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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

NORMAN M. FERNANDO, M.D.,

Holder of License No. 15894
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No.20A-15894-MDX

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

On May 7, 2020, this matter came before the Arizona Medical Board ("Board") for consideration of Administrative Law Judge ("ALJ") Tammy L. Eigenheer's proposed Findings of Fact, Conclusions of Law and Recommended Order. Norman M. Fernando, M.D., ("Respondent") was not present; 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

PROCEDURE

1. The Arizona Medical Board (Board) is the authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Norman M. Fernando, M.D., (Respondent) is the holder of License No. 15894 for the practice of allopathic medicine in Arizona.

3. On January 30, 2020, the Board issued a Complaint and Notice of Hearing to Respondent alleging Respondent had engaged in unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. § 32-1401(27)(r) ("[c]omitting any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); A.R.S. § 32-1401(27)(s) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter"); and A.R.S. § 32-1401(27)(mm) ("[c]ommitting conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient")

4. On or about September 2, 2014, the Board received a complaint from a member of the public claiming that Respondent had been over prescribing pain medications to her sister, T.G., a 36 year-old female. The complaining party specifically asserted that Respondent had been prescribing T.G. "astronomical amounts of prescription pain medications" and that Respondent prescribed T.G. "over 300 oxycodone . . . along with soma and xanax." The complaining party also indicated that T.G. had been seen at the hospital for multiple suicide attempts related to prescription drug overdoses.

5. On or about February 13, 2014, T.G. had her initial consultation with Respondent. The initial complaint from T.G. was back, shoulder, and neck pain. T.G. reported a history of chronic pain syndrome, cervical and lumbar spine degenerative disc disease, anxiety disorder, tobacco abuse, radiculitis, and sciatica. T.G. signed a release allowing Respondent to obtain records from her previous primary care physician. At. T.G.'s first visit, Respondent prescribed her a 30 day supply of Oxycodone (15 mg 4 times daily), Soma (350 mg as needed), and increased T.G.'s blood pressure medications.

6. On or about June 6, 2014, T.G. reported to Respondent that she had visited urgent care for cough and fever and was prescribed an antibiotic. Respondent did not obtain any records from the urgent care.

7. In June of 2014, T.G. presented to a hospital with an altered mental status and the hospital confiscated her Oxycodone.

8. On or about June 17, 2014, T.G. returned to Respondent's office presenting with an altered mental state. T.G. reported she had been admitted to Banner Estella. The records did not reflect that she told Respondent why she was admitted to the hospital. T.G. told Respondent that the hospital had taken her Oxycodone. Respondent noted that T.G. was experiencing opiate withdrawal leading to her altered mental state. Respondent also recognized that he did not have any records from T.G.'s previous primary care physician. Respondent recorded that he intended to send another release for records. Nothing in Respondent's records indicated that he ever received records from the prior primary care physician or hospitalizations or that he made any attempts to obtain those records. The records also do not indicate that Respondent took any action to address

T.G.'s opiate withdrawal, but Respondent prescribed T.G. a 30 day supply of Oxycodone (15 mg 4 times daily).

9. On or about July 2, 2014, T.G. reported feeling massive burning in her right leg. Respondent prescribed T.G. Oxycodone (15 mg 4 times daily).

10. On or about July 8, 2014, T.G. returned to Respondent and reported that no pharmacy would fill her prescription. Respondent provided T.G. a new prescription for Oxycodone (15 mg 4 times daily).

11. On or about July 10, 2014, T.G. returned to Respondent and again reported that no pharmacy would fill her prescription. Respondent provided T.G. a prescription for Oxycodone (1/2 tablet of 30 mg 4 times daily) as a result.

12. On or about August 7, 2014, T.G. saw Respondent for pneumonia and a cough resulting in her neck, back, and sciatica pain worsening. T.G. was diagnosed with acute bronchitis. Respondent provided T.G. a prescription for Oxycodone (1/2 to 1 tablet of 30 mg 4 times daily).

13. On or about August 7, 2014, T.G. was admitted to a hospital for an Ambien overdose, but signed out against medical advice.

14. On or about August 25, 2014, Respondent again prescribed Oxycodone for T.G. and ordered a urine drug screen, which was positive for cocaine.

15. On or about August 25, 2014, and August 27, 2014, T.G. filled Xanax prescriptions.

16. On or about August 28, 2014, T.G. was again admitted to the hospital. T.G. was reported to have taken two tablets of Flexeril and four tablets of Oxycodone within a 24 hour period. T.G. was transferred to an inpatient psychiatric unit for worsening anxiety and overdose.

17. On or about September 10, 2014, Respondent spoke to T.G. about her positive drug screen and referred her to a pain management specialist and Terros for chemical dependency.

18. On or about September 5, 2014, the Board sent a letter to Respondent informing him of the above-mentioned complaint.

19. On or about September 17, 2014, the Board sent another letter and an email to Respondent requesting that he provide a response to the complaint. Respondent did not reply to the letter or email.

20. On or about October 21, 2014, the Board sent a second notice letter to Respondent requesting that he provide a response to the complaint.

21. On or about November 5, 2014, Respondent submitted a response with accompanying materials to the Board. Respondent acknowledged that he did not update his email address with the board.

22. Once the Board obtained the relevant medical records, the matter was assigned to Muhammad Vasiq, M.D., medical consultant, who reviewed those records.

23. On or about August 12, 2015, Dr. Vasiq prepared a Medical Consultant Report and Summary (Report). In the Report, Dr. Vasiq concluded that the documentation provided was sufficient to establish multiple deviations from the standard of care.

24. Based on the Report, the Board issued a Complaint and Notice of Hearing alleging Respondent engaged in unprofessional conduct as to T.G.

25. The standard of care required a physician to obtain a history of a patient's current and past medication use prior to initiating the prescribing of controlled substances.

26. Respondent deviated from the standard of care by failing to obtain a history of T.G.'s current and past medication use prior to initiating the prescribing of controlled substances.

27. The standard of care required a physician to obtain medical records from current and past providers prior to and during a patient's treatment with controlled substances.

28. Respondent deviated from the standard of care by failing to obtain medical records from current and past providers prior to and during T.G.'s treatment with controlled substances.

29. The standard of care required a physician to document the rationale for escalating doses of controlled substances.

30. Respondent deviated from the standard of care by failing to document the rational for escalating T.G.'s doses of controlled substances.

31. The standard of care required a physician to obtain appropriate diagnostic testing when a patient has complaints of worsening symptoms.

32. Respondent deviated from the standard of care by failing to obtain appropriate diagnostic testing when T.G. complained of worsening symptoms.

33. Respondent's conduct resulted in harm to T.G. in that it perpetuated her abuse of narcotics.

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34. On or about July 7, 2016, the Board received a complaint from a treating Emergency Room physician in New Orleans, Louisiana indicating that Respondent had prescribed R.M., a 34 year old male patient, 180 Dilaudid 8mg tablets that, if taken within 10 days as prescribed, would have been 1,440 mg of Dilaudid a day. The physician opined that this was a "ludicrous amount of narcotics" and was dangerous to the patient.

35. During the course of the Board's investigation, the Board obtained Respondent's medical records for other patients. Stephen Borowsky, M.D., medical consultant, reviewed the care provided by Respondent to R.M. and five other patients and identified numerous deviations from the standard of care in Respondent's prescribing opioid medications.

Patient R.M.

36. Patient R.M. established care with Respondent in July 2006, at the age of 24, with a chief complaint of a pinched nerve in the right shoulder. R.M., by self-report, had a history of recurrent pneumothorax and pleurodesis, chemical and surgical. Respondent diagnosed him with postthoracotomy syndrome and atypical chest pain, as well as several other conditions.

37. Respondent first treated R.M.'s chest pain with controlled substances in September 2006, when he prescribed Vicodin. He prescribed Soma, as well, although that medication was not yet controlled.

38. Thereafter, over the course of treatment, Respondent consistently prescribed controlled substances to R.M. for various pain complaints, although, primarily chest pain. Respondent prescribed controlled substances including Oxycodone, Soma, OxyContin, Opana, and Dilaudid.

39. R.M. continued care with Respondent until he moved to New Orleans in or about the summer of 2016.

40. On or about May 16, 2016, Respondent prescribed R.M. Oxycodone 30 mg, quantity 360.

41. On or about May 26, 2016, Respondent prescribed R.M. Oxycodone 30mg, quantity 540 for a total daily morphine equivalent of 1056.52.

42. For several months after R.M. moved to New Orleans, Louisiana Respondent continued to prescribe large amounts of controlled substances to R.M. continuing through at least February 2017. R.M. would travel back to Arizona to see Respondent for his prescriptions.

43. On or about July 18, 2016, Respondent wrote R.M. a prescription for Dilaudid 8mg, quantity 180. In August and September 2016, Respondent wrote R.M. prescriptions for Oxycodone. In November 2016 and February 2017, Respondent wrote R.M. prescriptions for both Oxycodone and OxyContin. By February 2017, Respondent had escalated the daily morphine equivalent prescribed to R.M. to 1390.

44. The standard of care for the treatment of chronic pain with opioids requires a physician to document a legitimate purpose for the treatment, document a credible medical condition that requires such medication, to prescribe the medication in appropriate dosage and quantities, and appropriate monitoring and documentation noting improvement in pain and function.

45. During the course of treatment, Respondent deviated from the standard of care in that he did not document evidence of a credible pain condition but, instead, relied on R.M.'s statements. There were no exams documenting tenderness to palpation or pressure in the area claimed to be painful. Respondent prescribed R.M. opioids for subjective symptoms that were not substantiated by objective findings.

46. Respondent deviated from the standard of care by failing to follow pain management guidelines and failing to monitor R.M. and his prescriptions with drug testing and review of the CSPMP.

47. Respondent's conduct placed R.M. at risk of drug abuse and addiction.

Patient T.B.

48. Patient T.B. established care with Respondent in or prior to June 2013. Based on the Controlled Substance Prescription Monitoring Report (CSPMP), T.B. had consistently been prescribed opioid medications by previous physicians since at least 2011.

49. Respondent's notes from June 24, 2013, and October 31, 2014, note cervical spine degenerative disc disease, right lower extremity paresthesia, right third DIP joint amputation, increase PSA, and weight loss.

50. On or about June 24, 2013, Respondent prescribed Oxycodone 30 mg, quantity 360. Thereafter, Respondent consistently prescribed to T.B. Oxycodone and morphine in escalating dosages. By November 2016, T.B.'s daily morphine equivalent totaled approximately 2610. Additionally, Respondent prescribed carisoprodol (Soma), a muscle relaxer, through approximately August 2014. Thereafter, benzodiazepines (Lorazepam and/or Clonazepam) were added to the opioid regimen.

51. T.B. was admitted to the hospital on August 2, 2016, for altered mental state and liver dysfunction. The suspected cause was opioid intoxication.

52. The standard of care for the treatment of chronic pain with opioids required Respondent to document a legitimate purpose for the treatment, document a credible medical condition that required such medication, to prescribe the medication in appropriate dosage and quantities, and appropriate monitoring and documentation noting improvement in pain and function.

53. Respondent deviated from the standard of care by failing to justify a reason for prescribing opioids to T.B. Respondent's medical records lacked objective support from physical examinations, history, and diagnostic studies to warrant the use of opioids.

54. Respondent deviated from the standard of care by failing to follow pain management guidelines and failing to monitor T.B. and his prescriptions with drug testing and review of the CSPMP.

55. Respondent deviated from the standard of care as his records failed to demonstrate achieving the goals of pain management, failing to demonstrate improvement

1 in pain and function. Respondent utilized excessively high opioid dosages without
2 success.
3 56. Respondent's conduct placed T.B. at risk of complications, abuse, and
4 addiction. The concurrent use of benzodiazepines magnified those risks.
5 57. Respondent's medical records for T.B. were inadequate with vital signs and physical examinations either missing or duplicated from previous records.
6 *Patient K.F.*
7 58. Patient K.F. was first treated by Respondent on or about March 25, 2014.
8 K.F.'s previous primary care physician had prescribed Keppra for a history of seizures; however, K.F. was non-compliant. Additionally, K.F. had been prescribed Oxycodone,
9 Valium, and Methadone. Per the CSPMP, prior to seeing Respondent, K.F. was last
10 prescribed controlled substances by a previous provider in or about July 2013.
11 59. Respondent's records for March 25, 2014, included a checklist questionnaire,
12 hand-written note, and a problem list including chronic pain syndrome among numerous
13 other problems. Respondent's plan was to recommend a gynecological consult and he prescribed medications including Methadone (10mg quantity 600), Oxycodone (30mg
14 quantity 360), and clonazepam (1mg quantity 90).
15 60. Respondent continued prescribing K.F. Oxycodone and Methadone in large
16 quantities. In August 2014, Respondent provided two prescriptions each of Methadone
17 (10mg quantity 300) and Oxycodone (30mg quantity 180). Records noted the continuation of double prescriptions with intermittent reports of seizures. In November 2014,
18 Respondent prescribed Xanax as well.
19 61. Records from K.F.'s emergency room visit in 2015 noted a history of alcohol
20 abuse and detox drug abuse. K.F. requested detox from Xanax and Methadone in October
21 2015 and was admitted to Community Bridges for detox using Subutex protocol.
22 62. In April 2016, Respondent provided K.F. dual prescriptions for opioids without mention of the hospital visits or detox and continued these prescriptions through at least
23 July 2016.
24 63. The standard of care for the treatment of chronic pain with opioids requires a
25 physician to document a legitimate purpose for the treatment, document a credible medical

condition that requires such medication, to prescribe the medication in appropriate dosage and quantities, and appropriate monitoring and documentation noting improvement in pain and function.

64. Respondent deviated from the standard of care by failing to document a legitimate purpose for the treatment, failing to document a credible medical condition that required high-dose opioids, by prescribing the medication in inappropriate dosage and quantities, and by failing to appropriately monitor and document improvement in the patient's pain and function.

65. Respondent deviated from the standard of care by prescribing to K.F. medications totaling a daily morphine equivalent of 1170 without objective findings to support any use of opioids and with aberrant behaviors.

66. Respondent created a condition for K.F. that placed her at risk of drug abuse and addiction.

Patient J.G.

67. Patient J.G. had documented Ehlers Danlos Syndrome and chronic pain. On December 9, 2014, Respondent prescribed Opana ER (40mg twice daily) and Oxycodone (30mg quantity 540). After an unannounced visit on December 31, 2014, Respondent prescribed J.G. OxyContin (80mg quantity 180) and Oxycodone (30mg quantity 240), noting that Opana made him too sleepy.

68. On or about March 3, 2015, Respondent documented that "[u]ltra-high doses of opioids which is completely justified since his extremely rare and disabling joint disease." The CSPMP showed that Respondent continued to prescribe the high dose opioids; however, patient records were missing for the next year. Respondent's records indicated that he followed up with home visits in 2016.

69. The standard of care for the treatment of chronic pain with opioids required a physician to document a legitimate purpose for the treatment, document a credible medical condition that required such medication, to prescribe the medication in appropriate dosage and quantities, and appropriate monitoring and documentation noting improvement in pain and function.

70. Respondent deviated from the standard of care in that his exams failed to substantiate the pathology or symptoms of J.G.'s localized shoulder pain and he did not refer J.G. to orthopedic or pain management specialists.

71. Respondent deviated from the standard of care by failing to document improvement in pain and function while continuing to prescribe high dose opioids, totaling a daily morphine equivalent of 1430.

72. Respondent's conduct placed J.G. at significant risk of drug abuse and addiction.

Patient A.S.

73. Patient A.S. was seen by Respondent in 2012 with diagnoses of chronic pain syndrome, thoracic and lumbosacral disk disease and multiple other medical problems. A.S. was seen by Respondent through at least October 2016.

74. Although Respondent was notified by A.S.'s insurance companies about various other prescribers of narcotics, benzodiazepines, and muscle relaxants, Respondent continued to prescribe A.S. narcotics. Over the course of treatment, Respondent increased the opioid doses to monthly prescriptions for Methadone (10mg quantity 540) and Hydromorphone (8mg quantity 150) for a daily morphine equivalent of 732. In October 2016, Respondent added 200 more Methadone (10 mg).

75. The standard of care for the treatment of chronic pain with opioids required a physician to document a legitimate purpose for the treatment, document a credible medical condition that required such medication, to prescribe the medication in appropriate dosage and quantities, and appropriate monitoring and documentation noting improvement in pain and function.

76. Although A.S. had a significant history, Respondent deviated from the standard of care by failing to document current pathology to substantiate the use of high doses of opioids.

77. Respondent deviated from the standard of care by failing to appropriately monitor A.S.'s use of the opioids through drug testing and review of the CSPMP.

78. Respondent's conduct placed A.S. at significant risk of drug abuse and addiction.

Patient T.W.

79. Patient T.W. was seen by Respondent on March 30, 2015, with multiple diagnoses including severe and frequent migraines and chronic pain syndrome. Respondent prescribed T.W. Oxycodone (5mg quantity 100) and verapamil for headache prophylaxis.

80. Over the course of treatment, Respondent escalated the dose of Oxycodone and added MS Contin. On March 30, 2015, Respondent prescribed T.W. a daily morphine equivalent of 93.75. By October 25, 2016, Respondent prescribed T.W. a daily morphine equivalent of 1620.

81. The standard of care for the treatment of chronic pain with opioids required a physician to document a legitimate purpose for the treatment, document a credible medical condition that required such medication, to prescribe the medication in appropriate dosage and quantities, and appropriate monitoring and documentation noting improvement in pain and function.

82. Respondent deviated from the standard of care by prescribing opioids in excessive amounts without substantiation of a medical condition warranting this treatment. His physical examinations failed to support the diagnoses and opioid requirement.

83. Respondent deviated from the standard of care by failing to appropriately monitor T.W.'s opioid usage. While he mentioned urine drug screens, no results were documented and he failed to access the CSPMP. Respondent failed to prove that T.W. was actually taking her prescriptions.

84. Respondent deviated from the standard of care by failing to prove that T.W.'s pain and function had improved.

85. Respondent's conduct placed T.W. at significant risk of drug abuse and addiction.

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86. On or about May 9, 2017, Respondent entered into an Interim Consent Agreement for Practice Restriction, prohibiting him from practicing any form of medicine in the State of Arizona (Interim Practice Restriction).

87. On May 12, 2017, after the effective date of the Interim Practice Restriction, Respondent issued two prescriptions for OxyCodone to Patient M.M., with a notation that one was to be filled after June 11, 2017.

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88. On or about February 27, 2017, the Board received a complaint from someone who had performed a thorough analysis of the records of 13 Arizona Health Care Cost Containment System (AHCCCS) members who had been treated by Respondent. The complaint indicated that the review was initiated by a quality of care concern involving a 58 year old male with a history of lumbar spinal cord injury and chronic pain, documented substance and alcohol abuse, multiple emergency department visits requesting narcotics, and, "most concerning, an admission for respiratory failure due to narcotics during which he was in the intensive care unit on a Narcan drip in March 2014" all while Respondent was continuing to prescribe morphine (1200mg daily), Oxycodone (180mg daily), and Carisiprodol (1400mg daily). The complaint alleged that Respondent had several AHCCCS members as patients on up to 360 daily morphine equivalents of opioids, some in combination with benzodiazepines.

89. During the course of the Board's investigation, the Board obtained Respondent's medical records for other patients. Eric Boyd, M.D., medical consultant, reviewed the care provided by Respondent to six patients and identified numerous deviations from the standard of care in Respondent's prescribing opioid medications.

Patient P.C.

90. Progress notes for Respondent's care of Patient P.C. began on August 15, 2014. P.C.'s pain management diagnoses included left spine osteomyelitis, degenerative disc disease, and laminectomy fusion, although there were no x-rays or past surgical notes in the chart, nor was there an initial work-up. The plan was for MS Contin (100 mg 3 times daily) and Oxycodone (30mg up to 4 times daily) for a daily morphine equivalent of 480. Respondent also prescribed P.C. Adderall for ADD. Klonopin was later added with 5 refills without any reason listed. Over the course of treatment, early refills of medication, including opioids, were noted without providing a reason. Progress notes from month to

month appeared to be copied and pasted from prior visits. Three urinary drug screens were noted as being administered; however, no results were included in the charts.

91. The standard of care for chronic pain management required a physician to document the source of the patient's pain, document reasoning for high-dose therapy combined with other respiratory depressants at high doses; to establish a treatment plan and goals; to utilize outside consultations; to document results of urinary drug screens; to utilize adjuvant medications to manage pain; to assess risk with opioids and benzodiazepines; and to evaluate for sleep apnea with a patient on high-dose opioid therapy.

92. Respondent's conduct placed P.C. at risk of opioid related death and there was risk of opioid diversion.

Patient H.S.

93. Progress notes for Respondent's care of Patient H.S. began on October 20, 2015, with complaints of back spasms. H.S. had a history of schizophrenia and Suboxone was listed as a medication. H.S. was diagnosed with chronic pain syndrome, spinal spasms, knee pain, and headache. Soma was prescribed and a urine drug screen was done. Over the course of treatment, Soma was refilled; however, there was no documentation of a work up to identify the source of H.S.'s pain, which appeared to be getting worse. There were no urinary drug screen results in the chart. On June 21, 2016, H.S. was found deceased and an autopsy determined the cause of death was due to morphine toxicity with alcohol found along with other drugs.

94. The standard of care for chronic pain management requires a physician to evaluate and document the source of the patient's pain, to avoid using Soma in a patient with a history of addiction, and to provide alternatives to the plan of using Soma.

95. Respondent deviated from the standard of care by failing to evaluate and document the source of H.S.'s pain, by using Soma in a patient with history of addiction, and by failing to provide alternatives to the plan of using Soma.

96. Respondent's conduct in prescribing Soma to a patient who took illicit drugs contributed to the patient's overdose and death. Additionally, Respondent's failure to work up and address the source of H.S.'s increasing pain may have contributed to death.

Patient S.S.

97. Progress notes for Respondent's care of Patient S.S. began in March 2009, with a brief chart note. In 2011, cellulitis was noted along with a leg wound and degenerative disc disease. Medications included MS ER (100mg 4 times daily) and Dilaudid (8mg 4 times daily), resulting in a daily morphine equivalent of 330. Additionally, Respondent prescribed S.S. Soma and Klonopin. In August 2014, a typed note referenced chronic pain and a spinal cord injury. Over the course of treatment, MS Contin was increased and Oxycodone was added and increased resulting in a daily morphine equivalent of 1560. Even though S.S. reported stolen medications and there was a documented overdose, no urinary drug screen results were available in the chart.

98. The standard of care for chronic pain management required a physician to document proper pain management using high dose opioid therapy, regularly perform pain level assessment and plan beyond medications for management of pain, to not reports of functional capacity if this is how the pain level is to be measured, to accurately document patient encounters, to recognize symptoms of morphine toxicity, to utilize outside consultants, to document the results of urinary drug screens, to document patient consent and establish a pain contract, to lower the opioid dose after pain has improved or resolved, and to document reports of overdose.

99. Respondent deviated from the standard of care in his treatment of S.S. by failing to document proper pain management using high dose opioid therapy, failing to perform regular pain level assessment and documenting no other plan besides medications for management of pain. Respondent further deviated from the standard of care by failing to note report of functional capacity, by copying notes from previous visits with error (particularly vital signs), failing to recognize symptoms of morphine toxicity including myoclonic jerks, failing to utilize outside consultants, failing to document urinary drug screen results, and by failing to document patient consent and establish a pain contract. Additionally, Respondent deviated from the standard of care by failing to lower the opioid dose after pain from a foot fracture improved or resolved and by failing to document an overdose.

100. As a result of Respondent's conduct, S.S. suffered probably morphine toxicity resulting in myoclonic jerks and an opioid overdose. S.S. could have suffered an opioid related death. Additionally, Respondent's failure to treat other sources of pain may have resulted in S.S. suffering.

Patient S.C.

101. Respondent's first note for Patient S.C. was April 2, 2014, with diagnoses for pain, lumbar spinal stenosis, degenerative disc disease, leukemia, hepatitis, and bipolar with delusions. There was no mention of polysubstance abuse history. A note from January 15, 2015, stated tender in spine with no other details. Diagnoses were chronic pain syndrome and lumbar cervical degenerative disc disease. Respondent prescribed S.C. Oxycodone (30mg 4 times daily). On March 12, 2015, Respondent added a prescription for S.C. MS Contin (60mg 3 times daily). Respondent also prescribed S.C. clonazepam. On July 2, 2015, Respondent noted that S.C.'s psychiatrist was concerned with her pain medications. Despite S.C.'s reports of worsening pain, Respondent decreased her Oxycodone. Behavioral health records from January 2016 identified diagnoses of bipolar disorder and polysubstance abuse. Past notes also documented heroin, crystal meth, cocaine, and alcohol use. The documentation also included several management notes during 2015, including hospitalizations.

102. The standard of care for chronic pain management required a physician to document appropriate management of a patient on high dose opioids, document polysubstance abuse, perform on going work up for pain management including obtaining an MRI or using outside consultants for some of the pain issues. Further, the standard of care prohibited the use of central nervous system depressants concurrent with high-dose opioids.

103. Respondent deviated from the standard of care by failing to document appropriate management of a patient on high-dose opioids, failing to document polysubstance abuse, failing to perform ongoing work up for pain management including obtaining an MRI or using outside consultants for some of the pain issues, and by including treatment with other central nervous system depressants in addition to high-dose opioids.

104. Respondent's conduct placed S.C. at risk of opioid related death or poor outcome.

Patient H.C.

105. Respondent's incomplete handwritten notes for Patient H.C. began in October 28, 2005, and it appeared that his care of H.C. continued through at least August 2016 according to the records that were reviewed. A note from March 2011, indicated H.C.'s diagnoses were shoulder derangement, chronic pain, lumber degenerative disc disease, and hypogonadism. On January 3, 2012, Respondent recorded a diagnosis of depression and prescribed Oxycodone (30mg quantity 150).

106. Over the course of treatment, H.C. was seen for various pain complaints and the diagnosis continued to be chronic pain and lumbar degenerative disc disease. In February 2015, Respondent prescribed H.C. Oxycontin (40mg 3 times daily) without any reason provided for the prescription. In April 2015, the Oxycontin was increased 100 percent to 80mg 3 times daily. In 2015 and 2016, Respondent's progress notes for H.C. appeared the same for each visit. H.C. was ultimately prescribed Oxycontin (80mg 3 times daily) and Oxycodone (30mg 5 times daily) for a total daily morphine equivalent of 585. Additionally, the CSPMP demonstrated that H.C. had been prescribed clonazepam from other prescribers.

107. The standard of care for chronic pain management prohibited extreme escalations of opioid dosage without reason and the use of other central nervous system depressants by other providers in combination with high-dose opioid therapy.

108. The standard of care required documentation of management of high-dose opioid therapy.

109. The standard of care required a work up of back pain.

110. Respondent deviated from the standard of care by extreme escalations of opioid dosage without reason, failing to document management of high-dose opioid therapy, use of other central nervous system depressants by other providers in combination with high-dose opioid therapy, and failing to work up H.C.'s back pain.

111. Respondent's conduct placed H.C. at risk of overdose and opioid related death.

Patient F.T.

112. Handwritten notes for Patient F.T. began in 2013 and an MRI from 2011 showed mild L5/S1 degeneration. Respondent's EHR began in August 2014 and F.T.'s Oxycodone and MS Contin were increased by 40 percent. In October 2014, F.T. started to complain of mid-back pain; however, there was no work up for this pain. Respondent increased the Oxycodone and OxyContin for a total daily morphine equivalent of 490. Thereafter, F.T. was seen for various complaints of pain and Respondent increased the dose of Oxycodone by 50 percent in April 2015, noting shoulder pain. Many of the notes were duplicated from visit to visit. In October 2016, F.T. reported that he could not walk due to back and leg pain; however a work up was not done.

113. The standard of care for chronic pain management required Respondent to maintain proper documentation for a patient on high-dose opioid therapy, to work up pain issues with supporting documentation in the plan of care, and the standard of care prohibits extreme escalations of opioid doses without reason.

114. Respondent deviated from the standard of care by failing to properly document in a patient on high-dose opioid therapy, by failing to work up pain issues or document a plan of care, and by escalating opioid medication in extreme doses.

115. F.T. remained in significant pain month after month without any clear evidence of work up and treatment except for opioids. Respondent's conduct placed F.T. at risk of overdose and/or death.

116. A physician is required to maintain adequate legible medical records 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. Respondent's records were inadequate in that they were incomplete and often just duplicated the prior office visit. Charts lacked an initial HPI with PMH and comprehensive exam and plan with detailing sources of pain requiring extremely high amounts of opioid medications.

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Hearing Evidence

117. At hearing, Dr. Borowsky testified that, to enable medical professionals to consider the effects of narcotics, medications are calculated as daily morphine equivalents. While daily morphine equivalents of 120 was once considered high, it was reduced to 90, and then to 50.

118. Dr. Borowsky stated that Respondent exhibited a consistent pattern throughout the cases he reviewed—the patients' conditions could not be proven, Respondent's records were inadequate, Respondent prescribed opioids without purpose, and Respondent's prescribing of opioids was "out of control". Dr. Borowsky noted that he discovered only one urinary drug screen in all the records he reviewed, and while Respondent mentioned the CSPMP, no specifics were included in the records. Dr. Borowsky stated that any one of the patients could have died from what Respondent did.

119. At hearing, Dr. Boyd testified that Respondent did not meet the standard of care for any of the patients he reviewed. Dr. Boyd referenced the lack of urinary drug screens being administered and, when reportedly administered, the lack of results being noted. Dr. Boyd also observed numerous instances of progress notes being copied and pasted from one note to the next, including the same vital signs for each visit or that the patient had stopped smoking three months earlier being listed for several months in a row.

120. Dr. Boyd observed Respondent had a pattern of escalating opioid prescriptions from one month to another without working up the pain for the patients.

121. On or about October 19, 2010, the Board issued an advisory letter to Respondent in which Respondent was required to complete the PACE prescribing course within six months of the date of the order.

122. The hearing was held at the Office of Administrative Hearings (OAH) on March 6, 2020. Respondent did not request to appear telephonically at the duly noticed hearing and did not request that the hearing be continued. Although the start of the hearing was delayed 20 minutes to allow Respondent additional travel time, he did not appear, personally or through an attorney, and did not contact the OAH to request that the start of the hearing be further delayed. Consequently, Respondent did not present any evidence to defend his license.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Respondent and the subject matter in this case.

2. Pursuant to A.R.S. § 41-1092.07(G)(2) and A.A.C. R2-19-119(B), the Board has the burden of proof in this matter. The standard of proof is by clear and convincing evidence. A.R.S. § 32-1451.04.

3. The legislature created the Board to protect the public. *See* Laws 1992, Ch. 316, § 10.

4. A.R.S. 32-1401(2) provides that

> “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.

5. The weight of the evidence presented established by clear and convincing evidence that Respondent’s patient records were incomplete and inadequate as noted above. Respondent duplicated notes from one visit to the next, failed to note results of urinary drugs screens that were purportedly required, and failed to include objective findings to support the treatment plan.

6. The weight of the evidence presented established by clear and convincing evidence that Respondent’s treatment of the patients outlined *supra* failed to meet the standard of care. Respondent exhibited a pattern of escalating opioid prescriptions without subjective findings to support the need for the medication and alarmingly high daily morphine equivalents for several patients well over 1000 including one patient at 2610.

7. The weight of the evidence presented established by clear and convincing evidence that Respondent issued two prescriptions for controlled substances after entering into the Interim Practice Restriction.

8. Therefore, the Board established that Respondent’s conduct constituted unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) in that he failed or refused to maintain adequate records for his patients as defined by A.R.S. § 32-1402(2).

9. Further, the Board established that Respondent's conduct constituted unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r) in that he committed any conduct or practice that was or might be harmful or dangerous to the health of the patient or the public.

10. Additionally, the Board established that Respondent's conduct constituted unprofessional conduct pursuant to A.R.S. § 32-1401(27)(s) in that he violated the consent agreement entered into by the Board.

11. Finally, the Board established that Respondent's conduct constituted unprofessional conduct pursuant to A.R.S. § 32-1401(27)(mm) in that Respondent exhibited gross negligence, repeated negligence, and negligence resulting in harm to or the death of a patient.

12. Pursuant to A.R.S. § 32-1451(U), Respondent's prior non-disciplinary history may be considered in determining the appropriate discipline to be imposed.

13. Pursuant to A.R.S. § 32-1451(M), "[t]he board may charge the costs of formal hearings to the licensee who it finds to be in violation of this chapter."

ORDER

Based on the foregoing, it is **ORDERED** revoking Norman Fernando, M.D.'s License No. 15894 for the practice of allopathic medicine in the State of Arizona. It is further ordered that Respondent be assessed the cost of the formal hearing incurred by the Board in this matter.

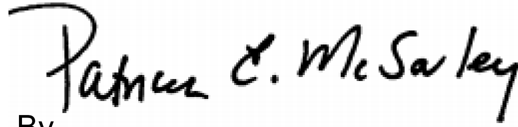
RIGHT TO PETITION FOR REHEARING OR REVIEW

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 _8th_ day of May 2020.

THE ARIZONA MEDICAL BOARD



By_______________________
Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this
__8th__ day of May, 2020 with:

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

COPY of the foregoing filed this
__8th___ day of May, 2020 with:

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

Executed copy of the foregoing
mailed by U.S. Mail and emailed this
_8th___ day of May, 2020 to:

Norman M. Fernando, M.D.
Address of Record

Anne Froedge
Assistant Attorney General
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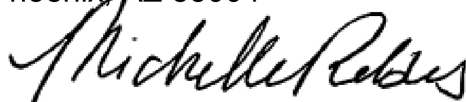
Phoenix, AZ 85004



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