1 BEFORE THE ARIZONA MEDICAL BOARD

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In the Matter of **KARNAIL S. DHILLON, M.D.** Holder of License No. 27921 For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-16-1106A; MD-17-0078A** **ORDER FOR LETTER OF REPRIMAND AND PROBATION WITH PRACTICE RESTRICTION; AND CONSENT TO THE SAME**

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7 Karnail S. Dhillon, M.D. ("Respondent") elects to permanently waive any right to a
8 hearing and appeal with respect to this Order for Letter of Reprimand and Probation with
9 Practice Restriction; admits the jurisdiction of the Arizona Medical Board ("Board"); and
10 consents to the entry of this Order by the Board.

11 **FINDINGS OF FACT**

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

14 2. Respondent is the holder of license number 27921 for the practice of
15 allopathic medicine in the State of Arizona.

16 ***MD-16-1106A***

17 3. The Board initiated case number MD-16-1106A after receiving a complaint
18 regarding Respondent's care and treatment of a 31 year-old male patient ("JH") alleging
19 that Respondent prescribed Suboxone and alprazolam even though the combination of
20 medications were contraindicated, and despite reports of alprazolam abuse by JH's wife.

21 4. During the course of the investigation, a Medical Consultant ("MC")
22 performed a review of Respondent's care and treatment of JH and five other patients (TB,
23 BP, ML, JJ and KW).

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Patient JH

5. Respondent began treating JH on August 1, 2014. JH's intake history and physical form identified a four year history of opioid abuse. JH presented to Respondent with symptoms consistent with opioid withdrawal. Respondent diagnosed JH with opioid dependence, and established a treatment plan for Suboxone that included random urine drug screens and counseling at a provider of JH's choice. JH signed a Suboxone Treatment Contract.

6. On August 18, 2014, Respondent's office documented a phone call from JH's girlfriend advising Respondent that JH was receiving Xanax from another provider, and alleging that JH was abusing the medication.

7. In November 2014, JH submitted to a urine drug screen that was subsequently found to be negative for JH's prescribed medications and positive for opioids. At JH's December 31, 2014 follow up visit, Respondent documented a discussion with JH regarding the results, and indicated that JH admitted to using opioids because he had run out of Suboxone. Respondent continued to prescribe Suboxone to JH.

8. On June 15, 2015, JH reported that he had taken Percocet for a back injury and self-adjusted to an increased dose of Suboxone. Respondent prescribed JH Clonidine for anxiety, and advised JH that self-adjustment of medications could be grounds for discharge from care.

9. On August 3, 2015, JH advised Respondent that the Clonidine was not helpful, and requested Xanax. Respondent prescribed JH Xanax in addition to Suboxone.

10. On September 14, 2015, Respondent's office received a letter from JH's wife alleging that JH was abusing his Xanax. On October 8, 2015, Respondent saw JH for a follow-up visit and refilled JH's Suboxone and Xanax.

11. On November 6, 2015, JH's wife called Respondent's office again to report that JH was abusing his Xanax. On December 3, 2015, Respondent documented a discussion with JH regarding the report, and JH admitted to taking a few extra Xanax in response to a family illness. Respondent continued to refill JH's Suboxone and Xanax.

12. On August 24, 2016, JH obtained Oxycodone from another provider. On September 20, 2016, Respondent documented that JH remained abstinent from opioids.

13. On October 18, 2016, Respondent saw JH for a follow-up visit, documenting that he was doing well on his prescribed medications. A urine drug screen from that day was negative for JH's prescribed medications.

Patient TB

14. Respondent treated TB, a 24 year-old female patient for opioid dependence between September 9, 2011 and March 18, 2015 with Suboxone maintenance. Respondent's treatment plan included monthly visits with Respondent and counseling with a provider of TB's choice, but did not include urine drug screens.

15. On October 6, 2011, TB reported that she was taking Ambien prescribed by another provider. On January 3, 2012, Respondent prescribed TB Ambien.

16. On January 18, 2012, TB reported that she had self-adjusted to an increased dose of Suboxone. Respondent provided an increased dose of Suboxone to TB.

17. TB saw Respondent early in April and May, 2012 for refills. On May 31, 2012, TB acknowledged taking more Suboxone than prescribed due to anxiety. TB reported that she would be giving her medications to her father so he could monitor the dosage. On August 21, 2018, TB saw Respondent and requested another early refill.

18. On October 14, 2014, TB saw Respondent and reported taking Adderall prescribed by another provider. Respondent required a urine drug screen, which was positive for morphine and Butalbital. A note from October 29, 2014 indicates that TB

reported taking medication for a severe migraine and requested an early refill due to travel. Respondent documented that TB remained in remission.

Patient BP

19. Patient BP, a 29 year-old male, initially established care with Respondent in 2012. BP returned in July 2015 and continued to be treated by Respondent until November 2016. Respondent saw BP monthly and prescribed Suboxone.

Patient ML

20. Patient ML established care with Respondent on August 24, 2012 with a presenting diagnosis of opioid dependence and mild withdrawal symptoms. Respondent's initial treatment plan included Suboxone, counseling with a provider of ML's choice and random urine drug screens.

21. Respondent continued to treat ML through March 11, 2016 with the exception of two periods of time when ML ceased care with Respondent and subsequently returned after having suffered a relapse.

Patient JJ

22. Patient JJ established care with Respondent on March 18, 2015 with a presenting diagnosis of opioid dependence and Attention Deficit Disorder ("ADD"), in addition to medical issues to be managed by the patient's Primary Care Physician. Respondent's treatment plan included Suboxone maintenance and counseling at a provider of JJ's choice.

23. In June and July of 2015, JJ requested early refills. On July 23, 2015, a Pharmacy called to report that JJ was filling prescriptions for Adderall from two different providers.

24. On August 5, 2015, Respondent issued JJ a prescription for 75 Suboxone. JJ returned later the same day and Respondent prescribed him a replacement prescription for 90 Suboxone.

25. A urine drug screen performed on August 28, 2015 showed high levels of both Suboxone and Adderall. The Pharmacy called again on September 16, 2015 to report that JJ was overfilling Adderall and Suboxone prescriptions, reporting that JJ had filled eight months' worth of prescriptions in four months' time. At a follow-up visit that same day, Respondent reviewed the urine drug screen results with JJ. Respondent increased JJ's prescription for Suboxone and decreased his prescription for Adderall. JJ reported self-adjusting his dosage of Suboxone.

26. On September 17, 2015, a second Pharmacy called to report that JJ was filling prescriptions for Adderall from two different providers. On October 6, 2015, Respondent prescribed JJ Clonidine in addition to Adderall and Suboxone.

27. On January 25, 2016, a telephone call report indicates that a pharmacy refused to fill JJ's medications due to the number of providers from whom JJ was attempting to fill prescriptions.

28. On February 10, 2016 and April 25, 2016, JJ reported that his prescriptions were stolen during home burglaries. Respondent continued to prescribe medications to JJ.

29. On July 28, 2016, JJ requested additional Adderall from Respondent, who prescribed a 20 mg Adderall supplement in addition to the 30 mg Adderall prescription already being prescribed by Respondent.

30. On August 16, 2016, JJ reported that he was moving to the east coast. JJ requested a 60 day supply of his Suboxone and Adderall from Respondent to allow him to move and establish care with new providers. Respondent provided the prescriptions.

31. On September 23, 2016, JJ reported again to Respondent that he was moving to Philadelphia, and requested refills of Suboxone and Adderall. Respondent provided the prescriptions as requested.

Patient KW

32. Patient KW was an established patient of Respondent with diagnoses of Mood Disorder, not otherwise specified, ADHD- combined type, and alcohol abuse in remission. Respondent's treatment plan included Adderall, Lamictal and Restoril.

33. Respondent's records indicate that KW requested and received early refills of prescribed medications on multiple occasions. A neurological test report received on December 9, 2014 documented a diagnosis of mild cognitive impairment, memory loss, depression and anxiety. Respondent continued prescribe Adderall to KW.

34. On April 27, 2015, KW saw Respondent with her husband, to discuss possible neurological issues. Respondent documented a cognitive disorder, possibly attributable to her ADHD, and recommended a consultation with a neurologist.

35. On May 8, 2015, Respondent documented a discussion of the December 9, 2014 neurological report. In June and August, KW requested additional prescriptions due to theft or loss.

36. On September 8, 2015, KW saw Respondent as a follow-up to a recent hospitalization due to medication overdose. KW admitted to taking more medication than prescribed. Respondent continued to prescribe medications to KW without changes.

37. On June 6, 2016, KW reported a hospitalization for a transient ischemic attack and dehydration. Respondent refilled KW's Adderall, and on June 7, 2016, Respondent refilled KW's Restoril after she called and requested the additional prescription.

38. On July 21, 2016, Respondent received the results of KW's most recent neurological testing, which showed a diagnostic summary of dementia, frontal lobe/executive functioning deficit, attention/concentration deficit, memory loss, HIV, depression, anxiety, PTSD and rule out diagnoses of vascular dementia, cerebral ischemia, and other cerebrovascular disease.

Deviations from the Standard of Care

39. The standard of care required Respondent to utilize the patient's Controlled Substance Prescription Monitoring Profile ("CSPMP") when prescribing controlled substances to patients, especially with regard to patients who have a known history of substance misuse. This became the standard of care after issuance of the 2014 Arizona Opioid Prescribing Guidelines ("Prescribing Guidelines"). Respondent deviated from the standard of care for all patients by failing to utilize queries of the CSPMP during the patients' care and treatment. For Patient KW, Respondent deviated from this standard of care beginning in 2016 after KW exhibited aberrant behavior. For all remaining patients, Respondent deviated from this standard of care for care rendered after issuance of the Prescribing Guidelines.

40. The standard of care requires a physician to utilize routine urine drug screens when prescribing opiate-based medications to patients who are at risk for abuse, misuse or diversion. Respondent deviated from the standard of care for patients JH, TB, BP, ML and JJ by failing to utilize routine urine drug screens to monitor these patients who were in treatment to address substance use disorders.

41. The standard of care requires a physician to appropriately document an assessment that supports the decision to prescribe medications that are contraindicated to use together. Respondent deviated from the standard of care by prescribing Suboxone and Xanax together to JH without sufficient justification.

42. The standard of care requires a physician to diligently monitor patient compliance and address aberrant "red flag" behavior. Respondent deviated from this standard of care by failing to appropriately respond to "red flag" behavior with patients JJ and KW who both had a pattern of early refills and reporting lost or stolen medication.

43. There was the potential for patient harm in that all patients were at risk for abuse and diversion of controlled substances being prescribed by Respondent. Patient JH was additionally at risk for respiratory depression and death.

MD-17-0078A

44. The Board initiated case number MD-17-0078A after receiving a complaint regarding Respondent's care and treatment of a 47 year-old male patient ("JD") alleging inadequate monitoring of controlled substances.

45. On May 12, 2015, JD presented to Respondent for an initial evaluation to continue Suboxone therapy. JD had been hospitalized for four weeks at an Inpatient Treatment Facility for opioid dependence, and alcohol abuse. Respondent prescribed JD Suboxone at a dose of 4/1mg, three times daily.

46. On May 21, 2015, Respondent was notified of potential concurrent use of two interacting prescriptions. JD had filled prescriptions for methadone 10 mg (60 tablets) and oxycodone/acetaminophen 10/325 mg (90 tablets) prescribed by another provider.

47. On May 26, 2015, Respondent addressed the prescriptions with JD. JD denied filling the prescriptions, and reported an ID theft issue. Respondent noted JD was improving and continued Suboxone treatment.

48. On May 28, 2015, a urine drug screen obtained by another provider was positive for Suboxone, methadone and oxycodone.

49. On June 22, 2015, JD's CSPMP report noted a second fill for methadone 10 mg (60 tablets) and oxycodone/acetaminophen 10/325 mg (90 tablets).

50. On July 6, 2015, JD reported that he had reduced his Suboxone to 4/1mg twice daily. Dr. Dhillon noted continued improvement on all subsequent follow-up visits until JD was last seen on November 10, 2015.

Deviations from the Standard of Care

51. The standard of care requires a prudent addiction specialist to query the CSPMP database prior to prescribing controlled substances to a patient with a known history of substance abuse. At a minimum, this would require checking the CSPMP at initiation of treatment, and upon receiving any credible information regarding potential aberrant behavior by the patient. Respondent deviated from the standard of care by failing to query the CSPMP database prior to prescribing Suboxone to JD, or after being notified that JD may be obtaining opioids from other providers.

52. The standard of care requires a physician to utilize routine urine drug screens when prescribing opiate-based medications to patients who are at risk for abuse, misuse or diversion. Respondent deviated from the standard of care for patient JD by failing to utilize routine urine drug screens to monitor the patient who was in treatment to address a substance use disorder.

53. There was actual patient harm in that Respondent's failure to appropriately monitor JD's compliance with Suboxone protocols facilitated controlled substance misuse. There was the potential for patient harm in that JD was at risk for addiction, overdose and death.

Procedural History

54. Respondent entered into an Interim Consent Agreement prohibiting him from prescribing controlled substances, effective March 15, 2018.

CONCLUSIONS OF LAW

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

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

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

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on Probation for a period of 5 years with the following terms and conditions:

a. Practice Restriction

Respondent's practice is restricted in that he is prohibited from prescribing controlled substances until he has completed the Continuing Medical Education ("CME") as stated in paragraph 2(b) of this Order, enters into an agreement with a Board-approved monitor to conduct chart reviews as stated in paragraph 2(c) of this Order, and provides Board staff satisfactory proof of compliance with these requirements.

b. Continuing Medical Education

Respondent shall within 6 months of the effective date of this Order obtain no less than 10 hours of Board Staff pre-approved Category I CME in an intensive, in-person course regarding prescribing controlled substances, and no less than 10 hours of CME in an intensive in-person medical recordkeeping course. Respondent shall within **thirty days**

of the effective date of this Order submit his request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure.

c. **Chart Reviews**

Within 30 days of completion of the CME, Respondent shall enter into a contract with a Board-approved monitoring company to perform periodic chart reviews at Respondent's expense. The chart reviews shall involve current patients' charts for care rendered after the date Respondent returned to practice as stated herein. Based upon the chart review, the Board retains jurisdiction to take additional disciplinary or remedial action.

d. **Obey All Laws**

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

b. **Tolling**

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

c. **Probation Termination**

Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will

be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 30 days prior to the Board meeting. Respondent may request early termination of Probation after completion of the CME and obtaining a minimum of three consecutive favorable chart reviews. Respondent's request for release must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(s)

DATED AND EFFECTIVE this 5th day of February, 2018.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

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

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

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

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

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

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

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

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

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

10. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(s) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.") and 32-1451.

1 11. Respondent acknowledges that, pursuant to A.R.S. § 32-2501(16), she/he
2 cannot act as a supervising physician for a physician assistant while her/his license is on
3 probation.
4 12. ***Respondent has read and understands the conditions of probation.***
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7 KARNAIL S. DHILLON, M.D. DATED: 1/10/19
8 EXECUTED COPY of the foregoing mailed
9 this 6th day of February, 2018 to:
10 J. Arthur Eaves, Esq.
Sanders and Parks, PC
11 3030 North Third Street, Suite 1300
Phoenix, Arizona 85012
12 Counsel for Respondent
13
14 ORIGINAL of the foregoing filed
this 6th day of February, 2018 with:
15
Arizona Medical Board
16 1740 West Adams, Suite 4000
Phoenix, Arizona 85007
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Board staff
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