1 BEFORE THE ARIZONA MEDICAL BOARD

2

3 In the Matter of

4 **DAVID A. RUBEN, M.D.**

5 Holder of License No. 11382
For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-17-0179A

INTERIM FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE

7 **INTRODUCTION**

8 The above-captioned matter came for discussion before the Arizona Medical Board
9 ("Board") at its April 5, 2017 regular Board meeting, where it had been placed on the
10 agenda to consider possible summary action against David A. Ruben, M.D.
11 ("Respondent"). Having considered the information in the matter and being fully advised,
12 the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for
13 Summary Suspension of License, pending a formal hearing or other Board action. A.R.S.
14 § 32-1451(D).

15 **INTERIM FINDINGS OF FACT**

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

18 2. Respondent is the holder of license number 11382 for the practice of
19 allopathic medicine in the State of Arizona.

20 3. Respondent has a prior Board history including:

21 a. A Letter of Reprimand and Probation issued in 2009 for prescribing high
22 dose opioids without proper indication and for failure to timely use objective
23 measures to assess compliance with treatment even after being aware of a
24 patient's cocaine addiction. The 2009 Probation Order required Respondent to
25 complete 15-20 hours of CME in pain management.

b. A Decree of Censure, Two Year Probation and One Year Practice Restriction issued in 2010. The 2010 Order prohibited Respondent from prescribing, administering, or dispensing opioids for a year, and required Respondent to complete a prescribing course offered by the Physician Assessment and Clinical Education ("PACE") Program with subsequent chart reviews for a total of two years.

c. An Order to complete 15-20 hours of intensive, in-person continuing medical education ("CME") issued in 2012.

4. The Board initiated case number MD-17-0179A after receiving notification that Respondent was in violation of the Amended Findings of Facts, Conclusions of Law and Order for a Decree of Censure, Practice Restriction, and Probation issued in Case No. 15A-11382-MDX by the Board on February 9, 2016 ("Board Order").

5. The Board Order identified numerous deviations from the standard of care with regard to Respondent's controlled substances prescribing practices. Specifically, the Board Order found that with regard to multiple patients, Respondent deviated from the standard of care by failing to perform an appropriate initial assessment to determine if opioid treatment was necessary, continuing to prescribe opioid medication without proper indications, escalating opioid and benzodiazepine medications without proper indications, and by failing to properly respond to aberrant behavior when a patient so presented.

6. The Board Order also found actual and potential patient harm in that Respondent's conduct perpetuated addiction and/or diversion, exposed patients to the medical risks inherent with long-term opioid use absent objective pathology to warrant such treatment and placed patients at risk for drug seeking, abuse, addiction, and/or diversion.

7. The Board Order included a practice restriction prohibiting Respondent from prescribing, administering or dispensing any schedule II controlled substances for a period of two years.

8. Between September, 19, 2016 and March 16, 2017, Respondent wrote a total of 25 prescriptions for schedule II controlled substances to 11 different patients. The prescriptions included Percocet (oxycodone/acetaminophen), Norco (hydrocodone/acetaminophen) and one prescription for Oxycodone.

9. On March 1, 2017, Respondent self-reported his prescription of Oxycodone written on February 23, 2017 in violation of the Board Order. Respondent stated that this prescription was issued in error.

10. During an investigational interview on March 24, 2017, Respondent stated that at the time he prescribed Norco and Percocet to his patients, he was unaware that these medications were classified as schedule II.

11. During the Board's consideration of the above captioned matter on April 5, 2017, Respondent again stated that he was unaware that the medications he was prescribing were schedule II medications. One Board member commented that part of the Board's role is to ensure that licensed physicians demonstrate competency in the practice of medicine, and that Respondent's admission that he lacked awareness regarding the schedule of medications he prescribed points to a significant gap in knowledge. The Board member noted that these medications are highly controlled by the DEA and that these are dangerous medications that need to be prescribed by a physician with current knowledge. This gave the Board member great concerns about Respondent's ability to follow the direction of the Board and be effectively regulated. Based on the evidence presented, the Board voted unanimously to summarily suspend Respondent's license.

INTERIM CONCLUSIONS OF LAW

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

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r) ("Violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under the provisions of this chapter.").

3. Based on the foregoing Interim Findings of Fact and Conclusions of Law, the public health, safety or welfare imperatively requires emergency action. A.R.S. § 32-1451(D).

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above,

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 11382, is summarily suspended. Respondent is prohibited from practicing medicine in the State of Arizona and is prohibited from prescribing any form of treatment including prescription medications or injections of any kind.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges within 60 days after the issuance of this order pursuant to A.R.S. § 32-1451(D).

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced within sixty days from the date of the issuance of this order, unless stipulated and agreed otherwise by Respondent.

DATED AND EFFECTIVE this 6th day of April, 2017.

ARIZONA MEDICAL BOARD

By [signature]
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed
this 6th day of April, 2017 to:

Robert Wolkin
Wolkin Law Group
3301 E Camino Campestre
Tucson, AZ 85716-5829
Attorney for Respondent

ORIGINAL of the foregoing filed
this 6th day of April, 2017 with:

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

[signature]
Board staff