BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MARSHALL W. JONES, M.D.** Holder of License No. 4192 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-14-1682A **ORDER FOR LETTER OF REPRIMAND AND PROBATION; AND CONSENT TO THE SAME**

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

FINDINGS OF FACT

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

2. Respondent is the holder of license number 4192 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-14-1682A after receiving a complaint regarding Respondent's care and treatment of a 31 year-old male patient ("MM") alleging failure to properly prescribe Adderall leading to the patient's psychosis.

Patient MM

4. On May 21, 2009, Respondent completed an initial psychiatric evaluation of MM, who provided a history of treatment for several years for attention deficit disorder ("ADD"), anxiety and depression. MM had been prescribed Adderall 30mg, Inderal 30mg, Effexor 75mg and Seroquel 50mg for sleep over the 4 years prior to his visit with Respondent. MM also identified a prior history of substance abuse and reported a sobriety date of over 6 years. Respondent diagnosed MM with Adult ADD, generalized anxiety

disorder and rule out bipolar disorder. Respondent continued MM on his current medications.

5. Respondent continued to treat MM through January 5, 2015 and his treatment included prescriptions for Adderall, Ambien, Lexapro and Effexor for diagnoses including ADD, obsessive compulsive disorder ("OCD") and general anxiety disorder ("GAD").

6. On January 5, 2015, Respondent received a call from MM's mother reporting that he had been arrested for trespassing and was in the process of being evaluated psychiatrically. Respondent stated at that time that he was ill and not available for consultation. MM was subsequently admitted for court-ordered treatment and on January 27, 2015, he was discharged to an inpatient treatment center in Tucson, Arizona.

7. A medical consultant ("MC") who reviewed Respondent's care of MM for the Board noted that MM's Controlled Substance Prescription Monitoring Program ("CSPMP") database report shows that MM received several early refills of Adderall from Respondent and was receiving Adderall and Ambien from another provider from April through July of 2014. The MC noted that there is no indication in Respondent's record that he reviewed the CSPMP information for MM.

Patient AW

8. Patient AW established care with Respondent beginning on June 14, 2005 for treatment of adjustment disorder and ADD. AW had a prior history of substance abuse, as well as a serious underlying heart condition for which a pacemaker was implanted in 2007.

9. Respondent continued to treat AW through June, 2016 and his treatment included Adderall, trazadone, bupropion and alprazolam for diagnoses of adult ADD,

adjustment disorder with depression and issues with sleep problems, and situational stressors.

Patient EN

10. EN, a 21 year-old female patient, established care with Respondent on December 23, 2003 for treatment of diagnoses including adjustment disorder with anxiety, rule out ADD and test phobia.

11. In 2007, Respondent treated EN with Adderall through 2008. Beginning in 2009, Respondent's treatment of EN consisted of Adderall and bupropion. In 2011, Respondent added concomitant Clonazepam and alprazolam for stress. In July of 2012, Respondent adjusted EN's diagnoses to included generalized anxiety disorder, panic disorder, adjustment disorder, and ADD. Respondent continued to treat EN through July of 2016 with medications including Adderall, Nuvigil, Clonazepam, alprazolam Lexapro and Prozac.

Patient JS

12. JS, a 21 year-old male patient, established care with Respondent on April 9, 2002 for treatment of major depression, social phobia and generalized anxiety disorder. JS was subsequently diagnosed with alcohol abuse disorder and underwent a substance abuse treatment program.

13. Beginning in March of 2007, Respondent's treatment included bupropion, Trazodone, Remeron and Clonazepam. During 2007 through 2008, JS admitted to self-adjusting these medications.

14. Between 2009 (when Respondent added ADD to JS's diagnoses) and 2016, Respondent continued to treat JS with medications including Vyvanse, Lexapro, Clonazepam, alprazolam, Adderall and Ritalin.

Patient RS

15. Patient RS, a 27 year-old male, established care with Respondent in June, 2011. Respondent initially diagnosed RS with generalized anxiety disorder, and panic disorder. Respondent prescribed citalopram and alprazolam.

16. Respondent continued to treat RS through July 2016 with medications including Clonazepam, alprazolam, zolpidem and Lexapro.

17. Beginning in 2012, Respondent treated RS with medications including those previously identified, as well as Adderall, Depakote and Seroquel for diagnoses including ADD, bipolar disorder, panic disorder and general anxiety disorder. RS experienced problems with opioid and benzodiazepine addiction during this same time.

18. Beginning in March of 2015, Respondent prescribed RS a regimen of alprazolam and Soma in combination with Adderall and venlafaxine. Respondent discontinued Soma in July of 2015 after RS complained of adverse effects.

Patient RR

19. Patient RR, a 44 year-old male, established care with Respondent in July, 2004. Respondent initially diagnosed RR with GAD with OCD traits and alcoholism in remission for over 9 years.

20. RR moved out of state, but re-established care with Respondent in October of 2007 when Respondent prescribed Lexapro at RR's request to treat his anxiety. In December, 2007 Respondent added Wellbutrin 450 mg.

21. Respondent continued to treat RR through January, 2016 with the above medications, as well as alprazolam, Diazepam, Zolpidem, Adderall, Vyvanse and Prozac. During this same time, RR was being prescribed opiates such as Oxycodone and Vicodin from his primary care provider.

22. In 2013, RR attempted to detox from controlled substances including two self-reports to a hospital for 30-day inpatient rehabilitation. In January, 2014 RR reported to Respondent that he continued to abuse the alprazolam prescribed by Respondent. Through 2015 Respondent's prescriptions for RR included alprazolam, bupropion, Vyvanse and Adderall. In January, 2016 RR reported suicidality and Respondent documented phone calls where RR appeared to be paranoid. In April, 2016 RR reported that he had relapsed with alcohol. The last fill date of alprazolam for RR was July, 2016.

Standards of Care and Deviations

23. The standard of care requires adequate prescribing of controlled substances to the patient, including appropriately addressing aberrant behavior and to refer a patient for substance abuse treatment when necessary. Respondent deviated from this standard of care by inappropriate prescribing of controlled substances to patients MM, AW, EN, JS, RS and RR. With regard to MM, Respondent deviated from the standard of care by maximizing the dosages of antidepressants, failing to consider less addictive treatment alternatives and by failing to minimize the doses of controlled substances in the long-term treatment of his disorders. With regard to MM, JS, and RS, Respondent deviated from this standard of care by failing to adequately address aberrant behavior and for continuing to prescribe controlled substances to JS after he reported abuse of alcohol. With regard to patients EN, JS, RS and RR, Respondent deviated from this standard of care by excessive prescribing of controlled substances to them.

24. The standard of care for treating a patient with amphetamines required Respondent to perform an adequate assessment and consider tapering MM, AW, EN, JS, RS and RR off stimulant medications. Respondent deviated from this standard of care by failing to perform an adequate assessment of MM, AW, EN, JS, RS, and RR including

obtaining an EKG and blood work, and by failing to recommend or discussing tapering off the stimulant medications.

25. The standard of care for when the patient reported insomnia while taking stimulants required Respondent to decrease the stimulant dose and avoid prescribing multiple sedating medications to counteract the activating effects of the stimulant. Respondent deviated from this standard of care by failing to decrease MM, AW, EN, JS, RS and RR's stimulant dose when the patients reported insomnia and by adding multiple sedating medications to counteract the activating effects of the stimulant to each of them.

26. The standard of care required Respondent to query the CSPMP database to monitor the patient's compliance with treatment. Respondent deviated from this standard of care by failing to query the CSPMP database profile of MM, AW, EN, JS, RS and RR which would have demonstrated that the patients were obtaining other controlled substances from other providers.

27. The standard of care for adults with ADHD and a history of substance use disorder required Respondent to consider atomoxetine or cognitive behavioral therapy as a first line treatment of ADHD rather than initially prescribing stimulants such as Adderall. With regard to MM, Respondent deviated from this standard of care by initially prescribing Adderall.

28. The standard of care required Respondent to have appropriate clinical justification prior to prescribing Soma to RS. Respondent deviated from this standard of care by prescribing Soma to RS for treatment of a mood disorder when that medication is intended for the treatment of musculoskeletal pain and not indicated for the treatment of psychiatric disorders.

Actual and Potential Patient Harm

29. There was potential for patient harm in that MM, AW, EN, JS, RS and RR were at risk for potential adverse effects of the medications prescribed by Respondent including adverse cardiovascular effects ranging in severity from mild to fatal.

30. With regard to patient MM, he would have been predisposed to the development of mania and possibly psychosis when prescribed a stimulant without any concomitant mood stabilizing agent.

31. With regard to RS, he reported insomnia and panic, which is common in bipolar disorder as well as a side effect of opiate withdrawal and stimulants use.

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)(q)("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 6 months with the following terms and conditions:

a. **Continuing Medical Education**

Respondent shall within 6 months of the effective date of this Order obtain no less than 15 hours of Board staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person course regarding controlled substance prescribing. 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. The Probation shall terminate upon Respondent's proof of successful completion of the CME.

b. **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.

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)(r).

DATED AND EFFECTIVE this 8th day of June, 2017.

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)(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.") and 32-1451.

11. ***Respondent has read and understands the conditions of probation.***

Marshall W. Jones M.D. DATED: 4/25/17
MARSHALL W. JONES, M.D.

EXECUTED COPY of the foregoing mailed this 8th day of June, 2017 to:

Marshall W. Jones, M.D.
Address of Record

ORIGINAL of the foregoing filed this 8th day of June, 2017 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Barbey
Board staff