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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **CRAIG W. TOLLESON, M.D.,** Holder of License No. 36928 For the Practice of Allopathic Medicine In the State of Arizona.	Case No.18A-36928-MDX **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER (License Revocation)**

On January 10, 2019, this matter came before the Arizona Medical Board ("Board") for consideration of Administrative Law Judge (ALJ) Jenna Clark's proposed Findings of Fact, Conclusions of Law and Recommended Order. Craig W. Tolleson, M.D., ("Respondent") appeared telephonically on his own behalf; Assistant Attorney General Anne Froedge represented the State. Assistant Attorney General Elizabeth A. Campbell was available to provide independent legal advice to the Board.

The Board, having considered the ALJ's Decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

PROCEDURE

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

2. Respondent is the holder of License No. 36928 for the practice of allopathic medicine in Arizona. Administrative Notice is taken that Respondent was first issued his license to practice in the State of Arizona on May 03, 2007.[1] Respondent's license is currently suspended and ineligible for renewal.[2]

Case MD-15-0771A

3. Case MD-15-0771A was opened by the Board on June 26, 2015, to investigate a notification that Respondent had been found guilty of an extreme DUI[3] on

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[1] *See* http://www.gls.azmd.gov/glsuiteweb/clients/azbom/Public/Profile.aspx?entID=1640351&licID=305959&licType=1.
[2] Once this matter is closed Respondent may reapply for licensure with the Board, if necessary.
[3] In violation of ARIZ. REV. STAT. § 28-1382(B).

February 11, 2009, which had never been reported to the Board although required by statute.[4] On July 07, 2015, the Board issued a letter to Respondent which stated, in pertinent part, that Respondent had until July 21, 2015, to provide a written narrative to the Board regarding his alleged violations of Ariz. Rev. Stat. §§ 32-3208(A) and 32-3208(D).[5]

4. The Board received Respondent's reply to the MD-15-0771A letter on or about August 08, 2015.[6] Respondent alleged that on the afternoon September 13, 2008, he crashed his sports car whilst returning from the market, during an effort to avoid hitting a deer on the road. Per Respondent, after the crash he retrieved a bottle of wine from amongst his groceries and consumed wine in an effort to alleviate injuries he suffered from the crash with the "diuretic."[7] Respondent alleged that he failed to report his arrest and conviction to the Board because he believed his supervisor at work would do it for him.[8] Respondent attached a letter from his supervisor along with his response to the Board, but nowhere in the supervisor's letter does the supervisor state that he agreed or intended to notify the Board about Respondent's DUI.[9]

5. On March 18, 2016, the Board investigator assigned to MD-15-0771A drafted an Investigative Report whereby it was alleged that Respondent was in violation of Ariz. Rev. Stat. §§ 32-1401(27)(a), 32-3208(A), 32-1401(27)(dd), and 32-1401(27)(jj).[10]

6. On June 16, 2016, the Board voted to offer Respondent an Interim Consent Agreement for a full practice restriction.[11]

Case MD-14-1140A

7. The Board opened case MD-14-1140A against Respondent to investigate a confidential complaint it received on or about August 07, 2014, regarding an allegation that Respondent had inappropriately prescribed medication to a patient, resulting in that patient's death.[12]

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[4] *See* Board Exhibits 71, 72, and 75.
[5] *See* Board Exhibit 73.
[6] *See* Board Exhibit 74.
[7] *Id.*
[8] *Id.*
[9] *Id.*; *see also* Respondent Exhibit A.
[10] *See* Board Exhibit 76.
[11] *See* Board Exhibit 77.
[12] *See* Board Exhibit 1.

8. During the MD-14-1140A investigation, the Board discovered adequacy issues with several of Respondent's patients' records. On September 01, 2015, the Board requested the records of patients L.D., S.D., S.W., M.W., and K.P., as well as a narrative response for each patient.[13] Respondent was given until September 15, 2015, to comply or request an extension. On September 15, 2015, the Board received a request for an extension of time from Respondent's attorney.[14] Respondent was given until October 06, 2015, to comply with the Board's request. On October 06, 2015, the Board received a request for an extension of time from Respondent's attorney.[15] Respondent was granted another extension and given until October 27, 2015, to comply with the Board's request.[16] Respondent partially complied.

9. On or about September 21, 2015, pursuant to a duly executed subpoena, the Board received affidavits and corresponding prescription records for patients S.D., B.B., S.W., K.P,. and L.D.[17] On or about November 12, 2015, pursuant to a duly executed subpoena, the Board received affidavits and corresponding prescription records for patient M.W.[18]

10. On November 18, 2015, the Board issued a Letter of Noncompliance to Respondent, whereby the Board alleged Respondent failed to timely provide information to the Board in violation of Ariz. Rev. Stat. § 32-1401(27)(dd).[19] Respondent was instructed to provide a written response to the allegation, as well as provide all outstanding patient records and written narratives by December 02, 2015.[20]

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[13] *See* Board Exhibits 15 and 32. Two patients with the initials S.W. appeared in the original letter to Respondent. Ms. Rivera testified that upon inquiry by Respondent's attorney on October 27, 2015, one of the S.W. patients was swapped out for patient M.W. because patient S.W. was the subject of the Board's prior MD-13-0458A investigation.
[14] *See* Board Exhibit 23.
[15] *See* Board Exhibit 31.
[16] *See* Board Exhibit 33.
[17] *See* Board Exhibits 24, 25, 26, 27, 28, 29, and 30.
[18] *See* Board Exhibits 34, 35, 36, and 37.
[19] *See* Board Exhibit 37.
[20] *Id.*

11. On December 08, 2015, the Board issued an Order to Appear to Respondent for his compulsory participation in an investigatory interview scheduled for December 18, 2015.[21]

12. On December 11, 2015, the Board received an Intent to Terminate Representation notification from Respondent's attorney effective December 31, 2015.[22]

13. On December 17, 2015, the Board received a termination rescission notification from Respondent's attorney and a request to postpone the Board's December 18, 2015, interview of Respondent.[23] Respondent's attorney offered that Respondent had been injured and was unable to travel as a result.[24] The Board agreed to reschedule Respondent's investigation interview date after it reviewed Respondent's medical records regarding his alleged injury.

14. On January 06, 2016, the Board attempted to reach Respondent by phone but received his voicemail instead.[25] The outgoing message on the voicemail box stated that Respondent was seeing patients by appointment.[26]

15. On January 11, 2016, a Board investigator attempted to complete a site inspection at the office address on file for Respondent in Sedona, AZ, but the office was essentially vacated.[27] The investigator attempted to visit Respondent's residence, but the address the Board had on file was a UPS Store.[28] Respondent's office manager, Mrs. Linda Tolleson, was contacted by telephone and reported to the Board that the outstanding records due to the Board were at a scanning facility but were unable to be copied or scanned.[29] Mrs. Tolleson also reported that Respondent had not been cleared by his personal physician to return to work. The Board agreed to extend their deadline until January 15, 2016.[30]

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[21] *See* Board Exhibit 38.
[22] Respondent Exhibit A.
[23] See Board Exhibit 40.
[24] *Id.*; *see also* Board Exhibits 41, 42, and 43.
[25] *See* Board Exhibit 52.
[26] *Id.*
[27] *See* Board Exhibit 44.
[28] *Id.*
[29] *Id.*
[30] *Id.*

16. On February 24, 2016, Respondent provided narrative statements for patients S.D. and K.P.[31] Respondent failed to provide narrative statements for patients S.D. and M.W., and also failed to provide medical records for patients S.D., K.P., S.W., and M.W.[32] In his narrative regarding patient S.D. Respondent argued, in pertinent part, that "[Patient's] chart is not a file but a file drawer. All of the documentation of imaging labs, hospitalizations, referrals and exceptional consulting physician's records, as well as the exhaustive hours of psychotherapy, make an excellent case for creating an electronic copy of medical records."[33] In his narrative regarding patient K.P. Respondent stated, in pertinent part, that he would attached a list of the medications he had prescribed the patient, but he did not.[34] Respondent also stated that the patient accused his own mother of stealing his prescribed medications, but Respondent did not state what he did in response to receiving that information, if anything.[35]

17. Respondent's file was forwarded to Calvin Flowers, M.D., an independent consultant for the Board.

18. On or about May 05, 2016, the Board received a Medical Consultant Report and Summary from Dr. Flowers regarding patients L.D., S.D., S.W., M.W., and K.P.[36]

19. On or about May 10, 2016, the Board received a Prescriber Rx History Report for Respondent.[37] The report shows that Respondent wrote patient prescriptions during the time Respondent alleged he was injured, unable to work, travel, or be interviewed by the Board.

20. On May 16, 2016, the Board investigator assigned to MD-14-1140A drafted an Investigation Report whereby it was alleged that Respondent was in violation of Ariz. Rev. Stat. §§ 32-1401(27)(dd), 32-1401(27)(ee), 32-1401(27)(e), and 32-1401(27)(q).[38] That same day the Board issued a letter to Respondent to afford him an opportunity to

[31] *See* Board Exhibits 46, 47, 48, and 49.
[32] *Id.*
[33] *See* Board Exhibit 48.
[34] *See* Board Exhibit 49.
[35] *Id.*
[36] *See* Board Exhibits 50 and 52.
[37] *See* Board Exhibit 51.
[38] *See* Board Exhibit 52.

provide commentary on Dr. Flowers' May 05, 2016 Medical Consultant Report.[39] The letter notified Respondent that any response from him, on that particular issue, needed to be received by the Board on or before May 30, 2016.[40]

21. On May 25, 2016, the Board received notification from Respondent's attorney that he would cease representation of Respondent effective June 15, 2016.[41]

22. Respondent entered into an ICA with the Board for a practice restriction on or about July 15, 2016.[42] Respondent was required to complete a competency evaluation as part of the agreement's terms[43] but failed to do so timely due to financial and medical setbacks.[44]

23. During Respondent's restriction period the Board received an allegation that Respondent had practiced medicine[45], which was later confirmed by the Board.

24. Respondent never completed the competency evaluation.

25. On October 05, 2016, the Board issued a notification letter to Respondent to advise him that he might be in violation of Ariz. Rev. Stat. § 32-1401(27)(r) based on the receipt of an additional complaint.[46] Respondent was ordered to supply a written explanation and the underlying patient's records to the Board no later than October 19, 2016.[47] On October 19, 2016, Mrs. Tolleson contacted the Board to request an extension of time to permit Respondent to comply with the Board's October 05, 2016, directive.[48] The Board received Respondent's response on October 21, 2016,[49] but the patient's medical records were not attached. The Board inquired with Respondent that same day via email but did not receive a response from Respondent.[50]

26. On November 09, 2016, the Board investigator assigned to MD-14-1140A drafted a Supplemental Investigation Report whereby it was alleged that Respondent was

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[39] *See* Board Exhibit 53.
[40] *Id.*
[41] *See* Board Exhibit 54.
[42] *See* Board Exhibits 55 and 59.
[43] *See* Board Exhibits 57 and 58.
[44] *See* Board Exhibit 60.
[45] *See* Board Exhibit 61.
[46] *See* Board Exhibits 62, 63, and 64.
[47] *Id.*
[48] *See* Board Exhibit 65.
[49] *See* Board Exhibit 66.

in violation of Ariz. Rev. Stat. §§ 32-1401(27)(dd), 32-1401(27)(ee), 32-1401(27)(e), 32-1401(27)(q), and 32-1401(27)(r).[51] That same day the Board issued a letter to Respondent to afford him an opportunity to provide commentary on the official investigation report.[52] The letter notified Respondent that any response from him, on that particular issue, needed to be received by the Board on or before November 30, 2016.[53]

27. On December 22, 2016, the Board's Staff Investigational Review Committee ("SIRC") voted to permit Respondent to voluntarily surrender his license in lieu of the Board initiating formal proceedings to revoke Respondent's license to practice medicine.[54]

28. A timely appeal from Respondent was received by the Board.

29. On April 05, 2018, the Board issued a Complaint and Notice of Hearing alleging Respondent had engaged in unprofessional conduct pursuant Ariz. Rev. Stat. §§ 32-1401(27)(a) ("[v]iolating any federal or state laws, rules or regulations applicable to the practice of medicine."); 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); and 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter").

30. Respondent's Answer was timely received by the Board.

31. The matter was referred to the Office of Administrative Hearings, an independent state agency, for hearing on May 17, 2018. The matter was continued to July 16, 2018, whereby testimony was taken, but the matter was rescheduled for September 17, 2018, through September 19, 2018, whereby it was concluded.

Additional Hearing Evidence

32. The Board presented the testimony of Calvin Flowers and Raquel Rivera, and submitted seventy-eight exhibits.[55] Craig W. Tolleson ("Respondent") appeared on his own

[50] *See* Board Exhibit 67.
[51] *See* Board Exhibit 68.
[52] *See* Board Exhibit 69.
[53] *Id.*
[54] *See* Board Exhibits 70 and 77.
[55] Board Exhibits 1-9, 11-30, 32-37, 40-44, 46-53, 55-56, 61-62, 66, and 68-70 are held in confidence pursuant to ARIZ. REV. STAT. § 32-1451.1(C).

behalf with Linda Tolleson, Mark Ipsen, and Thomas Taylor as witnesses. Respondent submitted eight exhibits.

33. Dr. Flowers is the Board's expert witness. Dr. Flowers is a Doctor of Medicine, specializing in psychiatry, and also has a Master's Degree in Public Health.[56]

34. Raquel Rivera is an investigations manager with the Board. Ms. Rivera's primary job duties are to provide investigative guidance to her staff, review reports for a medical consult, recommend dismissal if there are no violations , or schedule the case for the staff investigational review committee if it there are violations that need to be considered.

Patient B.B.: Case MD-14-1140A

35. Ms. Rivera testified that Respondent was apprised of a complaint regarding patient B.B. on or about August 15, 2014.[57] The Board instructed Respondent to provide a written response to the complainant on or before September 12, 2014.[58]

36. On September 25, 2014, the Board received a request for an extension of time from Respondent's attorney.[59] Ms. Rivera testified that she granted Respondent a two-week extension. Respondent's written response was received by the Board on October 10, 2014.[60]

37. In his response, Respondent identified that he had used, or attempted to use, a customized detoxification taper treatment called the "Ashton Protocol" to cease B.B.'s use of a particular prescription narcotic.[61] The Ashton Protocol called for a prescriber to issue a dependent patient two prescription narcotic medications in counter-descending amounts until one of the medications, the dependent prescription at issue, was reduced to a nonexistent amount. Per Respondent, he was able to successfully taper B.B. off of the dependent narcotic after eight-weeks of treatment. According to his letter, Respondent partnered with a pain specialist to continue B.B.'s treatment. The doctors agreed to

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[56] *See* Board Exhibit 10.
[57] *See* Board Exhibit 2.
[58] *See* Board Exhibit 3.
[59] *See* Board Exhibit 5.
[60] *See* Board Exhibit 6.

[61] *Id.*

continue to taper B.B. off of other narcotic medications. Respondent noted that B.B. died as a result of an accidental overdose of an illegal street narcotic as opposed to his treatment method or issued prescription.

38. During the Board's investigation it obtained B.B.'s prescription history report[62], B.B.'s patient records from Respondent[63], B.B.'s death certificate[64], and B.B.'s obituary.[65] Ms. Rivera testified that B.B.'s official date of death was May 06, 2014, due to "multiple drug intoxication." Per Ms. Rivera, the aforementioned records were forwarded to an independent medical consultant, Dr. Flowers, for review and reporting.

39. On or about December 15, 2014, the Board received a Medical Consultant Report and Summary from Dr. Flowers.[66] In his summary Dr. Flowers outlined the Standard of Care ("SOC") for complicated psychopharmacology cases, specifically for patients with significant psychiatric and physical comorbidity, as follows:

a. Limited supply and/or amount of controlled, dependency producing drugs,
b. Frequent follow up with the patient, including weekly visits, to ensure compliance with medications,
c. Medication assistive devices, such as "Bubble Packaging" medications, for improving adherence,
d. Limited use of polypharmacy practices such as two .... stimulant drugs (in other words one drug in a class),
e. Clear communication with patient and family about treatment plan, goals, and timeline,
f. Consistent documentation of the progress, or lack thereof, in the medical record.[67]

Dr. Flowers opined that Respondent deviated from the SOC in several ways. First, Respondent utilized a drug withdrawal treatment B.B. discovered online.[68] Respondent used a long-acting agent with continued use of a short-acting drug, with minimally documented instructions.[69] Respondent prescribed narcotic pain medications over a

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[62] *See* Board Exhibit 4.
[63] *See* Board Exhibit 8.
[64] *See* Board Exhibit 9.
[65] *See* Board Exhibit 7.
[66] *See* Board Exhibit 11.
[67] *Id.*
[68] *Id.*
[69] *Id.*

prolonged period of time, in high doses and large amounts, with limited clinical documentation to support it or follow up with the patient.[70] Lastly, there was no documentation of risk/benefit/side effect discussion with patient regarding the treatment plan.[71] That being said, however, Dr. Flowers refused to identify Respondent's deviations as the direct cause of B.B.'s death, but did state that death was a potential harm resulting from Respondent's conduct.[72]

40. On January 13, 2015, the Board received a request for an extension of time from Respondent's attorney.[73] Ms. Rivera testified that she granted Respondent a one-week extension. Respondent's written response was received by the Board on January 20, 2015.[74]

41. In his response, Respondent argued that he issued all medications "conservatively" and "as necessary."[75] Per Respondent, he created pages of notes during his initial four-hour examination of B.B.[76] Respondent opined that it was not feasible to have frequent visits with B.B. due to the distance between them.[77] Respondent also argued that B.B.'s mother, a registered nurse, had been very involved in his case and made it difficult for Respondent to treat B.B.[78]

42. The January 20, 2015, response letter from Respondent was forwarded to Dr. Flowers for consideration and review. As a result, Dr. Flowers issued a Medical Consultant Supplemental Report and Summary which was received by the Board on or about February 12, 2015.[79]

43. In his supplemental summary Dr. Flowers noted that his opinion had not changed post review of Respondent's lengthy response. Dr. Flowers cited the following three points of clarification:

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[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *See* Board Exhibit 12.
[74] *See* Board Exhibit 13.
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] *See* Board Exhibit 14.

a. A long distance and extensive travel time to a physicians office does not exempt the physician from good, safe medical practice. [sic] Many patients with complex physical and psychiatric comorbidity travel several hours each week to see health care providers, if that is the only safe way to manage their case.

b. If travel distance and time was indeed a factor that complicated prescribing and follow-up, this issue should have been resolved prior to the physician initiating any treatment plan.

c. Regarding the "Ashton protocol" withdrawal used: the FDA does not specifically approve treatment protocols, they generally evaluate the overall efficiency and safety of drugs and devices for specific indications. I am not aware of any FDA approval for the specific use of the "Ashton protocol" and no reference and/or citation to support this assertion is provided.

The Board's patient record concerns: e.g. patients L.D., M.W., S.D., and K.P.

44. On December 20, 2013, the Board issued Respondent an Advisory Letter for inadequate documentation.[80]

45. Ms. Rivera testified that after reviewing B.B.'s patient file the Board had concerns regarding the adequacy of Respondent's recordkeeping. Per Ms. Rivera, the Board asked Respondent to supply additional patient records for review. Ms. Rivera testified that she had given several compliance deadline extensions to Respondent, through his attorney, to supply the Board with documentation the Board requested, but that Respondent never fully complied. Ms. Rivera testified that Respondent's noncompliance raised several concerns regarding Respondent's safety to practice.

46. Respondent testified that he created an individualized charting system for each of patient, but could only provide one example.[81] Respondent recounted the prescriptions prescribed for each patient, and for what purposes. Respondent argued that most of his patient records, if not all, had been irreparably damaged during an eviction. Respondent blamed his failure to back up his patient files digitally on his lack of tech

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[80] *See* Board Exhibit 78.
[81] Respondent Exhibit H.

savviness. Respondent gave no clear or direct response to the question of why he did not provide the Board with his patients' records prior to his eviction, other than to generally state that several unforeseen circumstances prevented his full compliance. Although Respondent admitted that he had not signed up for access to the Prescription Drug Monitoring Program[82], he opined that he issued prescriptions conservatively and in appropriate quantities notwithstanding evidence he submitted identified him as an "outlier" for prescriptions.[83]

47. Mrs. Tolleson testified that she and Respondent suffered through the past number of years together, as her parents had fallen ill and passed away, Respondent had been in a car accident, Respondent had fallen off a ladder, Respondent had an industrial gate fall on him, and they had been wrongfully evicted from their office and had their patient records damaged by the rain. Mrs. Tolleson testified that because she had traveled out of state at a moment's notice, on multiple occasions over the past three years, she was unable to assist Respondent with his correspondence to the Board. Per Ms. Tolleson, she served as Respondent's scribe and was responsible for making digitized copies of his handwritten patient notes. Mrs. Tolleson argued that most of Respondent's patient records were handwritten and irreparably damaged in the rain during their eviction. She was unable, however, to account for why the records had not been digitized prior to the eviction date, other than to reiterate Respondent's sentiment about suffering unforeseen circumstances.

48. Mark Ipsen, M.D. testified that he is Respondent's friend and colleague. Dr. Ipsen possesses several allopathic licenses but none are in the State of Arizona. Dr. Ipsen admitted that he had not reviewed any of the underlying patient records or Complaint in this matter, but testified that although contemporaneous notes are best, if they become lost, stolen, or damaged, that a doctor may recreate them up to one year later.

49. Thomas Taylor testified that he is Respondent's friend and patient. Mr. Taylor admitted that he had not reviewed any of the underlying patient records or Complaint in this matter. Mr. Taylor opined, that in his professional experiences with Respondent,

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[82] *See* Respondent Exhibit D.
[83] *Id.*

Respondent assisted him with tapering off of medications Mr. Taylor believed had been liberally prescribed by other physicians.

ICA Violation

50. Respondent admitted that he issued a medical certification after he entered into an ICA with the Board. Respondent testified that he had intended to issue the certification for homebound services in a timely manner when it was requested by a patient months prior, but due to a personal emergency it "slipped [his] mind." Respondent did not backdate the certification. Respondent submitted a letter from the underlying patient's father to substantiate his contention that he was reminded to provide the certification.[84] Respondent's essential argument was that he had not engaged in the "practice of medicine" because he was finishing a task that he had started before the practice restriction was in place.

51. Ms. Rivera testified that the Board was going to "sit on" Respondent's cases until they received the results of Respondent's evaluation, but after they were alerted in October of 2016 that Respondent engaged in the practice of medicine while he was under a practice restriction, they decided to move forward.

Respondent's Unreported DUI: Case No. MD-15-0771A

52. Respondent admitted that he was convicted of a misdemeanor DUI on February 11, 2009.

53. Respondent testified that he believed he did not have to inform the Board of his DUI arrest and conviction because when they occurred because he had timely informed his employer. Respondent submitted a letter from his former employer to corroborate his contention, but the letter did not mention his employer's contact with the Board or that the supervisor informed Respondent he would contact the Board on Respondent's behalf.[85]

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[84] *See* Respondent Exhibit F.
[85] *See* Respondent Exhibit A.

CONCLUSIONS OF LAW

1. The legislature created the Board to protect the public.[86] The Board is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona. Therefore, the Board has jurisdiction over Respondent and the subject matter in this case.[87]

2. The Board bears the burden of proof to establish cause to sanction Dr. Tolleson's license to practice allopathic medicine and factors in aggravation of the penalty by clear and convincing evidence.[88] Dr. Tolleson bears the burden to establish affirmative defenses and factors in mitigation of the penalty by the same evidentiary standard.[89] The standard of proof is by clear and convincing evidence. Clear and convincing evidence is "[e]vidence indicating that the thing to be proved is highly probable or reasonably certain."[90]

3. ARIZ. REV. STAT. § 32-1451(D) provides that "[i]f the board finds, based on the information it receives under subsections A and B of this section, that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, the board may restrict a license or order a summary suspension of a license pending proceedings for revocation or other action. If the board takes action pursuant to this subsection, it shall also serve the licensee with a written notice that states the charges and that the licensee is entitled to a formal hearing before the board or an administrative law judge within sixty days."

4. ARIZ. REV. STAT. § 32-1451(M) provides that "[a]ny doctor of medicine who after a formal hearing is found by the board to be guilty of unprofessional conduct, to be mentally or physically unable safely to engage in the practice of medicine or to be medically incompetent is subject to censure, probation as provided in this section, suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently and under conditions as the board deems

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[86] *See* Laws 1992, Ch. 316, § 10.

[87] *See* ARIZ. REV. STAT. § 32-1401 *et seq.*

[88] *See* ARIZ. REV. STAT. §§ 41-1092.07(G)(2) and 32-1451.04; ARIZ. ADMIN. CODE R2-19-119(B)(1); *see also Vazanno v. Superior Court*, 74 Ariz. 369, 372, 249 P.2d 837 (1952).

[89] *See* ARIZ. ADMIN. CODE R2-19-119(2) and (3).

[90] BLACK'S LAW DICTIONARY at 596 (8th ed. 1999).

appropriate for the protection of the public health and safety and just in the circumstance. The board may charge the costs of formal hearings to the licensee who it finds to be in violation of this chapter."

5. ARIZ. REV. STAT. § 32-1401(2) defines "adequate records" to mean "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."

6. ARIZ. REV. STAT. § 32-1401(27)(a) defines "unprofessional conduct" to include, "[v]iolating any federal or state laws, rules or regulations applicable to the practice of medicine."

7. ARIZ. REV. STAT. § 32-1401(27)(e) defines "unprofessional conduct" to include, "[f]ailing or refusing to maintain adequate records on a patient."

8. ARIZ. REV. STAT. § 32-1401(27)(r) (formerly § 32-1401(27)(q)) defines "unprofessional conduct" to include, "[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public."

9. ARIZ. REV. STAT. § 32-1401(27)(s) (formerly § 32-1401(27)(r)) defines "unprofessional conduct" to include, "[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter." No intent is required.

10. The issue in this matter is whether Respondent engaged in acts of unprofessional conduct, and if so, whether grounds exist for the Board to discipline Respondent's license based on said conduct.

11. The material facts in this matter are not in dispute.

12. Here, the Board established by clear and convincing evidence that Respondent was arrested and convicted of a misdemeanor DUI which he failed to report to the Board, in violation of ARIZ. REV. STAT. §§ 32-1401(27)(a) and 32-3208(A).

13. The Board also established by clear and convincing evidence that Respondent failed to maintain adequate patient records in multiple patient cases, amounting to a violation of ARIZ. REV. STAT. § 32-1401(27)(e).

14. The Board also established by clear and convincing evidence that Respondent did not adhere to the established SOC in B.B.'s case, in violation of ARIZ. REV. STAT. § 32-1401(27)(r).

15. The Board also established by clear and convincing evidence that Respondent breached his ICA in violation of ARIZ. REV. STAT. § 32-1401(27)(s).

16. Therefore, the sole remaining issue to be addressed is whether Respondent has established one or more affirmative defenses or mitigating factors, and if so, whether those defenses or mitigating factors preclude the Board from disciplining Respondent's license.

17. Respondent did not sustain his evidentiary burden in this matter.

18. Respondent's testimony was mostly vague and non-specific. While he recalled his patients and their various ailments with great specificity, he was unable or unwilling to address the Board's specific allegations of wrongdoing, other than to disagree that he violated the SOC in B.B.'s case, or imply that he was unable to comply with the Board's request for records in the remaining patient cases because they had been destroyed and could not be replicated. Respondent did not offer evidence to rebut the Board's expert testimony regarding what constituted the accepted SOC, or evidence to establish that he had complied with the SOC for B.B.'s case, in full or in part. Although the record clearly reflects Respondent suffered a number of tribulations over the past three years, it also reflects that Respondent was not incapacitated to such a degree the entirety of that period such that compliance was impossible. This is evinced by the fact that Respondent secured legal counsel, secured several deadline extensions from the Board, and partially complied with some of the Board's requests.

19. Respondent's numerous personal ailments might have justified his lack of communication with the Board but for the undisputed facts in the record which establish Respondent could have maintained timely contact as he was admittedly working during

periods of alleged illness or injury. Additionally, Respondent did not submit any evidence to support an argument that he was unable to comply due to medical incompetence.

20. While it is unclear whether Respondent would have been able to backdate the medical certification he issued in October of 2016, it is clear that Respondent did not seek permission or inquire with the Board before prescribing the medical certification, which was a violation of his ICA. Moreover, Respondent never completed the mandatory competency assessment he was supposed to undergo per the terms of his ICA with the Board.

21. Respondent's belief that reporting his DUI to his employer satisfied the statutory requirement, or exempted him from compliance, is unreasonable.

22. Based upon a review of the credible and relevant facts in the record, this tribunal holds that the Board has sustained its evidentiary burden of proof in this matter. Thus, grounds exist for the Board to discipline Respondent's license to practice medicine in the State of Arizona.

ORDER

Based on the foregoing, it is **ORDERED** that the Board's COMPLAINTS for cases MD-15-0771A and MD-14-1140A be affirmed.

Based on the foregoing, it is further **ORDERED** that Craig W. Tolleson, M.D.'s License No. 36928 for the practice of allopathic medicine in the State of Arizona be revoked.

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.

1 Respondent is further notified that the filing of a motion for rehearing or review is
2 required to preserve any rights of appeal to the Superior Court.

3 DATED this 11th day of January 2019.

4 THE ARIZONA MEDICAL BOARD

5

6 By Patricia E. McSorley
Patricia E. McSorley
7 Executive Director

8

9 ORIGINAL of the foregoing filed this
11th day of January, 2019 with:

10

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

12

13 COPY of the foregoing filed this
11th day of January, 2019 with:

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

17 Executed copy of the foregoing
mailed by U.S. Mail this
18 11th day of January, 2019 to:

19 Craig W. Tolleson, M.D.
Address of Record

20

21 Anne Froedge
Assistant Attorney General
Office of the Attorney General
22 SGD/LES
2005 N. Central Avenue
23 Phoenix, AZ 85004

24 Michelle Rebe
7497456

25