



1 investigation revealed Respondent was practicing as a Physician Assistant without Board  
2 approval of his physician supervisor.

3 4. Respondent testified that working for the Indian tribe was an education and he had  
4 been told, because of Indian sovereignty, everything he had to do had to go through channels.  
5 Respondent testified he was in California where the tribe is and without his knowledge they made  
6 changes to Arizona. Respondent testified he had worked in California for twenty-five years and  
7 when he went to Arizona he had an active license, but he had not practiced in Arizona for twenty  
8 years. Respondent then corrected himself and testified he had worked for an Arizona physician  
9 for a while. Respondent testified he lost track of where he was.

10 5. Respondent testified California did not have the limitation on prescribing, but  
11 Arizona does. Respondent testified when he wrote the prescriptions none of the pharmacists  
12 called him and reminded him that he was in error, therefore he was oblivious to what he was  
13 doing. Respondent testified this did not excuse his conduct, but shows he was not  
14 knowledgeable and it was his own stupidity. Respondent testified he was never informed by his  
15 employer that his supervising physician was being changed and he was told by the Medical  
16 Director at that time that, because the Reservation was a sovereign nation, the physician did not  
17 have to have a Physician Assistant Arizona Board license. Respondent testified the Medical  
18 Director who told him this lost her job and he had multiple run-ins with her replacement.  
19 Respondent testified the new Medical Director had no knowledge of how to become a Director  
20 and used an acquaintance who was a pharmacist as her mentor. Respondent testified he  
21 submitted his application for approval of a Dr. W as a supervising physician and he lost track of  
22 the application after he submitted it because he was told the employer would take care of it.  
23 Respondent testified it had also been his experience that the Director or a supervisor would take  
24 the initiative and send in the application. Respondent testified he did not receive a formal letter  
25 from the Board saying Dr. W was approved, but he was under the assumption.

1           6.       The Board asked Respondent about two previous Advisory Letters he received in  
2 1990 and 1991 for inappropriate prescribing and why he thought he was back before the Board  
3 again. Respondent testified he received one advisory letter because he failed to slash his name  
4 behind the physician's – he had his signature and at that time Physician Assistants had to write  
5 their name and slash the physician's name behind it. Respondent testified he did not recall what  
6 the 1990 incident was and he needed more information about that case. The Board noted its  
7 concern about a Physician Assistant who has had problems with inappropriate prescribing  
8 coming back to the Board after two prior incidents.

9           7.       The Board asked Respondent if his testimony was that he was before the Board  
10 because of a mix up over which state he was practicing in. Respondent testified basically it was  
11 his error and he was totally knowledgeable he made a mistake. The Board asked Respondent  
12 how long he was allowed to prescribe controlled substances to a patient in California.  
13 Respondent testified there is no restriction in California. Respondent testified the physician signs  
14 the prescription because the Physician Assistant does not have unilateral ability to write  
15 prescriptions. The Board asked Respondent about one patient to whom Respondent prescribed  
16 450 Xanax. Respondent testified he thought everyone was stuck with the three month mail order  
17 type of thing and he did not like doing that. Respondent testified patients want three months  
18 because they have the ability to save money if he writes three months and then three refills  
19 because now, with prescription costs, many people order by mail.

20           8.       Respondent testified what he was trying to do with the Indian tribe was at the  
21 beginning he made several suggestions that patients have contracts and go to pain management  
22 and drug rehabilitation. Respondent testified he was told by the Indian tribe they do not pay for  
23 that and thus every time he submitted requests to go to Parker, Phoenix, or the Indian Health  
24 Hospital, he was denied each time because there was a form you fill out. Respondent testified he  
25 filled out the form so he cannot say why he is being accused of not sending patients to pain

1 management and drug rehabilitation. Respondent testified his attempts to do this were blocked  
2 by the Medical Director. Respondent testified there was a lot of difficulty with the Medical Director  
3 and he was told what to do with the Indian tribe. Respondent testified he would never again work  
4 for the Indian tribe and that you find yourself under their control.

5 9. The Board clarified that Respondent received an Advisory Letter in 1990 for failing  
6 to wear a name tag with the "PA" designation, prescribing controlled substances in excess of the  
7 amount authorized, and failing to affix his initials following the supervising physician Drug  
8 Enforcement Administration ("DEA") number on prescriptions for controlled substances and an  
9 Advisory Letter in 1991 for prescribing controlled substances in excess of the amount authorized  
10 and failing to affix his initials following his supervising physician's DEA number on controlled  
11 substances, and writing prescriptions for controlled substances on the same prescription blank as  
12 another drug. Respondent testified it was his negligence in not knowing that you cannot write two  
13 prescriptions at the same time on the same pad. The Board noted Respondent previously  
14 testified he received the Advisory Letters only for not affixing his initials. Respondent testified he  
15 just said he was not aware at the time the problem was that and maybe he should just renege on  
16 what he just said. Respondent testified he was not very knowledgeable about what he did in  
17 1990 and 1991 and he was not blowing smoke. Respondent testified he just did not recall the  
18 problem was with prescriptions and he thinks the issue was the name tag. The Board noted it  
19 appeared there were several issues. Respondent testified the other issue was that he did not  
20 sign his name and "slash" the physician's name after it. The Board noted in both the 1990 and  
21 1991 cases the record reflects one of the issues was prescribing controlled substances in excess  
22 of the amount authorized. Respondent testified he was not aware of that.

23 10. The Board asked Respondent what would allow it to believe Respondent has  
24 learned something if he was before the Board twice before and is now before the Board a third  
25 time and he still has a problem prescribing in excess of the authorized amount. Respondent

1 testified that he has been working for a physician and has not written any prescriptions to that  
2 level or that amount. The Board asked Respondent if he had any problems with the California or  
3 Nevada Boards. Respondent testified he had not. The Board asked Respondent if he was  
4 currently working in Arizona. Respondent testified he was. The Board asked Respondent if he  
5 knew for how many days he was allowed to prescribe controlled substances. Respondent  
6 testified he specifically knew it was for fourteen, but he would rather just not write prescriptions for  
7 narcotics himself.

8 11. The Board asked Respondent how he would document his writing for a fourteen  
9 day narcotic. Respondent testified he tends to dictate by notation and he is very verbal.  
10 Respondent testified his supervising physician co-signs Respondent's notation anytime he writes  
11 a narcotic. Respondent testified if the patient needs a narcotic like Darvocet or Fiorocet with  
12 codeine he will do those for fourteen days, but if it is Percocet or Percodan, he does not write the  
13 prescription.

14 12. The standard of care required Respondent to prescribe the correct amount of  
15 narcotic analgesic and follow applicable guidelines. The standard of care also required  
16 Respondent to evaluate and monitor patients with chronic pain complaints.

17 13. Respondent deviated from the standard of care when he prescribed excessive  
18 amounts of narcotics and failed to follow applicable guidelines. Respondent deviated from the  
19 standard of care by failing to evaluate and monitor patients with chronic pain complaints.

20 14. Patients were subject to potential harm of misuse of medications, addiction and  
21 overdose.

22 15. It is necessary for this decision to take immediate effect to protect the public health  
23 and safety and a rehearing or review is contrary to the public interest. A.A.C. R4-17-403(B).

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1 **CONCLUSIONS OF LAW**

2 1. The Board on the Regulation of Physician Assistants possesses jurisdiction over  
3 the subject matter hereof and over Respondent.

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

7 3. The conduct and circumstances above constitute unprofessional conduct pursuant  
8 to A.R.S. § 32-2501(21)(a) (“[v]iolation of any federal or state law or rule that applied to the  
9 performance of health care tasks as a physician assistant. Conviction in any court of competent  
10 jurisdiction is conclusive evidence of a violation”); specifically, A.R.S. § 32-2534(A) (“[a] physician  
11 assistant shall not perform health care tasks until the supervising physician receives approval of  
12 the notification of supervision from the Board”); (i) (“[p]rescribing or dispensing controlled  
13 substances or prescription-only drugs in excess of the amount authorized pursuant to this  
14 chapter”); and 32-2501(21)(j) (“[a]ny conduct or practice that is harmful or dangerous to the health  
15 of the patient or the public”).

16 **ORDER**

17 Based upon the foregoing, IT IS HEREBY ORDERED that:

18 1. Respondent is issued a Decree of Censure for the violations listed above.

19 2. Respondent is placed on Probation for one year with the following terms and  
20 conditions:

21 a. Respondent shall not prescribe any Schedule II through V controlled  
22 substances.

23 **RIGHT TO APPEAL TO SUPERIOR COURT**

24 Respondent is hereby notified that this Order is the final administrative decision of the  
25 Board and that Respondent has exhausted his administrative remedies. Respondent is advised

1 that an appeal to Superior Court in Maricopa County may be taken from this decision pursuant to  
2 Title 12, Chapter 7, Article 6.

3 DATED this 16 day of March, 2006.



4 ARIZONA REGULATORY BOARD OF  
5 PHYSICIAN ASSISTANTS



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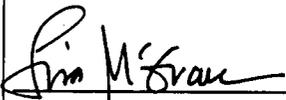
TIMOTHY C. MILLER, J.D.  
Executive Director

9 Original of the foregoing filed this  
10 16 day of March, 2006 with:

11 Arizona Regulatory Board of  
12 Physician Assistants  
13 9545 East Doubletree Ranch Road  
14 Scottsdale, Arizona 85258

15 Executed copy of the foregoing  
16 mailed by U.S. mail this  
17 16 day of March, 2006, to:

18 Leon Garza, P.A.-C  
19 Address of Record



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