.” She was also taking Xanax 35 mgs bid and tizanidine 4 mgs bid, and she denied any recent muscle spasms. She stated that her primary care physician for over ten years was Dr. Rene Lucas, who had been prescribing morphine 30 mgs po qhs and oxycodone 15 mgs po bid. She also stated that she had smoked cigarettes all her life and recently also E-cigarettes, she denied any SOB nor chronic cough.

I told her that if we were to make progress on her health, both parties patient and physician would have to be responsible. Therefore I told her it was not appropriate to have money for cigarettes but not for her thyroid supplement, since the latter was very important to take and being generic was not expensive.

My clinical Impression was she had hypertension poorly controlled and possible kidney damage from the high dosage of ibuprophen.

1 See the Board's Exhibit 1
2 See the Board's Exhibit 2. Another of V.C.'s daughters filed another complaint with the Board on or about September 12, 2016. See the Board's Exhibit 5.
3 See the Board's Exhibit 3.
Also I was concerned about her thyroid disease since she was non-compliant, and her potential for emphysema secondary to her tobacco abuse. From her gait and examination I did not feel she necessitated opiate analgesic. I told her that [amitriptyline] 25 mgs at bedtime is often helpful for sciatic pain, stress, and sleep. I also told her that I wanted to increase her milodipine to 10 mgs and hold on the Lisinopril and HCTZ til her next appointment, which I made for four days. I also insisted that she do blood chemistries that same day. On her return visit her blood pressure was stabilized at 130/78 and heart regular at 78 and no S4 was noted. She admitted that pain and her anxiety was less. I also stated to her that she be compliant with her levothyroxine .3 mgs since her TSH was 31.55. Because of her kidney damage she was told to stop ibuprophen. Since there was a fear [of] withdrawal I felt it appropriate to prescribe methadone 10 mgs three times a day and to take only when needed for severe pain. I also emphasized the importance of water aerobics, a proper diet, and most importantly to discontinue her smoking. She was given a prescription for follow-up laboratories and an appointment in two weeks.

Unfortunately, she deceased before the third visit to my office. The daughter . . . insisted on a private autopsy and the paperwork was filled out, though it was never done. It is my honest and clinical opinion that I did nothing to have caused her death. Presently I am a healthy 66 year-old man, who is semi-retired and see only approximately eight patients per day, for four days a week. All patients are given an hour for the initial visit and at least 30 minutes for any followup visits. I am honored to be in a profession I love and I try to give the highest quality of care to all patients.4

Dr. Porter enclosed V.C.'s medical records with his narrative response.

6. The Board obtained additional records from the healthcare providers who treated V.C. before Dr. Porter and printouts from the Arizona Board of Pharmacy's Controlled Substance Prescription Monitoring Program database ("CSPMP"). These documents were not included in Dr. Porter's records for V.C.

The Board furnished all the documents that it had obtained during its investigation to its outside medical consultant, William Thompson, M.D.

7. Dr. Thompson reviewed the records and on February 20, 2017, issued a report that opined that Dr. Porter's care of V.C. deviated from the standard of care
in three respects. Board staff requested that Dr. Porter file a supplemental response to Dr. Thompson’s report, but he did not do so.

8. On April 13, 2017, the Board’s Staff Investigational Review Committee (“SIRC”) considered the matter and determined that Dr. Porter’s care of V.C. deviated from the standard of care in the ways that Dr. Thompson had identified. SIRC noted that Dr. Porter’s care of V.C. had caused actual harm in that the pathologist who performed an autopsy noted that the methadone and amitriptyline that Dr. Porter had prescribed contributed to her death. As mitigating factors, SIRC found the following:

As per the autopsy and police reports, 17 tablets of methadone were missing from the patient’s bottle at the time of her death. As 5 days had passed between the fill of this medication and the time she was last seen alive by family members, this indicates that she had exceeded her prescribed dose during the period she was taking methadone. This was a likely contributor to her death. Further, in the police report it is noted that the patient had been exhibiting a marked change in her behavior and was having “difficulty communicating as she was ‘slurring’ her words” over the days preceding her death. Had these changes and symptoms been brought to the attention of her physician or assessed in a health care facility, one can’t help but hope that his unfortunate outcome would have potentially been avoided.

SIRC recommended that the Board issue a Decree of Censure and Probation with Practice Restriction, prohibiting Dr. Porter from prescribing methadone for the duration of his licensure in Arizona, and that the Board offer Dr. Porter a consent agreement under which a Board-approved monitoring company would perform periodic chart reviews.

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4 The Board’s Exhibit 4.
5 See the Board’s Exhibit 10.
6 See the Board’s Exhibit 11.
7 The Board’s Exhibit 13 at 2-3. Dr. Thompson’s report noted the same mitigating factors. See the Board’s Exhibit 10 at 4.
9. Dr. Porter declined the consent agreement that the SIRC recommended. At its meeting on May 4, 2017, the Board considered the matter. V.C.'s daughters addressed the Board. Dr. Porter also spoke, stating that he did not believe that methadone was a factor in V.C.'s death. Board members stated during their discussions that Dr. Porter did not appear to understand the ramifications of his prescribing and the drug-to-drug interactions of the medications he prescribed to V.C. One Board member was particularly concerned that Dr. Porter did not address the findings on the autopsy for V.C.\(^8\) The Board voted to summarily restrict Dr. Porter's license to prohibit him from prescribing controlled substances.

10. On May 5, 2017, the Board's executive director signed Interim Findings of Fact, Conclusions of Law and Order for Summary Restriction of License, restricting Dr. Porter from prescribing controlled substances in the State of Arizona. The order stated that because the Board determined that Dr. Porter's conduct and the circumstances that the Board found in its investigation had required that it take the emergency action of summarily restricting his ability to prescribe controlled substances in Arizona to protect the public health, safety, or welfare under A.R.S. § 32-1451(D).\(^9\)

11. The Board referred the matter to the Office of Administrative Hearings, an independent state agency, for an evidentiary hearing. On May 25, 2017, the Board issued a Complaint and Notice of Hearing. The hearing was continued several times due to Dr. Porter's health issues.

\(^8\) See the Board's Exhibit 20.  
\(^9\) See the Board's Exhibit 19.
12. On January 16, 2018, the Board issued a First Amended Complaint and Notice of Hearing, which also alleged that Dr. Porter had continued to prescribe controlled substances after the May 5, 2017 order summarily restricting his license. The First Amended Complaint and Notice of Hearing charged Dr. Porter with having committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(e), (q), and (r).

13. A hearing was held on February 21, 2018. The Board submitted 23 exhibits and presented the testimony of two witnesses: (1) Raquel Rivera, the Board’s Investigations Manager; and (2) Dr. Thompson. Dr. Porter submitted two exhibits and testified on his own behalf.

**Additional Hearing Evidence**

14. On V.C.’s first visit to Dr. Porter on March 2, 2016, he identified her chief complaint as “Chronic Pain,” secondary to fibromyalgia and lumbar stenosis with “all over” pain and occasional sciatica in the absence of a history of prior surgery. Dr. Porter also documented “severe stress” as a subjective complaint. He also noted that V.C.’s medication list included Morphine 30 mg at bedtime, oxycodone 15 mg twice daily, tizanidine 4 mg twice daily and Ibuprofen 800 mg three times daily for her pain, in addition to prescriptions for Xanax for anxiety and amlodipine. Dr. Porter noted that V.C. had a history of hypothyroidism, but was non-compliant with her medication for that condition.10

15. On March 2, 2016, Dr. Porter performed a physical examination of V.C. and documented tenderness over the lumbar spine at L3/4 with normal reflexes and no focal neurologic deficits. Dr. Porter’s plan was to add amitriptyline, to recommend water exercise, and to “consider methadone.” For V.C.’s non-pain
complaints, Dr. Porter ordered lab studies and adjusted V.C.’s blood pressure medications.

16. According to the CSPMP\(^{11}\) and V.C.’s medical records from previous providers,\(^{12}\) V.C.’s last prescriptions for morphine and oxycodone would have been due for refill on or about March 4, 2015, two days after her first office visit to Dr. Porter.

17. Dr. Porter saw V.C. again on March 7, 2016. V.C. reported improved pain and sleep and that she was more relaxed with amitriptyline. According to Dr. Porter’s office note, V.C. stated “I need morphine.” Dr. Porter recorded V.C.’s medication list as unchanged from the prior visit. Dr. Porter performed another physical examination and noted tenderness at L3/4. Dr. Porter documented a plan for V.C.’s pain including the addition of methadone 10 mg three times daily as needed and “—MS or oxy.”\(^ {13}\)

18. On March 12, 2016, V.C.’s daughter found her unresponsive and V.C. was later pronounced dead. After performing an autopsy, Michael Iliescu, M.D., concluded that V.C.’s cause of death was “[m]ixed drug toxicity, methadone and amitriptyline”\(^ {14}\) with a contributory cause of death as arteriosclerotic cardiovascular disease.

19. Dr. Thompson has been licensed to practice allopathic medicine since 2010. He is employed by Envision Health Care as a pain medicine specialist. Dr. Thompson is a board-certified pain specialist and practices outpatient pain

\(^{10}\) See the Board’s Exhibit 4 at 7.
\(^{11}\) See the Board’s Exhibit 6.
\(^{12}\) See the Board’s Exhibit 7.
\(^{13}\) See the Board’s Exhibit 4 at 8.
\(^{14}\) See the Board’s Exhibit 9.
management and intervention. Dr. Thompson completed a residency and internship in pain management and intervention and has practiced in those areas since he began his career.

20. Dr. Porter was first licensed to practice allopathic medicine in Arizona in 1984. He is board-eligible in internal medicine. For the last three years, the primary focus of his practice has been in internal medicine and geriatrics. Chronic pain patients comprise less than 5% of his practice. He testified that he last had specialized training in treating chronic pain 8 years ago at Odyssey (then Gentiva) Hospice, but that he has not had any specialized training in pain management.

21. Dr. Thompson’s report stated the following proposed standard of care and his opinion that Dr. Porter had deviated from the standard in certain respects, in relevant part as follows:

The standard of care for the evaluation and management of a patient who has been treated with chronic opiate therapy includes assessing the efficacy of the current regimen with respect to improvement in functional level and pain level and as well assessing any significant side effects with the current regime.

In the care of VC, a decision as to the necessity of opiate therapy was made based upon analysis of the patient’s gait and exam at initial consultation, which would have been performed at a time when the patient was taking her usual, chronic opiate regimen. No diagnostic studies, outside record or pharmacy board report information was utilized at the time of that assessment. Further it would be difficult to make the decision that a particular medication therapy was not necessary, when it would have directly contributed to the patient’s examination findings and gait at the time of the evaluation.15

Dr. Thompson testified at the hearing that when Dr. Porter first saw V.C., she was stable after eight years of opioid therapy for her chronic pain. The standard of care

15 The Board’s Exhibit 10 at 2, 3.
required Dr. Porter to consider diagnostic studies, outside records, and information from the Pharmacy Board before he initiated or changed V.C.’s opiate therapy.

22. Dr. Porter testified that three or four hundred people die every day from opioids. Because he did not believe that V.C.’s symptoms required opioid therapy, he felt that she should discontinue morphine and oxycodone. Because V.C. feared withdrawal, on March 7, 2016, he prescribed methadone. Dr. Porter testified that it was difficult to get a patient’s prior records and that the bond between a doctor and his patient is sacred. He trusted that what V.C. told him about her health conditions and prior treatment was accurate.

23. Dr. Thompson’s report stated the following proposed standard of care and his opinion that Dr. Porter had deviated from the standard in certain respects, in relevant part as follows:

The standard of care when converting a patient from one opiate medication to another is to account carefully for current regimen/dosing and to account for incomplete cross-tolerance: which refers to the fact that a patient’s tolerance to one opiate medication is NOT equivalent to their tolerance to another opiate medication. As such any calculated “equivalent” dose to a new opiate must be appropriately decreased for incomplete cross-tolerance to avoid unintentional overdose.

Methadone is a particularly challenging medication with respect to incomplete cross-tolerance and in general with respect to opiate management. As such the standard of care would require a physician prescribing Methadone to be familiar with the tenets of utilization of this medication. Methadone dosing calculations are based on variable conversion ratios based on starting dose, and due to its long half-life, the effects of a particular dose may not be evident for days. In addition, methadone is associated with prolongation of the QT interval and as such can lead to potentially fatal arrhythmias, and has multiple drug-drug interactions.

At the patient’s second visit to the clinic, she requested refill of her chronic opiate medication. The timing of her last dose of Morphine and oxycodone was not documented so it was unable to [be] known with certainty. Per her fill dates on the pharmacy board report, she could have run out of her medications 3 days prior to this
appointment, however if she had any remaining tablets from a prior prescription she could have been on her usual dose at that time. As such, when the decision was made to convert her opiate regimen from Morphine/Oxycodone to Methadone an accurate calculation of starting dose was unable to be done. Further, if either the scenario of her being on her chronic dose of that of her being off of medications for several days, starting her at a dose of 30mg of methadone/day represented a starting dose well above what would have been recommended. Compounding this, the duration of action of methadone with respect to analgesia is shorter than its duration of action with respect to other physiologic effects (such as respiratory depression), in particular during initiation of therapy. As such if not given appropriate guidance on expectations, patients may take more than prescribed due to lack of analgesia in early therapy, in particular when instructed to take the medication as needed for pain. In this case as well, it may have been prudent to consider obtaining a baseline EKG (to assess for QT prolongation) prior to starting methadone.\footnote{The Board's Exhibit 10 at 2, 3.}

Dr. Thompson testified that because Dr. Porter's records for V.C. were partially illegible and not detailed, it was impossible to know the discussion he had with V.C. when he prescribed methadone to her. Dr. Thompson testified that it was important for continuity of care for subsequent providers to be able to understand the care rendered by a previous provider.

24. Dr. Porter testified that he had a detailed discussion with V.C. about taking the methadone. Dr. Porter testified that he takes time to talk to and communicate with his patients, rather than spending time creating a detailed electronic record.

25. Dr. Thompson testified that Dr. Porter had moved V.C. to a higher risk medication without sufficient justification or analysis. Dr. Thompson testified that when Dr. Porter first saw V.C., she was taking 75 mg/day morphine equivalent. Due to a patient's incomplete cross-tolerance to methadone, most experts agree
that the starting dose of a new opiate needs to be reduced 50%. Dr. Thompson
testified that the morphine equivalent starting dose for methadone for V.C. should
have been much lower than what Dr. Porter prescribed.

26. Dr. Thompson's report stated the following proposed standard of care
and his opinion that Dr. Porter had deviated from the standard in certain respects, in
relevant part as follows:

    In the management of medication therapy, the standard of care
    includes knowledge of potential drug-drug interactions. These should
    be accounted for in the decisions to prescribe particular medications
    and in the counseling of the patient in this regard.

    In the care of VC, the potential for increased CNS depression, QT
    prolongation and cardiac arrhythmias existed with the combination of
    amitriptyline and methadone, in particular as both of those
    medications were new for the patient. As noted above, baseline EKG
    could have been considered in this case, not only for the institution of
    methadone alone, but as well in particular given the combination of
    methadone and amitriptyline. 17

Dr. Thompson testified that the general consensus in the medical profession is that
for patients with known risk factors, such as V.C. because she had been diagnosed
with hypertension and arteriosclerotic cardiovascular disease, a baseline EKG
should be taken before prescribing new medications that could cause respiratory
depression, cardiac arrhythmias, and potential overdose.

27. Dr. Porter noted that according to V.C.'s medical records, on May 24,
2011, she had been diagnosed with sleep apnea. 18 Dr. Porter testified that he
specifically asked V.C. whether she had sleep apnea and she responded that she
did not. Dr. Porter testified that he never would have prescribed methadone to V.C.
if he had known that she had sleep apnea.

17 The Board's Exhibit 10 at 2, 3.
18 See the Board's Exhibit 8 at 279.
28. Dr. Porter noted that when V.C. was found unresponsive, she had not followed his instructions and had taken more methadone than he prescribed. In addition, neither V.C. nor her daughters had called him or taken her to the ER when she was slurring her speech. Dr. Porter testified that he has a small practice and that he would have seen V.C. immediately.

29. Dr. Thompson opined that V.C. suffered actual harm in that she died and according to the pathologist who performed the autopsy, the cause of death was combined drug toxicity from methadone and amitriptyline.

30. Dr. Porter testified that the autopsy was performed by a doctor whom the family had hired. The report was not reliable because it characterized V.C.’s lungs as normal, even though V.C. had been a smoker for 20 years. Dr. Thompson noted that the autopsy report stated that “[b]oth lungs are markedly congested.”

31. After the Board issued the May 5, 2017 order summarily restricting Dr. Porter’s ability to prescribe controlled substances, it obtained a CSPMP to verify his compliance with the order. The Board determined that Dr. Porter apparently had continued to prescribe controlled substances, which it verified by obtaining hard copies of the prescriptions for a controlled substance that Dr. Porter had written for patient S.U.

32. Dr. Porter testified that he thought that the May 5, 2017 order would not be effective before the DEA served the order on him. Dr. Porter testified that he only wrote prescriptions for controlled substances for long-term patients who could not obtain their medication elsewhere on short notice.

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19 The Board’s Exhibit 9 at 3.
20 See the Board’s Exhibits 14, 15, 16, and 17.
21 See the Board’s Exhibit 23.
33. The Board submitted evidence of its history of disciplinary and nondisciplinary measures against Dr. Porter's medical license, as follows: (1) On November 16, 2016, the Board issued an advisory letter in Case No. MD-15-1450A; (2) On February 17, 2009, the Board issued an advisory letter for Dr. Porter initiating Methadone at a higher dose than recommended for a patient's chronic pain and required him to complete 15-20 hours of CME in prescribing opioids in Case No. MD-08-0592A; (3) On August 9, 2002, the Board issued a Letter of Reprimand and placed Dr. Porter's license on probation for five years after Dr. Porter arrived at a hospital in a state of intoxication intending to treat a patient in Case No. MD-01-0536; and (4) On November 23, 1998, the Board reprimanded Dr. Porter for his unprofessional conduct in removing a tattoo from an intoxicated patient in Case No. 10464.  

34. Dr. Porter submitted a letter dated February 16, 2018, from Herbert McReynolds, M.D., F.A.C.E.P., the Medical Director of Emergency Services at Carondelet St. Mary's Hospital. Dr. McReynolds' letter stated that he had known Dr. Porter since 1984, and that Dr. Porter had always provided exemplary care to his patients who had been referred to or who presented at the Emergency Center. Dr. McReynolds had never had any concerns about the quality of care that Dr. Porter rendered to his patients. Dr. McReynolds concluded his letter with the following description of Dr. Porter:

Dr. Porter is . . . a genuinely kind man who has always wanted the best for his patients and has provided excellent care for them. It's unfortunate that this case has shed doubt on his abilities. We all have encountered difficult cases over the years but I have no doubt that Dr. Porter did what he thought was best for the patient in question for this case. He has always had excellent critical thinking skills, so if something untoward happened, my belief is that it was beyond his

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22 See the Board's Exhibit 21.
control and was most likely the result of progression of underlying disease.\textsuperscript{23}

35. Dr. Porter also submitted his resume, which showed extensive experience, including as the Medical Director of numerous facilities and as volunteer under Catholic Relief Services in Cambodia in between 1989 and 1992, and extensive education and three residencies in internal medicine.\textsuperscript{24}

**CONCLUSIONS OF LAW**

1. The Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona. This matter lies within its jurisdiction.\textsuperscript{25}

2. The Board bears the burden of proof to establish cause to sanction Dr. Porter’s license to practice allopathic medicine and factors in aggravation of the penalty by clear and convincing evidence.\textsuperscript{26} Dr. Porter bears the burden to establish affirmative defenses and factors in mitigation of the penalty by the same evidentiary standard.\textsuperscript{27} Clear and convincing evidence is “[e]vidence indicating that the thing to be proved is highly probable or reasonably certain.”\textsuperscript{28}

3. A.R.S. § 32-1401(2) defines “adequate records” as follows:

"Adequate records" means legible medical records, produced by hand or electronically, 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.

\textsuperscript{23} Dr. Porter's Exhibit 2.
\textsuperscript{24} See Dr. Porter's Exhibit 1.
\textsuperscript{25} See A.R.S. § 32-1401 et seq.
\textsuperscript{26} See A.R.S. §§ 41-1092.07(G)(2) and 32-1451.04; A.A.C. R2-19-119(B); see also Vazzano v. Superior Court, 74 Ariz. 369, 372, 249 P.2d 837 (1952).
\textsuperscript{27} See A.A.C. R2-19-119(2) and (3).
\textsuperscript{28} BLACK'S LAW DICTIONARY at 596 (8th ed. 1999).
Dr. Thompson credibly testified that parts of Dr. Porter’s records for V.C. were illegible and did not contain sufficient detail to document any discussions he may have had with V.C. Dr. Porter did not dispute that his records were hard to read and did not contain much detail, but argued that his time was better spent talking to patients than making a legible, detailed record. The Board established by clear and convincing evidence that Dr. Porter failed to keep adequate records for V.C. as defined by A.R.S. § 32-1401(2), thereby committing unprofessional conduct as defined by A.R.S. § 32-1401(27)(e).\textsuperscript{29}

4. A.R.S. § 32-1401(27)(q) defines “unprofessional conduct” to include “[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.” The Board established that Dr. Porter prescribed methadone and amitriptyline to V.C. without assessing the efficacy of her previous regime, without an EKG, without obtaining a CSPMP or past medical records, and without calculating an accurate morphine equivalent. The Board established that five days later, V.C. died of combined drug toxicity. Therefore, the Board established by clear and convincing evidence that Dr. Porter committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(q).

5. The Board established by clear and convincing evidence that Dr. Porter continued to prescribe controlled substances to at least one of his patients after the Board issued its May 5, 2017 order summarily restricting his ability to prescribe controlled substances. Therefore, the Board established by clear and convincing evidence that Dr. Porter committed unprofessional conduct as defined by A.R.S. § 32-1401(27)(q).

\textsuperscript{29} A.R.S. § 32-1401(27)(e) defines “unprofessional conduct” to include “[f]ailing or refusing to maintain adequate records on a patient.”
convincing evidence that Dr. Porter violated a court order, thereby committing unprofessional conduct as defined by A.R.S. § 32-1401(27)(r).\(^{30}\)

6. Dr. Porter's refusal to accept any responsibility for V.C.'s death or to reconsider his prescribing practices for opioids after V.C. died and he received Dr. Thompson's report justify the Board's May 5, 2017 order restricting Dr. Porter's ability to prescribe opioids. The May 5, 2017 order comports with A.R.S. § 32-1451(D).\(^{31}\)

7. With respect to the appropriate penalty under A.R.S. § 32-1451(M),\(^{32}\) Dr. Porter has repeatedly and consistently refused to take any responsibility for V.C.'s death, arguing instead that she died because she was obese and did not exercise or eat right, she smoked cigarettes and e-cigarettes, she did not take her thyroid medication, she did not tell him that she had sleep apnea, she did not follow his instructions on dosage for the methadone and amitriptyline, and she did

\(^{30}\)A.R.S. § 32-1401(27)(r) defines "unprofessional conduct" to include "[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter." A.R.S. § 32-1401(27)(r) does not require any intent.

\(^{31}\)A.R.S. § 32-1451(D) provides as follows:

If the board finds, based on the information it receives under subsections A and B of this section, that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, the board may restrict a license or order a summary suspension of a license pending proceedings for revocation or other action. If the board takes action pursuant to this subsection, it shall also serve the licensee with a written notice that states the charges and that the licensee is entitled to a formal hearing before the board or an administrative law judge within sixty days.

\(^{32}\)A.R.S. § 32-1451(M) provides as follows:

Any doctor of medicine who after a formal hearing is found by the board to be guilty of unprofessional conduct, to be mentally or physically unable safely to engage in the practice of medicine or to be medically incompetent is subject to censure, probation as provided in this section, suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently and under conditions as the board deems appropriate for the protection of the public health and safety and just in the circumstance. The board may charge the costs of formal hearings to the licensee who it finds to be in violation of this chapter.
not tell him when she was slurring her speech. Unfortunately, the standard of care for the prescription of opioids to chronic pain patients requires physicians to evaluate their patients critically based on objective evidence, in part to protect the patients from themselves. Dr. Porter’s refusal to consider the Board’s evidence and continued insistence that he could not have taken any better care of V.C. due to her obstinately poor choices calls into serious question whether he can be regulated at this time.

ORDER

IT IS ORDERED affirming the Board’s May 5, 2017 order summarily restricting Gregory J. Porter, M.D.’s ability to prescribe controlled substances in the State of Arizona.

IT IS FURTHER ORDERED that on the effective date of the final order in this matter, Gregory J. Porter, M.D.’s License No. 14879 for the practice of allopathic medicine in the State of Arizona shall be revoked.

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 17th day of April 2018.

THE ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Executive Director

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

Arizona Medical Board
1740 W. Adams, Suite 4000
Phoenix, AZ 85007

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

Greg Hanchett, Director
Office of Administrative Hearings
1740 W. Adams Street, Lower Level
Phoenix, AZ 85007

Executed copy of the foregoing mailed by U.S. Mail this 17th day of April, 2018 to:

Gregory J. Porter, M.D.
Address of Record

Anne Froedge
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