BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

CEDRIC W. McCLINTON, M.D.,

Holder of License No. 12711
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No.19A-12711-MDX

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

On April 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. Cedric W. McClinton, M.D., did not appear; Assistant Attorney General Roberto Pulver 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

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. Cedric W. McClinton, M.D., (Respondent) is the holder of License No. 12711 for the practice of allopathic medicine in Arizona.

3. On November 15, 2019, 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") and 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").

Stipulated Findings of Fact

4. On January 30, 2018, the Board received a complaint from a physician claiming that Respondent had been over prescribing benzodiazepines to a 27 year old female patient, L.R., for over a year. Further, the physician alleged that when Respondent prescribed benzodiazepine to L.R., he failed to check the Controlled Substance

Prescription Monitoring Program (CSPMP) for this patient, which would have exposed L.R.'s activity of getting multiple benzodiazepine prescriptions from different physicians. Finally, the physician alleged L.R. had overdosed on benzodiazepines twice, which resulted in two emergency room hospital visits.

5. On April 2, 2018, the Board sent a letter to Respondent informing him of the above-mentioned complaint. Then a few days later, the Board sent another letter to Respondent informing him to provide a response to the complaint. He provided a narrative response and accompanying materials to the Board in May 2018.

6. On February 17, 2015, L.R. had her initial consultation with Respondent. The initial complaint from L.R. was rectal bleeding and headaches. The progress notes from that consultation stated L.R. had a hemorrhoid causing the bleeding and Respondent gave her a prescription for a cream and directions as to the use of the cream.

7. The progress notes from the consultation also stated that L.R. was using Tylenol PM, which contains Benadryl, known to have a sedative effect. Tylenol PM is marketed by the manufacturer as a sleep agent. The progress notes were silent as to any discussion about having headaches, any medical or family history about headaches, and no physical examination to discover the etiology of the headaches. Further, there was no discussion as to insomnia that may have been affecting L.R. due to her use of Tylenol PM.

8. On January 15, 2016, L.R. had her second consultation with Respondent. During this consultation, L.R. complained of headaches. However, L.R.'s patient records for this consultation under the categories of review of systems (ROS) and physical examination (PE) did not mention headaches. The patient records did not discuss any testing for headaches nor did they discuss the etiology of the headaches. Respondent prescribed Imitrex to L.R. and she was instructed to take Tylenol and Excedrin migraine for headaches.

9. During the January 15, 2016 consultation, Respondent also prescribed to Alprazolam (i.e., Xanax) to L.R. for sleep. Yet, L.R.'s patient records detailing the ROS and PE had no discussion about sleep issues, insomnia, or the type of insomnia. The patient records noted that L.R. is still taking Tylenol PM.

10. On November 7, 2016, L.R. telephoned Respondent's office for a Xanax refill. Respondent authorized the refill for 10 tabs of Xanax. As of that date, there was no indication in L.R.'s patient records that Respondent reviewed the CSPMP as to what prescriptions L.R. has received from other physicians.

11. On November 10, 2016, L.R. had her third consultation with Respondent. L.R.'s patient records indicate that Respondent discussed her complaint about headaches. Nevertheless, the ROS and PE had no diagnostic tests to understand the causes of the headaches and insomnia. Respondent prescribed Percocet for L.R.'s headaches if the Imitrex was ineffective and prescribed 30 more Xanax tablets with two refills. The patient records noted that L.R. was still taking Tylenol PM.

12. On December 27, 2016, L.R. had her fourth consultation with Respondent. L.R.'s principal complaint was dermatitis of her left leg. L.R.'s patient records for this consultation detailing the ROS and PE were negative as to headaches and insomnia. L.R. stated in her patient record that the Imitrex "is working well and if it doesn't know [the headache] out completely then she takes a single Percocet and works really well."

13. On January 25, 2017, L.R. obtained 20 more tabs of Percocet from another physician. But there was no notation in Respondent's records for L.R. that he was aware that L.R. received this additional Percocet from another physician. For over a year's time, there is no indication in Respondent's records for L.R. that he checked the CSPMP whether L.R. was obtaining opiods and benzodiazepine from other physicians.

14. On March 9, 2017, L.R. sent an email to Respondent requesting a refill of her Percocet prescription. L.R.'s explanation for a refill, "[t]his proves to be more effective than the Sumatriptan, as it can be very harsh on my stomach with or without food." L.R.'s medical records indicated that her Percocet prescription refill request was authorized, but her medical records did not notate the refill.

15. On June 8, 2017, L.R. had her fifth consultation with Respondent. L.R. continued to complain of headaches, insomnia, but also complained of back pain. There was still no mention in L.R.'s medical records about insomnia, other than L.R.'s complaint. Respondent authorized another prescription of Percocet, but there was no mention in the progress notes. Further, he authorized a first-time prescription for Temazepam (i.e.

Restoril) 30 mg, 30 tablets, 2 refills for better sleep and he instructed L.R. to stop using Xanax. The patient records noted that L.R. was still taking Tylenol PM.

16. On June 27, 2017, L.R. made a telephone call to Respondent's office. L.R. explained that her "anxiety has been through the roof lately. I was wondering if you have any suggestions, or anything you could prescribe?" Respondent prescribed Xanax to L.R. and increased the dosage from once a day to three times a day. But there was no instruction given to L.R. to stop taking Restoril. At this date, L.R. was taking Xanax, Restoril, and Percocet.

17. On July 14, 2017, L.R. makes a telephone call to Respondent's office. L.R. requested authorization for more Percocet. Her request for additional Percocet was denied by the on call physician.

18. On September 11, 2017, L.R. had her sixth consultation with Respondent. L.R. was following up with Respondent for prescription refills and complained of a urinary tract infection. L.R.'s medical records noted she had anxiety, but the PE stated that her mood and affect are "normal." Respondent took L.R. off Restoril, but continued with Xanax three times a day with one refill. The patient records noted that L.R. was still taking Tylenol PM.

19. On September 13, 2017, LR made a telephone call to Respondent's office. L.R. requested authorization for another refill of Percocet. L.R.'s request was granted. However, within 30 days of the above date, L.R. obtained 20 Xanax tabs from another physician. It appeared that Respondent was not aware that L.R. was obtaining Xanax from other physicians.

20. On October 5, 2017, Respondent discontinued L.R.'s prescription for Restoril.

21. On October 16, 2017, a review of the CSPMP disclosed that L.R. went to another physician and obtained Diazepam (i.e. Valium). There was no notation in L.R.'s medical records with Respondent that she had obtained Valium from another physician.

22. On January 9, 2018, L.R. made a telephone call to Respondent's office claiming her puppy had eaten her Xanax that she picked up two days ago, and she needed that prescription refilled. Respondent requested that L.R. provide evidence from her

veterinarian that her puppy had eaten the Xanax. L.R. failed to provide that evidence and her refill request was denied.

23. On March 1, 2018, L.R. had her seventh and final consultation with Respondent. L.R.'s consultation was for a medication check-up and she complained of anxiety and discomfort of her foot and back, which prevented her from exercising. The ROS for this consultation showed L.R. was nervous, but the PE stated, "[s]he has a normal mood and affect. Her behavior is normal." Respondent instructed L.R. to continue with the Xanax and with the Tylenol PM and Gabapentin.

Hearing Evidence

24. The Board opened an investigation regarding Respondent's care and treatment of L.R.

25. On or about April 2, 2018, the Board notified Respondent of the complaint and investigation.

26. On or about April 10, 2018, the Board notified Respondent that the investigation had been moved for further review. Respondent was requested to provide a complete narrative response to the complaint regarding L.R. by April 25, 2018. Respondent was granted an extension to file his response.

27. On or about May 24, 2018, the Board received Respondent's response, from his counsel, to the complaint in which he denied the allegations of the complaint.

28. Once the Board obtained the relevant medical records, the matter was assigned to James L. Woodman, M.D., medical consultant, who reviewed those records.

29. On or about March 14, 2019, Dr. Woodman prepared a Medical Consultant Report and Summary (Report). In the Report, Dr. Woodman concluded that the documentation provided was sufficient to establish multiple deviations from the standard of care.

30. Based on the Report, the Board issued a Complaint and Notice of Hearing alleging Respondent engaged in unprofessional conduct as to L.R. The Complaint and Notice of Hearing included the following advisement:

> Within twenty (20) days of service of this Complaint and Notice of Hearing upon you, you are requested to file with the Board and the State's attorney a written Answer to the Complaint.

31. Respondent did not file an Answer to the Complaint within 20 days.

32. On December 23, 2019, a prehearing conference was held in this matter. Respondent did not participate in the prehearing conference. At the conclusion of the prehearing conference, Administrative Law Judge Diane Mihalsky issued an Order Requiring Respondent to File a Written Answer and Requiring Parties to Make Disclosure in which Judge Mihalsky ordered Respondent to file a written answer to the Complaint and Notice of Hearing on or before December 31, 2019. Respondent did not submit a written answer or disclose any intended witnesses or exhibits by that date.

33. L.R. presented to the emergency room due to overdoses on two separate occasions while she was being treated by Respondent.

34. The standard of care in treating insomnia required Respondent to discuss cognitive behavioral training, use of medications, sleep hygiene, stimulus control, and relaxation. Respondent should have first determined the cause of the insomnia, then determined whether medications should be used to treat the insomnia. Insomnia medications should be used for up to six or eight weeks combined with therapy. Xanax was not an appropriate medication to treat insomnia, but Restoril would have been appropriate. If L.R.'s insomnia was not resolved within six months, at the most, Respondent should have referred L.R. to a sleep specialist.

35. The standard of care in treating anxiety required Respondent to discuss and document the potential risks, benefits, and treatment alternatives with L.R. Further, because Xanax has a high potential for misuse among patients when it is used for three months or more, the standard of care required Respondent to drug test L.R. to assure treatment compliance.

36. The standard of care in treating headaches required Respondent to determine the underlying cause of L.R.'s headaches through diagnostic testing, a focused medical and social history, and alleviating and aggravating factors affecting her headaches. Further, the standard of care requires appropriate medications be prescribed to treat chronic headaches, which does not include the use of opioids and benzodiazepines.

37. The standard of care required Respondent to periodically review the CSPMP for L.R. prior to prescribing medications.

38. Respondent asserted he was the busiest physician in his office during the time he was treating L.R. Respondent stated he had an average of 550 patient visits per month. Respondent denied that the medications he prescribed for L.R. were, in and of themselves, an issue. Respondent warned of the unintended consequences of the Board's position in this matter and how it may affect how physicians practice medicine. Respondent also noted that if emergency departments implemented the practice of calling the primary care physician of patients presenting for an overdose, this entire situation would have been avoided. Respondent also testified that urine drug screening was ineffective to determine overuse and was only effective to determine underuse of prescribed medications. Respondent stated that he was aware when one of his colleague in his office had prescribed L.R. a medication even if he did not note the prescription in his records. Respondent stated that after he received the interim order, he retired from the practice of medicine and had no intention of seeing patients in the future.

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 Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to discover and discuss with L.R. the underlying cause of her insomnia; by using inappropriate medications to treat L.R.'s insomnia; by failing to discuss sleep hygiene, stimulus control, and relaxation with L.R.; and by failing to provide a referral to a sleep specialist after L.R.'s insomnia continued for more than six months.

6. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to document in the medical records any discussion with L.R. regarding the potential risks, benefits, and treatment alternatives. Additionally, Respondent failed to require L.R. to undergo drug testing to ensure her use of Xanax was in line with the treatment plan.

7. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to determine the underlying cause of L.R.'s headaches through diagnostic testing, a focused medical and social history, and alleviating and aggravating factors affecting her headaches. Additionally, Respondent deviated from the standard of care by using highly addictive opioids and benzodiazepines.

8. The Board established by clear and convincing evidence that Respondent deviated from the standard of care by failing to document in L.R.'s medical records that he had checked the CSPMP to ensure L.R. was not engaged in drug-seeking behavior.

9. Accordingly, the Board established 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 L.R. as defined by A.R.S. § 32-1402(2).

10. Further, the Board established Respondent's conduct constituted unprofessional conducted 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.

ORDER

Based on the foregoing, it is **ORDERED** revoking Cedric W. McClinton's License No. 12711 for the practice of allopathic medicine in the State of Arizona.

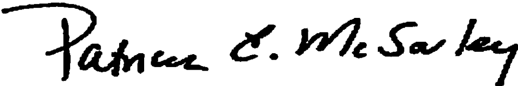
RIGHT TO PETITION FOR REHEARING OR REVIEW

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 10th day of April 2020.

THE ARIZONA MEDICAL BOARD



By______________________________
Patricia E. McSorley
Executive Director

ORIGINAL of the foregoing filed this
10th day of April, 2020 with:

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

COPY of the foregoing filed this
10th day of April, 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 this
10th day of April, 2020 to:

Cedric W. McClinton, M.D.
Address of Record

Roberto Pulver
Assistant Attorney General
Office of the Attorney General
SGD/LES
2005 N. Central Avenue
Phoenix, AZ 85004

Michelle Robles