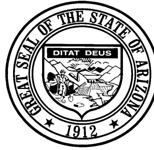

Arizona Medical Board

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FINAL MINUTES FOR BOARD REVIEW COMMITTEE B MEETING
Held on Wednesday, June 4, 2025
1740 W. Adams St., Board Room B• Phoenix, Arizona

Committee Members
Lois E. Krahn, M.D., Chair
Katie S. Artz, M.D., M.S.
Jodi A. Bain, M.A., J.D., LL.M.
David C. Beyer, M.D., F.A.C.R., F.A.S.T.R.O.
James M. Gillard, M.D., M.S., F.A.C.E.P., F.A.A.E.M.
Jessyca Leach

GENERAL BUSINESS

A. CALL TO ORDER
Chairwoman Krahn called the Committee's meeting to order at: 10:17 a.m.

B. ROLL CALL
The following Committee members were present: Dr. Krahn, Ms. Bain, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz.

ALSO PRESENT
The following Board staff participated in the meeting: Raquel Rivera, Interim Executive Director; Nicole Samaradellis, Investigations Manager and Heather Foster, Public Records Coordinator. Carrie Smith, Assistant Attorney General ("AAG") was also present.

C. OPENING STATEMENTS
Chairwoman Krahn read the civility policy for the record.

D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA
Individuals who addressed the Board during the Public Statements portion of the meeting appear beneath the case.

E. APPROVAL OF MINUTES

- December 13, 2024 Review Committee B Minutes

  MOTION: Dr. Gillard moved to approve the December 13, 2024 Review Committee B Minutes.
  SECOND: Dr. Beyer.
  VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Beyer and Dr. Gillard. The following Committee member who abstained: Ms. Leach. The following Committee members who were absent: Dr. Artz and Ms. Bain.
  VOTE: 3-yay, 0-nay, 1-abstain, 0-recuse, 2-absent.
  MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS

1. MD-22-0950A, RACHEL E. SWART, M.D., LIC. #36169

D.K. and J.B. addressed the Board during the Public Statements portion of the meeting. Dr. Swart was present with counsel Ms. Kathleen Rogers.

Board staff summarized that the case was brought to the board on October 6, 2022 from a National Practitioner Databank Report. A 67-year-old otherwise healthy woman with a potentially cured stage IA triple negative breast cancer had received 2 months of chemotherapy with four cycles of docetaxel + cyclophosphamide, the last dose 4/9/2021. She subsequently developed considerable diarrhea over several days (amount and duration variably reported). The patient died on 4/17/24, which is Day 9 while in her nadir, as also confirmed by the low platelet count of 94K and neutrophil count 2.02. This represents a treatment-related avoidable death. Each of these two drugs can cause diarrhea and together the risk from the diarrhea increases. There is also a rare form of severe diarrhea/enterocolitis that can occur with either of the two drugs administered separately and this can result in death if not properly managed. The patient's vital signs were severely abnormal and only worse before she was discharged from clinic - this despite getting 2 liters of IV fluids (which naturally made her feel transiently better). During the 2 liters of IV fluids: her BP readings were chronologically 82/44 to 80/40 to 70/40 to 75/42 with corresponding tachycardia back again at the end of the infusions. This should have been an easy red line: the infusion nurse should have reflexively informed the physician who had a great opportunity to then reflexively send the patient to the Emergency Room. If this did not happen, the nurse herself should have objected. Going home in a wheelchair was not the right option. SIRC stated that the Medical Consultant (“MC”) determined that Dr. Swart deviated from the standard of care by failing to recognize and properly manage reversible complications of adjuvant chemotherapy and failed to refer a patient to a higher level of care for severe chemotherapy-related toxicities. The MC stated that the patient was in the nadir period from her last chemo cycle and was acutely ill on presentation to the clinic and the MC noted that there was no documentation in the medical record that the patient was instructed to go to emergency department for evaluation. SIRC discussed the case and noted that despite Dr. Swart’s testimony during her deposition that she referred the patient to the hospital, there is no documentation to support this in the records reviewed. SIRC noted that a patient has the autonomy to refuse to go to the hospital; however, if Dr. Swart was concerned enough to direct her to the ER and she refused, it should be documented in the records. SIRC recognized Dr. Swart has no prior Board history. Board staff noted that this case was scheduled for the December 13, 2024, meeting. This case was pulled for further discussion wherein the members voted to offer Dr. Swart a Consent Agreement for a Letter of Reprimand and Probation to include, within 6 months, Dr. Swart complete no less than 5 hours of Board staff pre-approved Category 1 CME in the management of shock and complications from chemotherapy. Dr. Swart elected to appear before the Board for a formal interview.

Dr. Swart made an opening statement stating that her first meeting the patient RK was after her cancer diagnosis. The patient agreed to chemotherapy and went through treatments without complications. RK called stated she was having excessive amounts of diarrhea. Dr. Swart requested the patient to go to the ER for treatment. The patient declined. RK came into the clinic for hydration therapy and admitted at this time she was placed on an antibiotic by her primary care physician (PCP). Dr. Swart was concerned that the patient may have enterocolitis due to her symptoms and instructed her to go to the ER after her hydration treatment. RK refused to go to the ER. Dr. Swart stated that RK’s vitals were stable and she walked out of the office. The husband called Dr. Swart regarding RK’s condition. Dr. Swart informed him she needs to go to the ER for treatment. The husband brought his wife to the office instead as she had an appointment for hydration therapy. RK was provided with hydration therapy and labs were completed. Dr. Swart stated she instructed the NP to send in medications to the pharmacy as the patient was positive for C Diff colitis. The patient expired the next day. Dr. Swart stated she would not sign the death certificate as she opined the patient did not pass due to her cancer diagnosis. Furthermore, per office policy she could not sign the death certificate. Dr. Swart requested the Medical Examiner’s office signs the death certificate. Dr. Swart

acknowledged she lacked documentation in her medical records and stated that she now documents everything including phone call conversations and keeps up on her CMEs.

Dr. Beyer stated this case caught the Board's attention due to RK blood pressure readings.

During questioning, Dr. Swart stated that she was in between patients and the vital signs were never reported to her from her nurse. Dr. Swart stated that she informed the patient to go to the ER as the office could not provide the necessary treatments. The patient declined to go to the ER. The nurse informed Dr. Swart after RK left the office that her blood pressure did improve with hydration therapy. Dr. Swart stated she did not discharge the patient home. Dr. Swart stated she sees her patients the day before or the day of their chemotherapy treatments. Hydration therapy is scheduled on the fourth of fifth day after chemotherapy to help reduce nausea. Dr. Swart mentioned she can see her patients during the hydration therapy sessions when she has time in her schedule. Sometimes she needs to depend on nursing staff to help the patient. Dr. Swart stated she informed her nursing staff to send RK to the ER. The nursing staff did not inform her until the end of day that the patient refused and went home instead. Dr. Swart admitted a deficit in the medical records in that she did not document her recommendation to send the patient to the ER. She stated that they try to sign the medical records as quickly as possible. It may take some time to cosign her NP's medical records. Arizona Oncology does not have a form for a patient to sign to refuse medical advice. Snoran Quest laboratory is on site. CDC labs can be requested stat within 30 minutes. Any other lab test must be sent out for results. Dr. Swart commented that RK was her full-time patient. Dr. Swart requested all patients to call the on-call physician or seek out the ER with complications to their treatments. RK only called once that week and it was due to severe diarrhea. Clindamyacin antibiotics are common to cause C-Diff and should be avoided for chemotherapy patients. Dr. Swart opined if RK went immediately to the ER, she would have stat labs completed and treatments administered, which could have changed the outcome. Dr. Swart commented she did not check the EMR for notes about phone calls or updates on the patient. The practice's policy is to provide a message to the patient. Dr. Swart opined that RK could have had multiple factors that made her sick and opined that C-Diff was the reason for her death. Dr. Swart noted that antibiotics can make an infection worse while being at chemotherapy and her patients are informed to tell her when they are prescribed an antibiotic. Dr. Swart stated that on call coverage is provided after hours. During the day, all physicians care for their own patients. Patients who do not have an appointment and have complications are informed to go to the ER. If the patient has an appointment they are seen and then transferred to an appropriate facility if needed. There are no social workers provided within the office, only nurses. Dr. Swart informed the Board she has done that in the past, but that night she could not due to the intake of calls. Dr. Swart informed RK while she was in the infusion room that her infection could cause death and she needs to seek out the ER for assistance as the office could not assist with this care.

Dr. Beyer observed that the office is too busy to provide adequate care to RK and that RK should have seen Dr. Swart personally in the office.

Dr. Swart stated that she does not disagree with Dr. Beyer's statement. Arizona Oncology was busy during this time. Dr. Swart stated she has cut down the patient load. In hindsight, Dr. Swart stated that she realized she was not providing the adequate care RK needed.

Dr. Gillard stated the patient was in hypovolemic shock. An ambulance should have been called. If the patient refused to go to the ER by ambulance, then there would be a record of refusal. He was more worried about the hyperkalemic shock than the C-Diff infection.

Dr. Swart stated that RK's BP did improve with the hydration. Dr. Swart opined that if she called 911, the patient would still have refused to go to the ER. Dr. Swart noted that there were resource issues due to Covid.

Ms. Rogers made a closing argument noting that the case came from the NPDB due to a malpractice settlement. Dr. Swart was responsible. She noticed two issues within this case- a system failure and documentation. That is why she consented to settlement and changed her practice. Ms. Rogers stated that Dr. Swart's patient care is sound. Due to COVID, family members were not allowed to attend visits. Dr. Swart informed the patient to seek out the ER due to possible C-Diff. This information should have been relayed to the husband. In hindsight, Dr. Swart should have called the patient for follow-up. She was busy with on-call phone calls. Dr. Swart now documents everything. Ms. Rogers requested the case result in an Advisory Letter.

In Dr. Swart's closing statement, she stated that medicine is a constant, ever-changing process. She learns from every patient and every event and will continue to do so.

MOTION: Dr. Beyer moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) and (r).
SECOND: Dr. Gillard.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Ms. Bain, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

MOTION: Dr. Beyer moved for a draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand.
SECOND: Dr. Gillard.
Dr. Beyer stated that this case is mitigated due to COVID, but opined that COVID is not the reason behind it. The physician was not involved in the care of the patient. The patient was being managed by the nurse. Ms. Leach agreed with the motion.

Dr. Krahn spoke in favor of the motion, stating that she understands there is a systems failure, but also opined that there was a lack of physician care as well.

Ms. Bain asked how the Letter of Reprimand is processed.

Ms. Smith stated that it is a disciplinary action that is on the physician's permanent licensing record.

MOTION: Ms. Bain moved for the Board to enter into Executive Session pursuant to A.R.S. § 32-431.03(A)(3) to obtain legal advice.
SECOND: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Ms. Bain, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board entered into Executive Session at: 11:34 a.m.
The Board returned to Open Session at: 11:45 a.m.
No legal action was taken by the Board during Executive Session.

VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Beyer, Dr. Gillard, and Mr. Leach. The following Committee members voted against the motion: Ms. Bain. The following Committee members were absent: Dr. Artz.
VOTE:4 -yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. <u>MD-24-0062A, JOHN ADAN, M.D., LIC. #17530</u>
   Dr. Adan was present with counsel Michael Raine.

   Board staff summarized that the Board initiated this case after Dr. Adan notified Board staff that he needed a fitness for duty evaluation and to enroll in monitoring with our Board. Dr. Adan subsequently explained that the evaluation was requested by the Washington Board, who had issued a statement of charges against him based on an evaluation at a Board approved facility. Dr. Adan's attorney indicated that the Washington Board had reconsidered discipline to have Dr. Adan monitored and that it would consider Arizona's program for this purpose. Dr. Adan's attorney provided Board staff with information showing how the parties had agreed to proceed and how this Board could resolve Washington's concerns and permit Dr. Adan to continue to practice. According to documents provided by Dr. Adan and the Washington Board, the Washington Board's investigation was initiated in January 2021 after receipt of a complaint in December, 2020 alleging concerns with patient safety and identifying two patients that had concerning events. The Washington Department of Health investigated the hospital and identified nine events of patient harm, five of which involved Dr. Adan and two of which were included in the December, 2020 complaint. In total, there were 5 patients with identified concerns in Washington. The Washington Board confirmed that Dr. Adan's care of these five patients was never reviewed to evaluate the identified concerns and/or determine if he met the standard of care. Board staff noted that there were multiple emails exchanged between Dr. Adan, Washington Board staff and his attorney showing that he knew about their investigation as early as January 20, 2021. During the course of this Board's investigation, Dr. Adan underwent evaluations and was found safe to practice. SIRC reviewed the case and remained concerned with the lack of insight into the serious concerns documented by the Washington Board investigative file. Specifically, SIRC noted the evaluating facility's finding that Dr. Adan had no intention of limiting himself and would continue to work until someone told him to stop. SIRC found that it is unequivocal that Dr. Adan was notified of the open investigation in Washington in January, 2021, and even if he thought it was dismissed, an open investigation was confirmed in March, 2021. SIRC noted that Dr. Adan applied for an Compact license in February 2021 and February 2022 and failed to disclose the open Washington investigation which related to significant and egregious quality of care allegations. SIRC stated that a physician with an open investigation is not eligible for Compact licensure, and had Dr. Adan disclosed this information, he would not have qualified for an Compact license. SIRC also noted Dr. Adan's report that he does not practice in Arizona but resides here and commutes to Nevada and California for work. For these reasons, SIRC recommended a Letter of Reprimand.

   Mr. Raine made an opening statement to the Board and noted there was an administration error made on the Compact application. Dr. Adan's staff made the error on behalf of the physician. His staff provided a signed statement for the Board's review. Dr. Adan has taken responsibility for the administration error. He was unaware of the error until the Board addressed it. He has gone through several evaluations that state he is fit to practice. The investigations had taken several years of Dr. Adan's time. Mr. Raine requested that the Committee issue an Advisory Letter.

   In his opening statement, Dr. Adan agreed with his council's presentation.

   During questioning, Dr. Adan stated the signature on the application is an electronic signature and never reviewed the application prior to it being submitted to the Medical Board.

   MOTION: Dr. Krahn moved for the Board to enter into Executive Session pursuant to A.R.S. § 32-431.03(A)(3) to obtain legal advice.
   SECOND: Ms. Bain.
   VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Ms. Bain, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz

VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Board entered into Executive Session at: 12:06 p.m.
The Board returned to Open Session at: 12:31 p.m.
No legal action was taken by the Board during Executive Session.

MOTION: Dr Krahn moved to return the case for further investigation to review whether a A.R.S. § 32-1401(27)(jj) should be sustained.
SECOND: Dr. Gillard.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Ms. Bain, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz.
VOTE: 5-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

H. FORMAL INTERVIEWS

1. MD-23-1071A, PAUL R. VALBUENA, M.D., LIC. #41643
Dr. Valbuena was present with counsel Courtney Sullivan.

Board staff summarized the case was initiated on October 31, 2023, after receiving a report from the Arizona Board of Pharmacy indicating that Dr. Valbuena was non-compliant with the mandatory use requirements for the Arizona Controlled Substance Prescription Monitoring Program (CSPMP). Specifically, during September, 2023, Dr. Valbuena prescribed a total of 174 opioids and/or benzodiazepines with zero queries to the CSPMP. The CSPMP also reported the following potential deviations from best practice recommendations which are documented in the case file. In his response, Dr. Valbuena stated the number of prescriptions is not completely accurate but did not dispute the lack of queries on his end. He stated that he is the Corporate Chief Medical Officer of Buena Vista Health and Recovery, which is an acute in-patient setting. Dr. Valbuena stated that the substances patients are coming off of are alcohol, fentanyl, Heroin, and benzodiazepines. The facility is subacute without an in-house pharmacy and Dr. Valbuena stated he needs to be proactive and prescribe medications based on their history of substance use coming in. He stated that his prescriptions in September 2023 did seem excessive and there were a significant number of prescriptions that were sent from an inpatient setting and not his private practice. Dr. Valbuena indicated that he knows he could have done better and did not check the CSPMP as much as he wanted mainly due to the acute nature of his business, volume that month, and some sporadic IT issues. Dr. Valbuena stated that going forward, his goal is to check all patients in the CSPMP for any overlapping of prescriptions. Based on the information reviewed, Board staff determined that Dr. Valbuena engaged in unprofessional conduct by failing to comply with the mandatory use requirements for the Arizona CSPMP. Board staff performed a CSPMP review of Dr. Valbuena's prescribing from December 2022 to December 2023, and selected three patients for further review (JM, SR, and RM).

JM was a 37-year-old female patient seen since May, 2018. JM's medical history included ADHD, major depression disorder, generalized anxiety disorder, and panic attacks treated with Vyvanse 60 mg daily, Klonopin 0.5 mg daily, Ambien 5 mg at bedtime, Seroquel 100 mg at bedtime, Vistaril 100 mg twice daily, gabapentin 800 mg TID, Lexapro 20 mg daily, Effexor 75 mg daily. Dr Valbuena noted the history of substance use disorders and obtaining opioid prescriptions for pain. The patient was not on medications for ADHD prior to seeing Dr. Valbuena. The MC found Dr. Valbuena deviated from the standard of care by failing to complete an initial workup to fully diagnose ADHD before starting and maintaining stimulant medications, failed to coordinate care with other prescribers especially when prescribing the sedatives Klonopin and Ambien to a patient also receiving opiates for pain treatment, failed to maintain detailed records indicating patient vital signs, prescriptions including the name, directions, quantity and the number of refills. No actual harm was reported in the records. Potential harms were medical adverse events by prescribing stimulants without a workup,

combining stimulants and sedatives makes it difficult to determine the actual mood status and the risk of respiratory arrest or delirium by combining sedatives and opioids. In summary, the MC discussed the failure to protect a patient with substance use disorder from possible relapse by prescribing controlled substances.

SR was a 52-year-old male patient initially seen for transcranial magnetic stimulation (TMS). SR was experiencing depression, not fully responding to medications alone and had failed ECT and ketamine nasal spray. The patient was on Remeron 30 mg daily, Klonopin 2.5 mg daily Adderall 60 mg daily and Ambien 10 mg nightly. The MC found Dr. Valbuena deviated from the standard of care by failing to complete an initial workup to fully diagnose ADHD before starting stimulant medications, failed to coordinate care with other prescribers especially when prescribing the sedatives Klonopin and Ambien to a patient also prescribed opioids for pain, not obtaining records from previous psychiatrists, and failed to maintain detailed records indicating patient vital signs, prescriptions with the medication name, directions, quantity and refills. Potential harm was medical adverse events, difficulty determining the patient's actual mood by combining stimulants and sedatives and developing dependence. In summary, the MC stated Dr. Valbuena failed to protect a patient from possible substance use by prescribing controlled substances with early refills, noting concern about the patient's refill pattern but not following through with an intervention/discussion.

RM is a 43-year-old patient with opioid use disorder and bipolar II disorder prescribed Suboxone 24 mg daily, Ambien 12.5 mg Gabapentin 3600 mg daily, Cymbalta 120 mg daily and Seroquel 800 mg nightly. RM was first seen by a physician assistant supervised by Dr. Valbuena on 5-29-18. The note was detailed and contained the information necessary to communicate care to other prescribers. The patient was continued on Suboxone 24 mg daily, the maximum recommended dose for medication assisted treatment. Urine drug screens were obtained, and results recorded on a monthly basis for the first year and then stopped being recorded and the patient was seen by telephonic visits. The patient was seen in person and the first drug screen in 11 months was obtained. During Covid from April 2020 to early 2022 visits were by telephone, and no drug screens were obtained. The patient resumed in office visits, but no urine drug screens were recorded from 2022 to present. The MC found deviation from the standard of care when Dr. Valbuena failed to follow SAMHSA recommendations for following urine drug screens for Suboxone SUD patients. This patient was at maximum doses of both Suboxone and Ambien. The physician would never know if other drugs were in the patient's system without a UDS. The physician would also not know if the patient was taking Suboxone or diverting it without a UDS. Potential harm was respiratory arrest/failure by combining opioids and sedatives especially if the patient relapsed on other opioids.

In all three cases, the MC found Dr Valbuena failed to fully protect the patients from potential harm of his prescribing and as an Addiction Psychiatrist should have been aware of the risks and consequences. The medical records did not reflect this concern in any detail other than noting that there was a discussion of adverse possibilities.

The MC found no actual harm was reported in the records of the three patients.

Dr. Valbuena responded that the three patients selected for review were outliers and they are clearly a minority of his private practice patients. He reported multiple changes to his practice including having a proxy, his medical assistant, and uploading all the PMP's to the EHR prior to his patient visits.

SIRC observed that the MC noted that in all cases the documentation lacked clinical decision making, vital signs, and prescriptions. The MC also noted that Dr. Valbuena did not request records from the patients' previous treating providers.

SIRC discussed the case and acknowledged Dr. Valbuena's report of being the CMO for a subacute in-patient facility that provides drug and alcohol treatment to patients and

questioned whether Dr. Valbuena was exempt from mandatory use requirements as outlined in A.R.S. § 36-2606(H)(4). However, SIRC noted that the patients reviewed did not appear to be impatient but followed on an outpatient basis by Dr. Valbuena. SIRC further noted that the records do not indicate care rendered at Buena Vista Recovery and Dr. Valbuena's practice, according to his profile is Valbuena Wellness. SIRC remained concerned with the deviations identified by the MC noting Dr. Valbuena specializes in addiction psychiatry and failed to obtain UDS for Patient RM in 2022 and 2023 and agreed with the MC that Dr. Valbuena put JM at increased risk for adverse events due to the use of opiates along with the prescribed sedatives, and should have been more keenly aware of the risks and consequences. SIRC is not persuaded by Dr. Valbuena's report of practice changes, which SIRC noted did not include a plan to ensure documentation of vital signs and visits, how he intends to properly diagnose and treat ADHD, or ensure receipt of records from other treating physicians. SIRC recognized Dr. Valbuena's prior Board history involving inadequate documentation. Therefore, SIRC stated that based on the multiple deviations identified, this case rises to the level of discipline and recommended a Letter of Reprimand and Two-Year Probation to complete CME in controlled substance prescribing. SIRC noted that Dr. Valbuena was previously ordered to complete CME in medical recordkeeping which was completed in September 2024. SIRC further recommended Dr. Valbuena be required to enroll in chart reviews for outpatient cases from his private practice, Valbuena Wellness, to ensure he incorporates the education into his practice.

Dr. Valbuena made an opening statement without refuting the cases. He stated that he has made significant changes and is mindful of his time. He has integrated the CSPMP into his EMR system. Dr. Valbuena confirmed he has a proxy as his medical assistant has been with him for over 10 years now. He has made a pass through for the lab on urine drug screen. An Acknowledgement letter to show another provider that we are both treating the physician. He is no longer taking on NPs in the office. Learned to say no. Made a lifestyle change and sorry that it has come to this point to make these changes. Being a physician requires being mindful of safety.

Ms. Sullivan made an opening statement and noted that Dr. Valbuena completed the CME and exceeded the amount of CME requested and implemented changes based off the information from the CME. Due to both cases running in conjunction with each other, Dr. Valbuena opined that the case has been resolved in conjunction with the other case. Dr. Valbuena works for six different impatient facilities with substance abuse patients. He understands that documentation is important and requests for this case result in an Advisory Letter with CME Order.

Dr. Gillard stated that JM had a history of anxiety and panic attacks and was prescribed an amphetamine. Dr. Valbuena agreed that it was not a good decision to prescribe amphetamines that can make anxiety worse.

Dr. Beyer asked Board staff how patient charts are selected.

Board staff commented patient charts are picked through a data analysis and an Internal Medical Consultant chooses the three charts based on the data analysis. Dr. Valbuena stated that knew these well and these three patients are ones who take the most medications in his practice. Board staff stated that these patients were not chosen randomly, they were chosen based on the number of medications, quantities of medications and number of pharmacies.

During questioning, Dr. Valbuena stated that all the psychotropic drugs were prescribed by him. Dr. Valbuena's outpatients are suffering from anxiety, insomnia, panic attacks and more. Dr. Valbuena stated that urine drug screens were utilized, but then fell by the wayside. He was aware of the CSPMP requirement and neglected the requirement as he was not sure how important it was until now. Dr. Valbuena stated he has been practicing addiction psychology since 2011. He never had formal training in addiction psychology and thought about sitting for the boards due to his years of knowledge, but he has not.

He stated these medications were not prescribed at once. They were prescribed over the years.

Dr. Valbuena made a closing statement that this process had rejuvenated his career. He is not refuting or arguing about his shortcomings.

Ms. Sullivan made a closing statement noting the lack of patient harm. He has taken significant time to understand and know his patients. Ms. Sullivan requested to have the case result in an Advisory Letter or Advisory Letter with CME.

MOTION: Dr. Gillard moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(a) (A.R.S. § 36-2606(f)), (e) and (r).
SECOND: Dr. Beyer.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz and Ms. Bain.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Gillard moved for a draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand.
MOTION FAILED DUE TO NO SECOND.

MOTION: Dr. Gillard moved to issue an Advisory Letter and Order for Non-Disciplinary CME for inappropriate prescribing of controlled substances, failing to query the CSPMP prior to prescribing controlled substances, and inadequate documentation. While the licensee has demonstrated substantial compliance through rehabilitation or remediation that has mitigated the need for disciplinary action, the board believes that repetition of the activities that led to the investigation may result in further board action against the licensee. Within six months, complete no less than 15 hours of Board staff pre-approved Category I CME in an intensive, virtual course regarding controlled substance prescribing. The CME hours shall be in addition to the hours required for license renewal.
SECOND: Dr. Beyer.

Dr. Beyer opined that the prescribing could have caused patient harm. Dr. Beyer stated he appreciated the measures the physician has taken in making changes to his practice.

Dr. Krahn stated this could have been a disciplinary action and recommended that Dr. Valbuena be less busy and spend more time with his patients.

VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz and Ms. Bain.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

I. FORMAL INTERVIEWS

1. MD-23-1077A, HABIB U. KHAN, M.D., LIC. #27915
   Dr. Khan was present with counsel Ms. Robin Burgess.

   Board staff summarized the case was opened after the Board received a complaint that Dr. Khan recommended suicide as a solution for a patient's chronic pain and depression. In October of 2023, while incarcerated at the ICE facility, OF, a 35-year-old male with a history of depression, chronic lumbar radiculopathy, and balanitis saw Dr. Khan at the Arizona Institute of Neurology. The patient complained of not being able to exercise, sleep, stand or sit without pain. He also complained of testicular pain and impotence which he said added to his depression. Dr. Khan told the patient that he could kill himself as a way to relieve his pain. In his response letter, Dr. Khan stated that he quickly

recognized this suggestion was a mistake and immediately apologized explaining to the patient that was a joke. Dr. Khan said that he was embarrassed and wanted to offer an unconditional apology. OF stated Dr. Khan caused him mental pain and that he was not being properly treated because Dr. Khan never provided a care plan for his chronic pain. The Board's MC reviewed the case and determined that Dr. Khan deviated from the standard of care when he inappropriately recommended that a vulnerable patient commit suicide and for failing to provide a referral to a mental health provider for treatment of depression. The AMA code of medical ethics states patients have the right to receive treatment information from their physicians and to have the opportunity to discuss the benefits, risks and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance on the optimal course of action for the patient based on the physician's objective professional judgement. Recommending suicide to this patient, even in jest, is a violation of the AMA code of ethics. The standard of care for treatment of a patient with depression by a non-psychiatrist, is to refer them to a psychiatrist or mental health provider. It also involves providing care within one's scope of practice and referring a patient to another provider when the care required is outside of that practitioner's expertise. Dr. Khan was not providing psychiatric care to OF. He made a recommendation related to the patient's complaints that falls well below the standard of care in the practice of any discipline of medicine and is controversial in the practice of psychiatry in the state of Arizona. He did not offer a psychiatric referral nor did he suggest that the patient see a behavioral health provider for further evaluation and management of depression. Dr. Khan did not give an objective professional opinion that included the risks, benefits or alternatives. He did not provide guidance on the optimal treatment of depression resulting from chronic pain. He recommended suicide. In the state of Arizona, suicidal ideation is considered a medical emergency. This caused psychological harm to the patient, it did not alleviate his pain, and it may have made additional interventions necessary to control the patient's depression and anxiety. A Letter of Reprimand and completion of the CPEP Enhanced Patient Communication course have been recommended.

Ms. Burgess provided an opening statement, and asserted that Dr. Khan's care of the patient was appropriate. The conversation with the patient was the issue. The patient was in pain. The patient and Dr. Khan were both frustrated about the system and the control of the patient's pain. He made a statement to the patient that could be misconstrued. He apologized for the comment. Ms. Burgess noted that Dr. Khan acknowledged faults and was remorseful for this comment. Dr. Khan has never had a complaint against his license and has signed up for CME for enhanced communication and requested to have this case dismissed due to the lack of patient harm.

Dr. Kahn made an opening statement and apologized for the comment, stating that he immediately regretted making the comment to the patient.
During questioning, Dr. Khan reiterated he had no other complaints on his license. This is the first regarding miscommunication. He does have training in psychology and neurology, as he is board certified in both specialties, but stated that he only practices in neurology. The patient was an established patient within the practice. The patient's care and treatment would have been the same whether he was incarcerated or not. Dr. Khan stated to the patient that if he was not here, the pain would not have been complicated. Dr. Khan asserted that he did not inform the patient to commit suicide, but that he immediately apologized for the statement as he knew the verbiage could have been misconstrued. He meant that the patient's incarceration was making his pain complicated.

Ms. Leach asked Board staff if written statements were obtained from the three security guards who were present at the visit.

Board staff stated there was no documentation obtained from the guards on what was said between the physician and the patient during the visit. The original complaint was not made by the patient but by someone else on behalf of the patient. Board staff noted

that the medical records would have indicated that guards were present for the visit. There was no mention made in the medical records of three guards being present for the visit.

Dr. Khan stated that it is typical for guards to be present for incarcerated patients. Therefore, the physician does not make a statement within the medical records that security guards were present for the visit. The patient did not speak fluid English but understood what was being said during the visit.

Ms. Burgess made a closing statement that Dr. Khan recognized he made a comment that could have been misconstrued and immediately apologized to the patient. There is room for interpretation for any conversation. The Board had an outside MC review of the patient's care and did not identify any additional recommendations. Ms. Burgess asked for the case to be dismissed.

Dr. Khan made a closing statement and expressed regrets regarding the comment.

Dr. Beyer commented the patient reported to his psychiatrist that Dr. Khan stated that he should kill himself. Whether those were the words that were spoken, that was the understanding of the conversation. Dr. Beyer stated he appreciated the immediate apology, but commented that it appeared the patient did not hear the apology.

MOTION: Dr. Beyer moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r).
SECOND: Dr. Krahn.
Dr. Gillard stated that he has a hard time finding a violation of conduct in light of the clear and convincing evidence standard and the language in the complaint and spoke against the motion. Ms. Leach agreed with Dr. Gillard and spoke against the motion.

Dr. Beyer stated a physician needs to take responsibility for their communication to a patient. It is not the patient's responsibility to understand the nuance of the message. It was clear of the message the patient heard. That is not the way a physician should care for the patient and a violation of conduct was made.

Ms. Leach stated that communication could mean that if you're not incarcerated you could have better care. The nuances matter.

Dr. Krahn opined that it could have caused patient harm as the patient felt it was necessary to inform his psychiatrist, causing emotional distress.

Dr. Gillard opined it was secondhand information, and incarcerated patients are always finding something to complain about. Not convinced it was the patient who complained.

VOTE: The following Committee members voted in favor of the motion: Dr. Krahn and Dr. Beyer. The following Committee members voted against the motion: Dr. Gillard and Ms. Leach. The following Committee members were absent: Dr. Artz and Ms. Bain.
VOTE: 2-yay, 2-nay, 0-abstain, 0-recuse, 2-absent.
MOTION FAILED.

MOTION: Dr. Gillard moved to dismiss.
SECOND: Ms. Leach.
Dr. Gillard opined the complaint looked like it was a prosecuting attorney who filed it.
VOTE: The following Committee members voted in favor of the motion: Dr. Gillard and Ms. Leach. The following Committee members voted against the motion: Dr. Krahn and Dr. Beyer. The following Committee members were absent: Dr. Artz and Ms. Bain.
VOTE: 2-yay, 2-nay, 0-abstain, 0-recuse, 2-absent.
MOTION FAILED.

MOTION: Dr. Gillard moved to dismiss.
SECOND: Ms. Leach.
Dr. Krahn stated the board struggles with the adjudication process of this case.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz and Ms. Bain.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

GENERAL BUSINESS

J. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

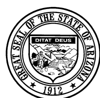
Lois E. Krahn, M.D., Chair

Dr. Krahn opined new equipment would be appreciated in Boardroom B.

K. ADJOURNMENT

MOTION: Dr. Gillard moved for adjournment.
SECOND: Ms. Leach.
VOTE: The following Committee members voted in favor of the motion: Dr. Krahn, Dr. Beyer, Dr. Gillard, and Ms. Leach. The following Committee members were absent: Dr. Artz and Ms. Bain.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

The meeting adjourned at 2:54 p.m.



Raquel Rivera

Raquel Rivera, Executive Director