BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

JOHN W. MCGETTIGAN, M.D.

Holder of License No. 12606
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-21-0494A, MD-21-0881A

ORDER FOR LETTER OF REPRIMAND; AND CONSENT TO THE SAME

John W. McGettigan, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for a Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 12606 for the practice of allopathic medicine in the State of Arizona.

3. Respondent's license is subject to Findings of Fact, Conclusions of Law and Order for Decree of Censure and Probation with Practice Restriction in case MD-18-0026A effective January 8, 2021 ("Current Order"). The Current Order requires Respondent to successfully undergo periodic chart reviews.

MD-21-0494A

4. The Board initiated case number MD-21-0494A after receiving a complaint regarding Respondent's care and treatment of a 78 year-old male patient ("DR") alleging failure to properly manage pain medications, failure to explore other pain management options, and failure to address concerns of the patient's ongoing addiction.

5. DR was an established patient of Respondent's practice, with a medical history including chronic pain syndrome, osteoarthritis, post-procedure pain, Crohn's disease, PTSD, depression, and anal fistula.

6. On June 7, 2017, DR presented for an annual wellness visit with Respondent. DR's medication list included oxycodone hydrochloride 15mg every 4-6 hours 7max/day, Phenergan 25mg every six hours, and Humira. Respondent recommended not tapering the oxycodone too soon.

7. On October 23, 2017, DR requested a dose decrease from 6 to 4 tablets of oxycodone. Respondent noted that DR had run out of medications early last visit so the UDS was negative for oxycodone. DR was noted to be improving with regard to opiates with treatment of depression. Respondent adjusted DR's oxycodone dosage to every six hours.

8. On November 17, 2017, DR requested a dose decrease from 4 to 3 tablets of oxycodone. Respondent changed DR's oxycodone to three times daily.

9. On December 4, 2017, DR requested a dose increase from 3 to 6 tablets of oxycodone in order to control his pain all month long. Respondent doubled DR's oxycodone to 15mg six tablets daily.

10. On January 25, 2018, Respondent prescribed DR buprenorphine 8mg every eight hours.

11. On February 23, 2018, DR's wife reported that he stopped buprenorphine for a week because it was causing severe side effects with balance, dizziness, dark urine and confusion. DR was also using medical marijuana. DR reportedly had been suicidal, irritable, and disappointed in himself because he needed oxycodone. DR was noted to have thoughts about hanging himself but lacked the courage to do it.

12. On March 27, 2018, DR reported increased tolerance to oxycodone reporting that the dose only lasted two hours. DR reported severe pain with loss of mobility and potential for falls. Another provider started prescribing DR Adderall. Respondent increased DR's Oxycodone 15mg to five times daily.

13. On April 3, 2018, DR requested an increase of his oxycodone dosage. Respondent increased DR's oxycodone to 20mg five times daily.

14. On April 27, 2018, DR reported that oxycodone was not effective at relieving his pain and requested to increase his dose. Respondent prescribed morphine sulfate extended release ("MSER") 15mg every twelve hours in addition to the oxycodone.

15. On July 17, 2018, DR reported an unsanctioned dose increase and ran out early. Respondent noted a concern regarding DR potentially treating his PTSD with his oxycodone rather than pain and that he was working with a psychiatrist. Respondent provided a bridge of oxycodone at 20mg 7 per day for 7 days as a bridge and 7 per day for 30 days. DR agreed to remain strictly compliant and make the quantity last a month.

16. On August 14, 2018, DR reported that the opioids were not relieving his pain and he was taking medications every two hours. DR additionally disclosed suicidal ideations. Respondent increased DR's oxycodone to 8 tablets daily.

17. On September 10, 2018, DR admitted to having a challenge taking his medication as prescribed. Respondent added a fentanyl patch 37.5mcg/hr every 72 hours.

18. On October 22, 2018, DR reported that the fentanyl patch was working but he had run out of the oxycodone a week ago and wanted to increase the dose to 9 tablets daily. Respondent documented that DR appeared to be experiencing a combination of pseudo addiction as well as more psychological driven pain.

19. On November 19, 2018, DR attempted to increase his Fentanyl dose to 200 mcg/hr. With that increased dose, DR's total morphine equivalent dose ("MED") was 720. Respondent discontinued the Fentanyl based on DR's report that it was no longer working.

20. On January 4, 2019, DR requested reduction from 8 to 5 tablets of oxycodone, and that his daughter and wife wanted him to stop taking opioids completely. One daughter wrote an email expressing concern about his increased use of opiates.

21. On January 29, 2019, DR requested to stop taking oxycodone and try Suboxone. DR's wife was interested in other methods of pain management. Respondent changed DR to Suboxone with home induction and instructed him to call if needed. Respondent prescribed DR Suboxone 8/2mg film at 2 strips daily.

22. On February 8, 2019, DR's wife reported that DR was having partial withdrawal. DR did not like the Suboxone, as it did not help with his pain. DR was using marijuana ("THC") and CBD oil. DR reported having suicidal thoughts, but no plans.

23. On May 14, 2019, DR reported that he was only functional when on opioids. Respondent discontinued DR's Suboxone and stated oxycodone 20mg five times daily.

24. On August 6, 2019, DR reported taking all five of his daily oxycodone in one dose and was suicidal. DR denied plans but was frustrated with his pain and stated that the only way to make it go away permanently was to end his life.

25. On December 23, 2019, Respondent noted that opioid medications were DR's crutch and that he had difficulty without using them for the treatment of chronic pain and other issues. Respondent increased DR's oxycodone to 7 tablets per day.

26. On February 18, 2020, Respondent increased DR's oxycodone to 30mg every four hours.

27. On February 15, 2021, DR reported having Ketamine infusions for pain and depression. DR additionally reported that his suicidal ideation had resolved. DR's new primary care physician requested referral to interventional pain specialist.

28. On February 22, 2021, DR was prescribed lorazepam 1mg twice daily by another provider.

29. On April 26, 2021, DR reported to Respondent that he self-admitted to a detox program two weeks previously and had stayed five days hoping to cut down on oxycodone. DR requested a new prescription for oxycodone from Respondent.

30. On April 29, 2021, DR's wife stated that if he went back on oxycodone, she would leave him. Respondent prescribed DR amitriptyline and ibuprofen.

31. On May 6, 2021, DR reported that the amitriptyline and ibuprofen were not helping much, and he wanted to go back on oxycodone because it was the only medication that relieved his pain. Respondent recommended that DR find a new physician. Respondent prescribed oxycodone 10mg every four hours and instructed DR to follow-up with a pain specialist.

32. On June 3, 2021 DR reported recently being released from inpatient treatment for opioid detoxification after a car accident involving opioid impairment. DR had left treatment against medical advice after non-compliance. Respondent saw DR along with his wife and daughter. DR declined Suboxone. Respondent noted that since DR did not take medications as prescribed and endangered himself and others that he would no longer prescribe opioids but would treat withdrawal and assist DR to stay off opioids. Respondent referred DR for physical therapy and noted that the family was working to place him in a residential facility. Respondent prescribed clonazepam 0.5mg #12 for four days.

33. The standard of care prohibits a physician from prescribing high dose opioids without clinical justification. Respondent deviated from the standard of care by prescribing high dose opioids without clinical justification.

34. The standard of care requires a physician to recognize signs and symptoms of abuse when prescribing controlled substances. Respondent deviated from the standard of care by failing to recognize the signs and symptoms of opioid use disorder.

35. The standard of care requires a physician to utilize adjuvant treatments in a patient with opioid use disorder. Respondent deviated from the standard of care by failing to utilize adjuvant treatments in a patient with opioid use disorder.

36. The standard of care requires a physician to address aberrant behaviors. Respondent deviated from the standard of care by failing to properly address aberrant behaviors in a patient on chronic opioid therapy.

37. Actual patient harm was identified in that DR experienced opioid addiction, withdrawal, increased pain, narcotic bowel syndrome, inadequate treatment of PTSD, and a motor vehicle accident while intoxicated from an unsanctioned dose increase.

38. There was potential for patient harm in that DR was at risk of impaired balance, falls, endocrine dysfunction, overdose, suicide and death.

MD-21-0881A

39. The Board initiated case number MD-21-0881A after receiving a complaint regarding Respondent's care and treatment of two patients alleging inappropriate prescribing of high dose opioids without a diagnosis or medical condition to warrant the prescribed amounts.

40. RD was a 65 year-old female who had established care with Respondent's Clinic in October of 2018. RD had a medical history of fibromyalgia with chronic pain on high dose opioid treatment, prior cancer of the vulva with vulvectomy, degenerative joint

disease ("DJD"), and hypothyroidism. Respondent prescribed RD medications including oxycodone hydrochloride 15mg every six hours, Oxycontin ER 80mg every six hours, and amitriptyline 10mg at bedtime. RD's total morphine milligram equivalents ("MME") were 570mg MME. In August of 2021, Respondent recommended physical therapy. Additionally, RD's UDSs were positive for Morphine on several occasions, and this was addressed twice without any change in the prescribed Oxycodone and Oxycontin. RD's confirmation UDS was positive for hydrocodone in December of 2019, when no hydrocodone was prescribed.

41. DH was a 54 year-old female who established care with Respondent's Clinic in November of 2018. DH had a medical history of chronic pain after failed back surgery and cervical spinal surgery on high dose opioid treatment, PTSD secondary to childhood sexual assault, and tobacco use. Respondent prescribed DH medications including Baclofen 10mg three times daily, oxycodone hydrochloride 30mg every 4-6 hours, and Oxycontin ER 80mg three times daily. Respondent reduced DH's opioid dose from a MED of 780 in December of 2020 to an MED of 585 in November of 2021. DH's confirmation UDSs were positive for morphine on three occasions, although morphine was not prescribed, and a confirmation UDS in January of 2021 was positive for hydromorphone when it had not been prescribed.

42. The standard of care prohibits a physician from prescribing opioids for long term use without clinical justification. Respondent deviated from the standard of care for RD and DH by prescribing high dose opioids for long term use without clinical justification.

43. The standard of care requires a physician to utilize non-opioid medications and non-pharmacological treatment modalities in the management of fibromyalgia prior to prescribing opioids. Respondent deviated from the standard of care for Patient RD by

failing to utilize non-opioid medications and non-pharmacological treatment modalities in the management of fibromyalgia.

44. The standard of care requires a physician to utilize non-opioid medications and non-pharmacological treatment modalities in the management of arthritis/DJD prior to prescribing opioids. Respondent deviated from the standard of care for Patient DH by failing to utilize non-opioid medications and non-pharmacological treatment modalities in the management of arthritis/DJD.

45. The standard of care requires a physician to address aberrant urinary drug screens. Respondent deviated from the standard of care for Patients RD and DH by failing to properly address their aberrant urinary drug screen results.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described in MD-21-0494A above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e)("Failing or refusing to maintain adequate records on a patient.").

c. The conduct and circumstances described in MD-21-494A and MD-21-0881A above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r)("Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

DATED AND EFFECTIVE this 7th day of October, 2022.

ARIZONA MEDICAL BOARD

By [signature]
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent in this Order are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or

federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Notwithstanding any language in this Order, this Order does not preclude in any way any other State agency or officer or political subdivision of this state from instituting proceedings, investigating claims, or taking legal action as may be appropriate now or in the future relating to this matter or other matters concerning Respondent, including but not limited to, violations of Arizona's Consumer Fraud Act. Respondent acknowledges that, other than with respect to the Board, this Order makes no representations, implied or otherwise, about the views or intended actions of any other state agency or officer or political subdivisions of the State relating to this matter or other matters concerning Respondent

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

10. ***Respondent has read and understands the terms of this agreement.***

JOHN W. MCGETTIGAN, M.D.

DATED: 9 Sep 2022

EXECUTED COPY of the foregoing mailed
this 7th day of October, 2022 to:

John W. McGettigan, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 7th day of October, 2022 with:

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

Michelle Rhodes
Board staff