BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

DAVID G. LAWSON, M.D.

Holder of License No. 23145
For the Practice of Allopathic Medicine
In the State of Arizona

Case No. 22A-23145-MDX

ORDER DENYING REQUEST FOR REHEARING OR REVIEW

At its public meeting on May 3, 2023, the Arizona Medical Board ("Board") considered David G. Lawson, M.D.'s ("Respondent") Motion for Review of the Board's Order dated March 2, 2023 in the above referenced matter. Respondent was present and represented by Counsel, Sara Stark, Esq. The State was represented by Assistant Attorney General Carrie Smith. The Board received independent legal advice from Assistant Attorney General Diane DeDea. After considering all of the evidence, including arguments of the parties, the Board voted unanimously to deny Respondent's Request for Rehearing or Review for the reason that he failed to demonstrate that he was entitled to a rehearing for any of the reasons set forth in A.A.C. R4-16-103(D).

ORDER

IT IS HEREBY ORDERED that:

Respondent's Request for Rehearing or Review is denied. The Board's March 2, 2023 Findings of Fact, Conclusions of Law, and Order for revocation of Respondent's license in Case 22A-23145-MDX is effective and constitutes the Board's final administrative order.

1 **RIGHT TO APPEAL TO SUPERIOR COURT**

2 Respondent is hereby notified that he has exhausted his administrative remedies.
3 Respondent is advised that an appeal to Superior Court in Maricopa County may be taken
4 from this decision pursuant to title 12, chapter 7, article 6 of the Arizona Revised Statutes
5 within thirty-five (35) days from the date this decision is served.

6 DATED AND EFFECTIVE this 10th day of May, 2023.

7

8 ARIZONA MEDICAL BOARD

9

10 By [signature]
Patricia E. McSorley
11 Executive Director

12

EXECUTED COPY of the foregoing mailed via
13 US and Certified Mail
this 10th day of May, 2023 to:
14

David G. Lawson, M.D.
15 Address of Record

16
Sara Stark
17 5425 E. Bell Road, Suite 107
Scottsdale, Arizona 85254
18 Attorney for Respondent

19

ORIGINAL of the foregoing filed
20 this 10th day of May, 2023 with:

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

23

24 [signature]
Board staff
25

1 **BEFORE THE ARIZONA MEDICAL BOARD**

In the Matter of **DAVID G. LAWSON, M.D.,** Holder of License No. 23145 For the Practice of Allopathic Medicine In the State of Arizona.	Case No.22A-23145-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER (Revocation)**

On March 1, 2023, 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. David G. Lawson, M.D., ("Respondent") was present and represented by Sara Stark Esq.; Assistant Attorney General Carrie Smith represented the State. Assistant Attorney General Ben Norris 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

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. David G. Lawson, M.D., (Respondent) is the holder of License No. 23145 for the practice of allopathic medicine in Arizona.

3. On or about September 14, 2022, 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)(ee) ("[f]ailing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board.").

4. Effective August 8, 2014, the Board issued a Decree of Censure and Probation and Consent to the Same (Board Order) in MD-13-1115A. The probation terms and conditions included in the Board Order required that Dr. Lawson enter into a contract with a Board-approved monitoring company for the performance of quarterly chart reviews to commence after completion of Category I Continuing Medical Education (CME) course in controlled substance prescribing.

5. The Board initiated case number MD-18-1070A after receiving notification that Dr. Lawson was non-compliant with his chart monitoring requirement found in the Board Order.

6. On or about September 5, 2014, Dr. Lawson entered into a contract with a Board-approved Monitoring Company (First Monitor) and completed the CME on January 26-28, 2015.

7. Dr. Lawson failed to make timely payment to the First Monitor, and despite multiple extensions, his contract with the First Monitor was terminated on March 13, 2017. At the time the contract was terminated, Dr. Lawson had a balance of $3,162.30. His initial contract retainer of $1,488.00 was applied to the contract balance leaving an outstanding balance of $1,674.50 owed by Dr. Lawson. Dr. Lawson eventually paid the remaining balance, but his contract was not reinstated.

8. On or about August 29, 2017, Dr. Lawson entered into monitoring with another Board-approved Monitoring Company (Second Monitor).

9. On or about October 3, 2018, the Second Monitor notified Board staff that Dr. Lawson was non-compliant with his Board Order. The Second Monitor reported that Dr. Lawson failed to provide his patient schedules for two reviews, failed to remit payment, and was non-responsive to the Second Monitor's request for contact.

10. Dr. Lawson subsequently brought his account with the Second Monitor current for the second quarterly chart review, but the review was never completed due to Dr. Lawson's failure to submit the appropriate records for the review.

11. Dr. Lawson later requested termination of his Board Order, but had failed to complete the appropriate number of quarterly chart reviews.

1 12. The Second Monitor's review of care provided in March/April 2018 noted that
2 Dr. Lawson provided 9 of 10 charts requested by the Second Monitor. The Second
3 Monitor's report noted that Dr. Lawson failed to meet generally accepted standard in 7 of 9 charts. Specifically, Dr. Lawson's documentation was incomplete in 3 of 9 charts and failed
4 to substantiate a clinical course and treatment in 4 of 9 charts; there was no assessment of
5 pain in 7 of 9 charts; inappropriate indications for controlled substances in 7 of 9 charts,
6 some of those indications were no risk assessments and no treatment goals identified;
7 failure to obtain appropriate referrals in 7 of 9 charts; inappropriate choice and dose of
8 controlled substance in 7 of 9 cases; inadequate Controlled Substance Prescription Monitoring Profile (CSPMP) monitoring in 6 of 9 cases; prescribing greater than 90
9 morphine equivalent dosage (MED) in 6 of 9 charts, and 2 patients were prescribed opioid
10 and benzodiazepine concurrently with no appropriate plan or rationale.
11 13. Based on the above findings, Dr. Lawson entered into an Interim Consent
12 Agreement for Practice Restriction prohibiting him from prescribing controlled substances in the State of Arizona, effective March 6, 2020.
13 14. After signing the Interim Consent Agreement for Practice Restriction, Dr.
14 Lawson sent a letter to the Board's Executive Director requesting this clarification: Does
15 the practice restriction prevent me from prescribing just opioids or "any scheduled
16 medications"?
17 15. On or about March 11, 2020, a Board compliance officer sent an email to Dr.
18 Lawson informing him: "All the substances you mentioned in your letter [to the Board's Executive Director] are controlled. You are restricted from prescribing any controlled
19 substance. If you prescribe any controlled substance you will be in violation of the Interim
20 Consent Agreement and will be scheduled for a Summary Suspension."
21 16. On or about March 16, 2020, contrary to the clarification he received from the
22 Board about prescribing controlled substances, Dr. Lawson wrote one prescription for the controlled substance Lyrica 100 mg, 30 day supply with 3 refills to patient LH in violation of
23 his practice restriction.
24
25

17. Based on concerns raised by the Second Monitor's review of care provided in March/April 2018, Board staff requested that a Medical Consultant (MC) review three patient charts (SB, SW and JJ).

18. SB was a 63 year-old female with complaints of low back pain and chronic cough. Dr. Lawson prescribed SB medications including oxycodone 15 mg every six hours, as needed, and promethazine with codeine syrup 5 ml every 6 hours, as needed.

19. SW was a 57 year-old male with low back pain, diabetes mellitus type 2, seizure disorder, osteoarthritis, and bipolar disorder. Dr. Lawson prescribed SW medications including Prozac 20 mg twice daily, OxyContin 80 mg 1 tablet in the a.m., OxyContin 80 mg 2 tablets in pm, oxycodone 15 mg every four hours, as needed, and clonazepam 2 mg daily. SW also had a medical marijuana card recommended by Dr. Lawson.

20. JJ was a 50 year-old female with rheumatoid arthritis, fibromyalgia, attention deficit disorder, obstructive sleep apnea, morbid obesity, depression osteoarthritis, asthma, COPD, and chronic respiratory failure. Dr. Lawson prescribed JJ medications including Ritalin 20 mg three times daily, oxycodone 20 mg every four hours, as needed, zolpidem 10 mg at bedtime. During the course of Dr. Lawson's treatment of JJ, JJ had urinary drug screen results that were positive for fentanyl and negative for prescribed zolpidem and Ritalin.

21. The MC identified deviations from the standard of care due to Dr. Lawson's treatment of SB, SW and JJ including by prescribing high dose opioids without clinical justification, by prescribing opioids and other controlled substances concurrently without a clinical rationale, by failing to appropriately monitor for compliance or address aberrant behavior such as chronic early refills or abnormal urine drug screen results.

22. Dr. Lawson caused actual harm in that Patient JJ experienced ongoing opioid abuse and worsening hypoxic respiratory failure. There was potential for patient harm in that all the patients were at risk of overdose, abuse, diversion, and death.

MD-18-1197A

23. The Board initiated case number MD-18-1197A after receiving a complaint regarding Dr. Lawson care and treatment of a 35 year-old male patient (JE) alleging inappropriate prescribing.

24. Dr. Lawson received notification of the complaint and Board staff directed him to provide a response to the complaint. Dr. Lawson failed to timely respond to the complaint which prompted Board staff to notify him of this failure.

25. Based on the complaint, Board staff requested that a MC review Dr. Lawson's care and treatment of JE and two other patients (CS and SK).

26. JE was a 32 year-old male that established care with Dr. Lawson in 2015. JE's medical history included hypertension, temporomandibular joint (TMJ) pain, chronic chest wall pain with recurrent cartilage dislocation, and pain from a past hand surgery. Dr. Lawson prescribed JE medications including oxycodone 30 mg every four hours, trazodone 100 mg 2 tablets at bedtime, amlodipine 50 mg daily, and clonidine 0.1 mg every six hours, as needed.

27. CS was a 54 year-old female who established care with Dr. Lawson in 2013. CS's medical history included adult attention deficit disorder (ADD), depression, anxiety, migraine, low back pain, and dental problems resulting from dry mouth. Dr. Lawson prescribed CS medications including Norco 7.5/325 mg every six hours as needed, Adderall 20 mg three times daily, and Xanax 1 mg three times daily. In February 2019, Dr. Lawson filled out a medical marijuana certificate at CS's request.

28. SK was a 54 year-old female with a past medical history of diabetes, COPD, hypertension, post-traumatic stress disorder, hyperlipidemia, diabetic polyneuropathy, and obstructive sleep apnea, who established care with Dr. Lawson in January 2013. At that time SK was taking 40 mg of Methadone (4x 10 mg tablets) four times a day (#480 per month) for a diagnosis of fibromyalgia syndrome. Dr. Lawson continued prescribing Methadone at the same dosage. Adderall was added by a sleep specialist in November 2015, for daytime hyper somnolence. In July 2018, SK was seen by a psychiatrist who advised tapering the Methadone.

29. The MC identified deviations from the standard of care due to Dr. Lawson's treatment of JE, CS, and SK including prescribing high dose opioids without clinical justification, failing to address chronic early refills for all patients, failing to recognize signs of opioid dependence or abuse in patient JE, prescribing opioids to patient CS with a history of mental illness without a clinical rationale, and prescribing high dose Methadone to patient SK for non-malignant pain.

30. Dr. Lawson caused actual and potential patient harm in that opioid dependence and/or abuse was perpetuated on the patients and they were at risk for addiction and/or withdrawal.

Hearing Evidence

31. At hearing, the Board presented the testimony of Twana Fairbourn, Senior Compliance Officer, and Raquel Rivera, Investigations Manager.

32. At hearing, Respondent testified on his own behalf and presented the testimony of Joseph L. Chatham, M.D.; Mary Katherine Harper, M.D.; Syed Masood, M.D.; and Veronica Collier, Medical Assistant.

33. The Board's witnesses concluded that Respondent had been given multiple opportunities to comply with the Board Order and had failed to do so. Further, Respondent's failure to comply with the Board Order and failure to timely respond to the Board's requests for information demonstrated that Respondent could not be regulated. Ms. Rivera also expressed a concern that, even after attending a CME focused on patient records, Respondent failed to maintain adequate records.

34. Respondent did not dispute the underlying allegations set forth in the Complaint and Notice of Hearing. Respondent asserted that the Board had failed to establish by clear and convincing evidence that he was non-compliant with the practice monitoring requirement. Respondent argued that his license should not be revoked as a result of this proceeding and cited the applicable disciplinary statutes that provide for a range of disciplinary actions. Respondent proposed a permanent practice restriction with respect to controlled substances.

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. The conclusions of the Second Monitor and the MC both demonstrated that Respondent failed to maintain adequate records even after attending a CME focused on patient records.

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 repeatedly prescribed medications without clinical justification or rationale and failed to monitor for compliance with medication use.

7. The weight of the evidence presented established by clear and convincing evidence that Respondent issued a prescription for a controlled substance after entering into the Interim Consent Agreement for Practice Restriction.

8. The weight of the evidence presented established by clear and convincing evidence that Respondent failed to respond to Board staff request for information when requested.

9. 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).

10. 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.

11. 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 Board Order.

12. Finally, the Board established that Respondent's conduct constituted unprofessional conduct pursuant to A.R.S. § 32-1401(27)(ee) in that Respondent's failed to furnish information in a timely manner to the Board or the Board's investigators when legally requested by the Board.

13. 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.

14. 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 David G. Lawson, M.D.'s License No. 23145 for the practice of allopathic medicine in the State of Arizona.

It is further ordered that, pursuant to A.R.S. § 32-1451(M), David G. Lawson, M.D. be charged the cost of the formal hearing as determined by the Board. Dr. Lawson shall pay the Board $2752.36, by certified funds, within 90 days of the effective date of this Order.

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 2nd day of March 2023.

THE ARIZONA MEDICAL BOARD

By Pat E McSorley
Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this 2nd day of March, 2023 with:

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

COPY of the foregoing filed this 2nd day of March 2023 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 2nd day of March, 2023 to:

David G. Lawson, M.D.
Address of Record

Sara Stark, Esq.
CHELLE LAW PLC
5425 E Bell Rd, Suite 107
Scottsdale, AZ 85254
Sara.Stark@chellelaw.com
Attorney for Respondent

Carrie H. Smith
Assistant Attorney General
Office of the Attorney General
SGD/LES
2005 N. Central Avenue
Phoenix, AZ 85004

By: Michelle Robles
Arizona Medical Board

10981708