BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL FROM THE STATE MEDICAL BOARD

In the Matter of	)	
	)	
MAHMOOD AHMAD	)	OAH No. 16-0514-MED
	)	Agency No. 2015-002049

DECISION ON SUMMARY SUSPENSION

I. Introduction

The Division of Corporations, Business and Professional Licensing initiated disciplinary proceedings against Dr. Mahmood Ahmad, alleging he was overprescribing controlled substances. At the same time, the Division petitioned the Medical Board to summarily suspend Dr. Ahmad's medical license pending resolution of the disciplinary matter, on the basis that his prescribing practices constitute a clear and immediate danger to public health and safety. After the Board summarily suspended his license, Dr. Ahmad appealed, and an expedited evidentiary hearing was held. Because the Division demonstrated that Dr. Ahmad engaged in reckless and dangerous prescribing behavior, this decision concludes that his medical license should remain suspended pending completion of proceedings on the merits of the accusation filed May 4, 2016.

II. Factual and Procedural History

A. Background

1. Prescription drug abuse and regulation of scheduled narcotics

Abuse of prescription drugs is a major public health problem in Alaska and nationally. "[A]dverse outcomes associated with the misuse, abuse and diversion of prescription opioids have increased dramatically" over the last ten years.[1] A recent New England Journal of Medicine review article pointed to "alarming increases in diversion, overdose, and addiction," noting:

> First, opioid analgesics are widely diverted and improperly used, and the widespread use of the drugs has resulted in a national epidemic of opioid overdose deaths and addictions. More than a third (37%) of the 44,000 drug-overdose deaths that were reported in 2013 (the most recent year for which estimates are available) were attributable to pharmaceutical opioids[.] At the same time, there has been a parallel increase in the rate of opioid addiction, affecting approximately 2.5 million adults in 2014. Second, the major source of diverted opioids is physician prescriptions. For these reasons, physicians and medical associations have begun questioning prescribing practices for opioids, particularly as they relate to the management of chronic pain.[2]

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[1] Ex. D, p. 2.

[2] Ex. F, p. 1.

The rate of death from opiate overdose has quadrupled in the past fifteen years, and the frequency of nonfatal opiate overdoses have increased six-fold during that time.[3]

At the same time, treatment of chronic pain is a real, significant, and too often unmet medical need.[4] The Federation of State Medical Boards has acknowledged "undertreatment of pain" as "a serious public health problem that compromises patients' functional status and quality of life."[5] Yet medical professionals have increasingly recognized that opioids are contraindicated for many chronic pain conditions.[6] Practitioners, professional organizations, and state and federal agencies have sought to identify the appropriate balance necessary to meet patients' needs for effective pain treatment without endangering public health.[7]

The Board most recently updated its guidelines for prescribing controlled substances in November 2015.[8] The guidelines recognize "that controlled substances are useful and can be essential in the treatment of acute pain that results from trauma or surgery, as well as in the management of certain types of chronic pain." At the same time, practitioners "are expected to be knowledgeable about best clinical practices, aware of associated risks, and to practice in compliance with … relevant practice standards."[9] Under the guidelines, "inappropriate management of pain, particularly chronic pain," includes, *inter alia*:

- "Inadequate attention to initial assessment to determine what, if any, controlled substances are clinically indicated and to determine risks associated with their use in a particular patient";
- "Inadequate monitoring during the use of potentially abusable medications";
- "Unjustified dose escalation without adequate attention to risks or alternative treatments";
- "Excessive reliance on opioids, particularly high dose opioids for chronic pain management"; and
- Failure to "practice in accordance with the Guidelines issued by the Federation of State Medical Boards (FSMB) in their Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain."[10]

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3 Ex. F, p. 3. Relatedly, the Division's expert witness, Dr. Brett Stacey, pointed in his testimony to CDC data showing that "[f]or every overdose death, there are hundreds of patients with adverse effects from opioids."

4 *Id*.; Stacey testimony.

5 Ex. D, p. 2.

6 Stacey testimony.

7 Stacey testimony; Ex. D.

8 Ex. C.

9 Ex. C, p. 1.

10 *Id*. The cited model policy directs physicians to carefully weigh the risks and benefits of opioid therapy on a case-by-case basis for each patient, and, broadly, sets forth standards and expectations for evaluation, assessment, development of treatment plans, documentation, monitoring, and other facets of opioid prescribing. Ex. D.

2. Dr. Ahmad background

Mahmood Ahmad is a highly trained, well-credentialed physician. Dr. Ahmad attended medical school in Pakistan, and then moved to the United States in 1993 to enter the residency training program in anesthesiology at Yale University Medical School. Following his residency, Dr. Ahmad stayed on at Yale for a one-year fellowship in pain medicine. Dr. Ahmad is board certified in anesthesiology and holds a subspecialty certification in pain management.[11]

Dr. Ahmad initially focused his practice in anesthesiology, but since 2006 he has focused his practice on pain management. He is trained to perform a variety of interventional pain procedures, including surgical procedures. He has practiced in other states (including Arkansas) and other countries (Dubai and Australia). Dr. Ahmad testified that his practice in Arkansas is "predominantly" procedures-based, and that he refers patients in need of "medical management" to another physician.

In December 2012, the Arkansas medical board began an investigation into Dr. Ahmad's practice. As in the current case, that matter concerned Dr. Ahmad's prescribing practices. Following a hearing, the Arkansas Board issued a disciplinary order in June 2013, which was later vacated as part of a monetary settlement.[12]

While the Arkansas investigation was ongoing, Dr. Ahmad applied for licensure in Alaska, but failed to disclose the pending investigation on his application.[13] The Alaska State Medical Board disciplined Dr. Ahmad for failing to disclose the ongoing investigation on his application. In a consent agreement adopted in November 2013, Dr. Ahmad agreed to a public reprimand and a fine, as well as ongoing monitoring of his Alaska medical license for the length of time in the Arkansas order.[14]

3. Development of Dr. Ahmad's Alaska medical practice[15]

At the time he began to explore opening a medical practice in Alaska, Dr. Ahmad was practicing pain management in Arkansas, Dubai, and Australia. The Dubai clinic closed in late

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[11] The certification in anesthesiology is a lifetime certification. The subspecialty certification in pain management must be renewed every ten years. Dr. Ahmad most recently recertified this credential in 2009. Dr. Ahmad has also undergone additional pain medicine training in Australia, his country of citizenship, and is qualified as a "fellow" of anesthesiology there.

[12] Div. 002437-002440. Dr. Ahmad appealed this order and eventually entered into a consent agreement to globally settle that appeal and a new disciplinary action. Under that agreement, Dr. Ahmad agreed to pay a fine, and the Arkansas Medical Board agreed to vacate its prior findings of facts and conclusions of law. Resp. 51-55.

[13] Div. 002441.

[14] Div. 002441-002447.

[15] Where not otherwise indicated, the information in this section was provided during Dr. Ahmad's testimony.

2015.[16] From that time until the suspension of his Alaska license, Dr. Ahmad was spending approximately one week per month in Arkansas and Australia, and one long weekend per month in Alaska.

As noted, Dr. Ahmad characterizes his Arkansas practice as "predominantly" procedures-based. In Australia, his practice consists of one day per month conducting independent medical examinations for legal proceedings, one day per month conducting a pain clinic within a group of family practice physicians, and occasional locum work in anesthesiology. To date, the focus of his Alaska practice has been the treatment of chronic pain through medication.

While Dr. Ahmad received a license to practice medicine in Alaska in December 2013, he did not begin seeing patients here for more than a year. During 2014, he attempted to market his pain management practice to other local physicians in order to secure patient referrals. Those attempts were not particularly fruitful, however, resulting in virtually no physician referrals to the new practice.[17] In the meantime, Dr. Ahmad secured a location on Lake Otis Parkway for his clinic, leased it, and made necessary modifications to the space.

Dr. Ahmad began seeing Alaska patients in early 2015, but his practice was slow to get off the ground. Having been largely unsuccessful in securing physician referrals, Dr. Ahmad relied on prospective patients who saw the clinic signage outside the building, and, later, on word of mouth referrals from existing patients to potential new patients. As a general matter Dr. Ahmad flew to Anchorage once a month to see patients for several days. In March 2015, Dr. Ahmed saw just three patients. The next month he saw four patients. He saw 9 patients in June 2015, 15 patients in July 2015, and 32 patients in August 2015.

By fall and into winter 2015, Dr. Ahmad's practice was growing significantly. Over the course of one three-day weekend per month, Dr. Ahmad saw 54 patients in September 2015, 76 patients in October 2015, 124 patients in November 2015, and 179 patients in December 2015.[18] The limited period of time that he was in Alaska and seeing patients each month resulted in very busy days at Dr. Ahmad's practice – with appointments scheduled in 15-minute increments from 7:00 a.m. through 8:30 p.m. On the busiest of his three practice days in October 2015, Dr.

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[16] Testimony of Dr. Ahmad; testimony of Dr. Hussein Huraibi.

[17] Although Dr. Ahmad testified that he received zero physician referrals, the record does not bear this out. Patient C.L. was referred from another provider and began seeing Dr. Ahmad in February 2015, making her one of his earliest Alaska patients. See Div. 000636-000643, 000654.

[18] Although Dr. Ahmad testified that his short visits to Alaska were a function of his small patient population, and that he intended to spend one week per month in Alaska, the appointment schedules in the agency record – through December 2015 – generally continue the pattern of clustering patient appointments over three- or four-day weekend, even as his practice expanded considerably.

Ahmad saw 48 separate patients;[19] on his busiest day in November 2015, he saw 54 separate patients.[20]

4. Complaints and investigation

In November 2015 the Division began receiving complaints about Dr. Ahmad from pharmacists based in Anchorage and nearby areas.[21] These complaints coincided with Dr. Ahmad's mid-November visit to Anchorage, during which he saw 124 patients and wrote 229 controlled substances prescriptions between Saturday, November 15 and Monday, November 17.[22]

On November 17, 2015, six different pharmacists in Anchorage and the Mat-Su Valley contacted Division Senior Investigator Ed Riefle with concerns about an influx of patients with high dose narcotic prescriptions.[23] Mr. Riefle assigned the matter to Investigator Susan Winton.[24] As it investigated, the Division continued to receive additional pharmacists' complaints.[25] In general, the pharmacists described what they found to be unusual and troubling prescribing patterns, with new patients without a documented history of prior opioid prescriptions presenting with simultaneous prescriptions for multiple controlled substances, or high dose opioids, or both.[26] Additional concerns were raised about the similarities between large numbers of prescriptions, including the same vague diagnoses – typically, "chronic pain" –listed on all prescriptions.[27] Ultimately, a total of ten different pharmacists called or wrote the Division with similar concerns about Dr. Ahmad.[28]

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19 Div.001911-001912.

20 Ahmad testimony; Div.01906-01910.

21 Riefle testimony; Winton testimony; Div. 000043, 000052, 000055, 000064, 000065.

22 Div. 001906-001910.

23 Riefle testimony; Div. 000345, 000346, 000349-000350. Mr. Riefle had also received an email the previous week from a Cook Inlet Tribal Council fraud investigator relaying allegations made by a patient. Div. 000345, 000351-000354. And On November 16, 2015, a Board of Pharmacy representative had contacted the Division about concerns from "members of [the] Pharmacy community." Div. 000345.

24 Riefle testimony; Winton testimony; Div. 000349.

25 *See* Div.00224-225, 00227-228, 00347.

26 Ruffridge testimony; Moore testimony; Winton testimony; Riefle testimony; Div. 002372, 002382, 002383. Dr. Ahmad objects to evidence of pharmacist complaints outside of the hearing testimony as hearsay. First, this evidence is not hearsay insofar as it is admitted to prove that multiple complaints were made, rather than to prove that the complaints were accurate (that is, not to prove "the truth of the matter asserted"). For this purpose, the complaints are not hearsay. But even if accepted as proof of the underlying matters, the complaints corroborate and supplement non-hearsay testimony in the record – namely, the testimony of pharmacists Moore and Ruffridge, and Investigators Winton and Riefle – and are therefore admissible here. AS 44.62.460(d).

27 *See id.*

28 Winton testimony.

With Board approval, the Division subpoenaed records from each pharmacy from which a complaint had been received.[29] In response to the subpoena, Geneva Woods provided copies of prescriptions for eight patients; Walgreens provided copies of prescriptions for sixteen patients; Target provided copies of prescriptions for twelve patients; Costco provided copies of prescriptions for three patients; and Fred Meyer provided copies of prescriptions for seven patients.[30]

The Division then subpoenaed patient records from Dr. Ahmad. Specifically, the Division subpoenaed all appointment and scheduling records from August through December 2015, as well as the full charts of the 38 patients for whom prescriptions had been received as a result of pharmacy subpoenas.[31] The Division also subpoenaed Dr. Ahmad's controlled substance prescription records from the Prescription Drug Monitoring Program (PDMP).[32]

The Division retained University of Washington pain management specialist Brett Stacey to evaluate the evidence it had gathered. Dr. Stacey is Board Certified in Anesthesiology, holds a subspecialty certification in Pain Management, is a diplomate of the American Board of Pain Medicine, and directs the outpatient pain clinic at the University of Washington. He previously directed the Pain Center at the Oregon Health & Sciences University, where he helped developed OHSU's guidelines for safe opioid prescribing.[33]

On March 24, 2016, investigator Winton sent Dr. Stacey the materials the Division had compiled, and a letter asking for his opinions.[34] In his April 22, 2016 response, Dr. Stacey opined that Dr. Ahmad's patient assessment and prescribing practices were inappropriate and unsafe. His particular concerns included: insufficient patient assessments; systematic prescribing of controlled substances to all patients; and prescribing at doses uniformly in excess of the starting dose, even

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[29] *See* Div. 002045-002046; 002071-002072, 002120-002121, 002128-002129, 002145-002146, 002184-002185, 002202-002203, 002261-2262, 002344-00245. For "chain" pharmacies with more than one branch in Anchorage, the scope of the subpoenas included all local branches, not just the branch(es) from which a complaint had been made. *Id.*; Winton testimony. Because most pharmacies did not keep copies of prescriptions they refused to fill, the records received did not fully reflect all patients whose prescriptions had raised concerns. Winton testimony; Div. 002072.

[30] Div. 001929. Because some patients had filled prescriptions at more than one pharmacy, the total number of patients for whom prescriptions was received was thirty-eight. Winton testimony; Div. 001929.

[31] Div. 0000031- 000420.

[32] Winton testimony; Div. 000389-000412. The subpoena sought "all records in the Prescription Drug Monitoring Program database, related to this practitioner, from August 1, 2015 to December 22, 2015." Div. 000389.

[33] Stacey Aff., pp. 1-2; Stacey testimony; Ex. 5 (Resp. 062-073).

[34] Div. 0002427-0002429, 0002454-0002455. The Division posed specific questions to Dr. Stacey, including his opinions of Dr. Ahmad's patient assessment, prescribing practices, recordkeeping, and overall patient care, and whether Dr. Stacey needed any additional information to reach a conclusion on any of other questions posed. Div. 002427-002429.

for opioid naïve patients, and often in concert with other dangerous controlled substances.[35] Dr. Stacey summarized his impression of Dr. Ahmad's prescribing practices as follows:

> He prescribes controlled substances for patients with no opioid history, patients with histories of substance abuse, patients with non-prescribed medications in their urine – in short, every patient, regardless of situation[,] receives a prescription for controlled substances.[36]

Dr. Stacey concluded that the volume of prescribing, and the uniformly high doses prescribed, are "impossible to justify," stating: "There is no population of chronic pain patients anywhere in the world who would uniformly require the high dose opioids Dr. Ahmad prescribes."[37] Dr. Stacey said that these practices are "at odds with every published guideline for both chronic pain management and the use of opioids in treating chronic pain," are "not the standard of care," and "pose a clear and immediate danger to the public health and safety."[38]

B. Procedural History

On May 4, 2016, the Division filed a nine-count Accusation against Dr. Ahmad, along with a petition seeking summary suspension of his medical license under AS 08.64.331(c). The Division supported its petition with an April 27, 2016 Affidavit of Investigator Susan Winton, and an April 28, 2016 Affidavit of Dr. Stacey, which included as an exhibit Dr. Stacey's April 22, 2016 report.[39]

The Board granted the Division's petition on May 6, 2016.[40] The Board's summary suspension Order finds that Dr. Ahmad "poses a clear and immediate danger to the public health and safety if he continues to practice medicine." As is his right under AS 08.64.331(c), Dr. Ahmad then requested a hearing at which a fuller record could be developed to reweigh the Board's summary suspension decision.

The Division referred Dr. Ahmad's appeal – both of the summary suspension and in defense of the Accusation –to the Office of Administrative Hearing on May 11, 2016. At a status conference held that day, Dr. Ahmad elected to waive his right to a hearing within seven days of the suspension decision so that he could retain counsel and have sufficient time to prepare. A hearing on the summary suspension was ultimately held on May 26, May 27, June 6, and June 7,

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35 Div.002352-2357.

36 Div.002353.

37 Div.002356.

38 Div.002352-2357; Stacey Affidavit, p. 3.

39 Ex. B, pp. 13-16 (Winton Affidavit), 4-6 (Stacey Affidavit), 7-12 (Stacey Report). The Division also attached the June 7, 2013 Order of the Arkansas State Medical Board (Ex. B, pp. 17-20), and the November 25, 2015 Consent Agreement between Dr. Ahmad and the Division addressing that Order and Dr. Ahmad's failure to disclose the underlying investigation when he applied for licensure in Alaska. (Ex. B, pp. 21-28)

40 Ex. B, p. 29.

2016. The parties agreed that this hearing, which was still highly expedited, would not be the final hearing on the counts of the accusation, but would instead be limited to whether the summary suspension should continue.

The Division was represented by Assistant Attorney General Robert Auth. Dr. Stacey, Senior Division Investigator Edward Riefle, retired Division Investigator Susan Winton, Soldotna pharmacist Justin Ruffridge and Anchorage pharmacist Nichelle Moore testified on the Division's behalf. Dr. Ahmad was represented by Drake Mann and Carmen Clark. Dr. Ahmad, one of his patients ("D.R."), and Dr. Hussein Huraibi testified on Dr. Ahmad's behalf. Counsel stipulated to the admission of all exhibits submitted by both parties. Post-hearing briefing was submitted on June 15, 2016, and the summary suspension appeal was taken under advisement.

C. Testimony and evidence presented

1. Complaints made to the Division

At the hearing on Dr. Ahmad's appeal of the Board's emergency suspension, two pharmacists testified credibly about complaints they made to the Division and the concerns that gave rise to those complaints. Nichelle Moore, Pharmacist in Charge at an Anchorage Costco pharmacy, explained that concerns arose during fall 2015 about "droves of patients" with vague diagnosis codes, high dose opioid prescriptions, and no record of prior opioid prescriptions in the PDMP. Some of the prescriptions were written for doses so high that the Costco pharmacy does not stock them – for example, the pharmacy does not stock "Oxy 30s," the highest available dose of oxycodone. Ms. Moore had to turn away eighteen patients in a single morning – all seeking to fill prescriptions for high dose opioids and other controlled substances. Ms. Moore felt that the prescribing patterns represented a "safety hazard to the public."[41] Ultimately, in December 2015, Costco sent Dr. Ahmad a letter informing him that it would no longer fill his prescriptions.[42]

Soldotna pharmacist Justin Ruffridge reported that in February 2016, two patients came to the pharmacy at the same time seeking to fill prescriptions for high dose opiates.[43] The prescriptions were written for high doses of "high abuse medications" (specifically, oxycodone and methadone), in large amounts (at least 90 tablets). Both patients were "extremely young" and presented with "little visible physical evidence" for needing what Mr. Ruffridge considered high

[41] Moore testimony.

[42] Moore testimony; Div. 0001938. In his post-hearing filings, Dr. Ahmad objected to the Costco letter as hearsay. The objection is overruled because it was not timely raised at the hearing, and also because the letter supplements or explains other non-hearsay evidence – namely, that in late 2015 multiple local pharmacists identified and expressed concerns about Dr. Ahmad's prescribing practices.

[43] Mr. Ruffridge holds a Pharm.D, has been a licensed pharmacist since 2008, and is the Pharmacist in Charge at Soldotna Professional Pharmacy. The findings in this paragraph are derived from his testimony.

doses of the prescribed medications. Mr. Ruffridge characterized the prescription doses as higher dosing than most prescriptions for post-operative pain, and as being in a range that is "sometimes" seen "in long term cancer care."

Upon checking the PDMP, Mr. Ruffridge found that one patient had no documented history in the PDMP, and the other had previously filled opiates, but had not done so in many months. Neither patient had previously filled prescriptions at Soldotna Professional Pharmacy, and both wanted to pay cash. Additionally, the patients acted as if they did not know each other, but they arrived at the same time, both had out-of-town addresses, both said they had recently relocated to the area, and both provided supposed new local addresses that did not appear to be legitimate.[44] Based on these numerous "red flags," Mr. Ruffridge and his colleagues jointly decided not to fill the prescriptions. Mr. Ruffridge then spoke with several other local pharmacists to discuss the prescriptions and make them aware of his pharmacy's decision not to fill them. A month or two after these events, Mr. Ruffridge had two additional patients try to fill opioid prescriptions written by Dr. Ahmad, and declined to fill them based on what appeared to be the "same pattern of prescribing behavior" that gave rise to his initial concerns.

Investigators Winton and Riefle also testified about additional similar complaints the Division received during its investigation, and which are included in the agency record. As a general matter, pharmacists who contacted the Division or who were interviewed as part of the Division investigation tended to raise concerns about numerous high dose prescriptions, most of which were for patients for whom the Alaska PDMP had no recent record of opioid prescribing.[45]

2. Dr. Ahmad's appointments

During the time that he has been practicing in Alaska, Dr. Ahmad has typically held clinic hours in Anchorage one weekend per month, generally seeing patients all day Saturday, Sunday and Monday.[46] On his busiest days, typically Sundays, Dr. Ahmad held appointments – mostly 15-minute appointments, with a few 30-minute slots – from 7:00 a.m. until 8:45 p.m.[47]

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[44] Specifically, when Mr. Ruffridge "googled" the local addresses the two patients provided, neither appeared to be a legitimate physical address.

[45] Winton testimony; Riefle testimony; recorded interviews in record. As noted above, Dr. Ahmad's hearsay objection to the recorded interviews is overruled in that these interviews are used here only to supplement or explain non-hearsay evidence in the record – namely, that local pharmacists developed concerns about Dr. Ahmad's prescriptions; that the Division received numerous complaints from pharmacists during its investigation; and that practicing pharmacists observed and reported what they found to be questionable practices.

[46] Div. 001906-001915.

[47] Div. 001901-001915.

For new patient appointments, patients fill out an 8-page questionnaire, almost all of which is a check-the-box format.[48] Dr. Ahmad indicated he spends most of the initial appointment time interviewing the patient and going over the responses to the questionnaire. In what remains of the appointment after devoting "most" of it to the interview, he says he conducts a physical examination targeted to the problems identified, asking patients to perform certain movements – such as walking on their heels or toes, or bending in a certain direction – that provide diagnostic information.[49] Dr. Ahmad estimates that he is able to complete a targeted physical exam of this nature in a matter of minutes, and is able to use this information and the patient interviews to confidently arrive at diagnoses such as spondylosis or radiculopathy.

Dr. Stacey found that Dr. Ahmad's physical exam findings were not sufficiently specific to support the specific diagnoses listed in the patient records. Dr. Stacey testified that while those diagnoses can be suspected based upon a physical examination, they cannot be confirmed without specific diagnostic testing or imaging studies – additional information which, in the 38 patient charts received by the Division, Dr. Ahmad never ordered.

Additionally, Dr. Ahmad's testimony about targeted physical exams raises questions about the accuracy of his patient records, which purport to document more comprehensive physical examinations of patients' entire bodies. Each initial appointment chart entry lists separate assessments of each patient's head and neck, ribs, spine, pelvis, and extremities – including range of motion measurements and assessment of neurological response.[50] Dr. Stacey characterizes these entries – and Dr. Ahmad's medical records in general – as too superficial and non-specific to provide any clinically useful information.[51] In his review of the 38 patient charts in the record, Dr. Stacey testified that he "could not find the basis for the diagnosis for most of the patients," noting the frequent identification of diagnoses such as "radiculopathy" or "spondylosis" without any evidence in the chart of specific signs, symptoms, or diagnostic tests associated with those diagnoses.

Dr. Ahmad's expert witness, Dr. Huraibi, testified that in his own pain management practice he spends an average of forty-five minutes examining a new patient. Dr. Ahmad did not

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[48] The questionnaire was designed by Dr. Ahmad, apparently with some input by Dr. Hussein Huraibi, who testified as an expert on Dr. Ahmad's behalf. Dr. Huraibi does not use the questionnaire in his own practice, and appeared reluctant to endorse the questionnaire as his own work product.

[49] At some point during the visit, patients sign a "pain contract" outlining the rules they are expected to follow if Dr. Ahmad prescribes them controlled substances. Of the 38 patient charts subpoenaed, two – C.L. and M.S. – did not contain a pain contract. See Div. 000507-543 (C.L.); Div. 001405-1443 (M.S.).

[50] See, e.g., Div. 000425-000426 (A.B.); 000840-000841 (D.B.).

[51] Stacey testimony.

specifically identify how long he spends on each new patient's initial appointment, other than to say that it can take fifteen minutes to go through the evaluation form.[52] However, in at least four cases documented in the record – patients A.B., J.D., J.S., and J.H. – Dr. Ahmad prescribed two or more controlled substances each to new patients after an initial appointment that was scheduled for only fifteen minutes.[53] The number of patients seen per day – as reflected in Dr. Ahmad's scheduling records, which document days on which he sees more than fifty patients – makes it highly unlikely that Dr. Ahmad's initial appointments are consistently taking any longer than the scheduled time.[54]

Following an initial appointment, Dr. Ahmad meets with patients monthly. For these appointments with established patients, Dr. Ahmad meets with the patient and interviews them about any changes in their symptoms. At both initial and follow up appointments, Dr. Ahmad conducts POCT ("point of care testing") urinalysis. Dr. Ahmad sometimes conducts additional drug testing through an outside lab, which is more expensive but more reliable.[55] During the period covered by the subpoena – that is, as of the end of December 2015 – Dr. Ahmad had not "fired" any of the 38 patients, nor had he referred any for follow-up imaging, diagnostic testing, or complementary treatments (such as physical therapy).[56]

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[52] Dr. Ahmad testified that his initial appointment with D.R. was probably forty-five minutes long. Ahmad testimony. Ms. R. had testified that the appointment lasted for "hours," of which she probably spent an hour and fifteen minutes meeting with Dr. Ahmad. D.R. testimony. The appointment was scheduled for 30 minutes, but was also the last appointment on Dr. Ahmad's schedule that day, so conceivably could have lasted longer. Div.001907.

[53] Div. 000044-000049, 001896, 001898, 001906, 001907, 001909. For each of these four patients, Dr. Ahmad prescribed two or more controlled substances during the initial visit. Div.000426 (A.B.: prescriptions for 180 methadone 10 mg, and 90 each of oxycodone 15 mg and valium 10 mg); Div.001104 (J.S.: prescription for 180 methadone 10 mg and 90 Oxycodone 15 mg); Div.001152 (J.D.: prescription for 90 each of methadone 10 mg, oxycodone 15 mg, and valium 10 mg); Div.001176 (J.H.: prescription for 180 oxycodone 10 mg and 90 oxycontin 40 mg).

Of the 38 patients whose records were subpoenaed, 32 had their initial appointment between August and December 2015 – the period during which the agency record also includes Dr. Ahmad's full appointment schedule. The vast majority whose initial appointment fell during this time had a first appointment scheduled for 30 minutes, with monthly follow up appointments then typically scheduled for 15 minutes. *Compare* Div. 001896-001900 *with* Div. 001901- 001916.

[54] *See* Div. 001906-001910. Certainly, some of Dr. Ahmad's patient schedules show days where multiple patients were scheduled for thirty-minute appointments. On November 14, 2015, for example, Dr. Ahmad had fourteen separate patients in thirty-minute slots, as well as eighteen additional patients with fifteen-minute appointments. As scheduled, Dr. Ahmad was to see patients from 8:00 a.m. through 7:30 p.m., with no breaks. *Id*.

[55] Of the 38 patient charts subpoenaed, at least one (C.L.) contained no drug testing results; another (G.S.) contained no drug testing after the second visit; and another (J.H.) appear to reflect continued prescribing after a POCT that Dr. Ahmad noted to be positive for cocaine – although a conflicting handwritten entry suggests that the drug test was not actually positive. *See* Div. 00044-00049; Div. 000507-000543 (C.L.); Div. 000893-000943 (G.S.); *compare* Div. 001127 (stating J.H.'s POCT was positive for cocaine on 11/16/15) *with* Div. 001136 (stating J.H. 11/16/15 POCT was negative for cocaine).

[56] The one partial exception is D.W., a patient with a history of breast cancer, whose records include a letter from Dr. Ahmad apparently related to her attempt to secure health insurance coverage, and urging such coverage in order to obtain appropriate imaging and treatment of a newly-discovered breast lump. Div. 000783.

3. Information considered by or available to Dr. Ahmad at the time of prescribing

The Division contends that Dr. Ahmad fails to conduct sufficiently rigorous assessments of his patients before prescribing controlled substances. Specific concerns include: a failure to obtain prior medical records, a failure to obtain imaging studies, and a failure to conduct rigorous screenings for mental health or substance abuse concerns.

a. Records from past providers

Dr. Stacey criticizes Dr. Ahmad's check-the-box patient questionnaire as containing an insufficient level of detail about patient history to provide meaningful clinical information. For example, patients are asked to identify previously-taken medications, but the questionnaire does not indicate when the medication was taken, what dose was taken, how long the medication was used, or why it was stopped. This lack of detail is compounded, Dr. Stacey finds, by a lack of prior medical records to clarify past medical history.[57]

The Federation of State Medical Boards policy incorporated by reference into this Board's policy concludes that "[i]nformation provided by the patient is a necessary but insufficient part of the evaluation process."[58] The policy directs providers to confirm prior evaluations and treatments "by obtaining records from other providers, if possible."[59] Obtaining and reviewing past records allows a provider to verify the history the patient is providing, learn what diagnostic tests have been performed, and learn what treatments have been attempted and what the outcome has been.[60] Dr. Stacey believes it is impossible to fully evaluate chronic pain patients without this information to serve as a baseline. For this reason, and because opioids are not properly viewed as a first-line treatment, Dr. Stacey rarely prescribes opioids without first reviewing prior patient records.

Dr. Huraibi characterized Dr. Stacey's views on this topic as unduly rigid. Dr. Huraibi noted that he would not withhold pain medication from a patient with objective manifestations of significant distress simply because prior medical records had not arrived. If he found that pain medication was necessary, Dr. Huraibi would prescribe the medication and then see the patient for a follow up in a week or two when the patient's records arrived. Unlike the practice endorsed by Dr. Huraibi, however, there is no evidence that Dr. Ahmad ever makes efforts to obtain prior records. While his chart notes always reference the need to obtain prior records, there is no

[57] Stacey testimony.
[58] FSMB Model Policy at p. 7.
[59] FSMB Model Policy at p. 7.
[60] Stacey testimony.

evidence this is actually attempted or occurs.[61] Nor does Dr. Ahmad schedule a follow up to an initial visit within the 7 to 10 days contemplated by the testimony of his own expert on this topic. Rather, after prescribing high dose opioids to a new patient for whom he has obtained no confirming medical records, Dr. Ahmad sees the patient back in a month – at which point, despite still not having obtained any prior confirming patient records, he continues prescribing opioids.

b. Imaging studies

The various witnesses disagreed about the value of imaging studies and the need to obtain prior imaging as part of an initial diagnostic work up, or to conduct imaging to confirm specific diagnoses. Dr. Ahmad contends that imaging studies are of limited usefulness unless a procedure is being contemplated. Dr. Ahmad used the example of a telephone, noting that a photograph of a phone does not tell the viewer whether the phone is ringing. Similarly, he explained, radiology does not always show symptomology, and the large number of "false positive" imaging results (e.g. asymptomatic members of the population with abnormal MRI findings) makes imaging less important to pain management than patient-reported symptoms. Dr. Stacey disagrees with Dr. Ahmad's dismissal of the usefulness of imaging studies. In particular, Dr. Stacey testified that certain diagnoses – diagnoses that appear as findings in many of Dr. Ahmad's patient charts – simply cannot be confirmed without imaging.

c. PDMP

The Alaska Prescription Drug Monitoring Program database is available to physicians who register for access to it.[62] Accessing the PDMP allows a provider to view any controlled substance prescriptions a patient has filled in the prior twelve months. This enables practitioners to confirm or supplement patient-provided history, and to check for and avoid duplicative or adversely interacting prescriptions.[63]

During the period covered by the subpoenas – when Dr. Ahmad held more than five hundred patient visits and wrote more than seven hundred controlled substance prescriptions – Dr. Ahmad was not registered to access the PDMP.[64] Accordingly, he did not check the PDMP prior

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[61] Dr. Ahmad testified that he asks patients to bring in records from past providers, but that this can be time consuming and he will not withhold treatment while waiting for records. But only two of the 38 patient records contain any prior medical records. *See* Div. 000636-000643 (patient C.L., whose chart contains a physician's referral letter, lab test results, and medication list); Div. 001588-001665 (records from prior pain provider in patient S.G.'s chart).

[62] Winton testimony; Ahmad testimony.

[63] Stacey testimony; Huraibi testimony.

[64] Winton testimony; Ahmad testimony.

to writing any of the hundreds of controlled substance prescriptions reflected in the agency record.

d. Substance abuse screening.

Patients with substance abuse disorders are at elevated risk for adverse outcomes from prescribed controlled substances.[65] All of the testifying physicians agreed that substance abuse screening should be conducted before prescribing controlled substances for chronic pain.[66]

Dr. Ahmad believes that he adequately addresses this issue by conducting urinalysis and because his patient questionnaire includes questions about substance abuse.[67] First, page 5 of Dr. Ahmad's questionnaire contains a section titled "Medication management," in which patients are asked to check any applicable boxes. Most of the eight items listed are items associated with or easily inferred to relate to substance abuse (including "I think I am addicted to pain medications"). Next, at page 7, the questionnaire contains five specific questions about alcohol abuse (for example, asking whether the patient ever feels guilty about drinking, has ever been told to cut down on drinking, or has ever been arrested for DWI). Immediately after the section titled "Alcohol" is a section titled Substance Abuse, the heading of which reads: "Substance Abuse: [check] if applicable." Next to these instructions, the questionnaire provides a lengthy list of several dozen illicit substances – first naming each substance by a well-known name, and then providing numerous slang or street names. No further explanation is provided as to the meaning of the instruction to "check if applicable," and no follow-up questions address the nature of the patient's use or abuse, or whether the patient is currently undergoing or has ever undergone any sort of substance abuse treatment.

Dr. Ahmad testified that he believes his questionnaire is "very thorough" on the issue of substance abuse, citing specifically the wide array of alternate names provided for each substance listed.[68] But Dr. Stacey testified that the measures Dr. Ahmad takes are inadequate, particularly when prescribing high dose opioids. In particular, Dr. Ahmad's questionnaire is not a validated, standardized tool for assessing opioid risk.[69] Such tools are validated through research, and provide a numerical score to indicate the level of risk associated with the prescribing opioids to a particular patient.[70] While Dr. Ahmad's list of substances and the array of street names provided

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65 Ahmad testimony; Stacey testimony; Huraibi testimony.
66 Ahmad testimony; Stacey testimony; Huraibi testimony.
67 Ahmad testimony.
68 Ahmad testimony.
69 Stacey testimony.
70 Stacey testimony.

are indeed "thorough," the list is not a validated substance abuse screening tool, does not appear to be particularly effective at obtaining disclosures, and provides no measure by which to determine or implement any level of risk stratification between patients.[71]

e. Mental health screening

A mental health screening is also necessary before prescribing controlled substances for chronic pain.[72] This is because patients with higher levels of anxiety, depression, and other mental health problems have less success obtaining pain relief or improved function from opioids, while also being at higher risk for overdose and other adverse effects.[73] Dr. Ahmad believes that he adequately addresses mental health issues because his patient questionnaire includes questions about a patient's mood, stress level, and sleep habits.[74] But Dr. Stacey concluded that Dr. Ahmad fails to conduct adequate mental health assessments of patients to whom he then prescribes opioids. In particular, Dr. Stacey noted the lack of a validated, standardized screening tool for mental health concerns, the lack of any questions about past or current treatment for mental health concerns, the lack of any documented follow-up to any items checked on the patient questionnaire, and the lack of confirming patient records for patients self-identifying as experiencing depression or anxiety.[75]

4. Evidence about prescribing practices

Even though Dr. Ahmad was not checking the PDMP before prescribing controlled substances, controlled substance prescriptions he wrote that were filled by Alaska pharmacies were entered into the database. The agency record contains subpoenaed PDMP records for August through December 2015.[76] Between Saturday, August 15, and Tuesday, August 18 – a period where Dr. Ahmad's scheduling records show he saw 32 patients – the PDMP database shows that Dr. Ahmad wrote 81 separate controlled substance prescriptions.[77] In September

[71] Indeed, of the 38 patients whose charts are in the record, only three – D.W., J.S., and S.M. – disclosed having used any substance other than marijuana. While it is possible that not a single one of the remaining patients has used any of the illicit substances listed, a more likely interpretation – particularly given that ten of the 38 patients were eventually fired for use of illicit substances – is that the list is not an effective mechanism for screening patients for substance abuse.

[72] Ahmad testimony; Stacey testimony; Huraibi testimony.

[73] Stacey testimony.

[74] Ahmad testimony.

[75] Stacey testimony.

[76] Div. 000389-000412.

[77] Div. 000407-000410.

2015, Dr. Ahmad saw 54 patients over three days.[78] During this time, he wrote 138 separate prescriptions for controlled substances.[79]

In October 2015, Dr. Ahmad saw 76 patients over three days, and wrote 175 separate prescriptions controlled substances.[80] On the busiest day, Sunday, October 11, he saw 48 separate patients, with appointments from 7:00 a.m. through 8:30 p.m.[81] In November 2015 Dr. Ahmad saw 124 patients over three days, including seeing 54 patients on Sunday, November 15.[82] Dr. Ahmad wrote 229 prescriptions for controlled substances during these three days.[83] In December 2015 Dr. Ahmad saw 179 patients and wrote 166 controlled substance prescriptions over a four-day period.[84]

All told, Dr. Ahmad wrote more than 700 controlled substance prescriptions during a five-month period – a rate Dr. Stacey described as "phenomenally high for any practitioner." But the rate is "particularly high" given the very part-time nature of Dr. Ahmad's Alaska practice during that time – typically seeing patients only three days per month. As explained by Dr. Stacey, "the majority" of chronic pain patients can be effectively managed without opioids, and opioids are not a first line treatment for chronic pain. The Federation of State Medical Boards model policy advises that, "[g]enerally, safer alternative treatments should be considered before initiating opioid therapy for chronic, non-malignant pain"; that opioids should be prescribed for a defined period of time ("usually no more than 90 days"); and that "[w]hen initiating opioid therapy, the lowest dose possible should be given to an opioid naïve patient and titrate to affect."[85] Yet, during each three-day visit, Dr. Ahmad saw large numbers of patients and prescribed opioids for all of them. Dr. Stacey opined that this pattern of prescribing "is not standard of care anywhere."[86]

Coupled with what he sees as inadequate assessments and a blanket refusal to consider non-opioid treatments, Dr. Stacey also expressed grave concern about the high doses Dr. Ahmad prescribes. It was the frequent prescribing of high doses, even among patients with no opioid history in the PDMP, that initially led to pharmacist complaints about Dr. Ahmad.[87] Higher doses

78 R. 1913-1914; Ahmad testimony.
79 Div. 000403, 000406-000409.
80 Div. 000403-000406; 001911-001912.
81 Div. 001911-001912.
82 Ahmad testimony; R. 1906-1910.
83 Div. 000399-000403.
84 Ahmad testimony; Div. 000395-000399; Div.001901-001906.
85 Ex. D, p. 9.
86 Stacey testimony.
87 Moore testimony; Ruffridge testimony; Winton testimony.

of opioids are associated with higher risks.[88] Higher doses increase the risk of death as well as the risk of other adverse outcomes.[89] Additionally, patient response and reaction to opioids is highly variable, often in unpredictable ways.[90] For all of these reasons, "the suggestion in every guideline, every paper you can read about initiating opioid therapy, or any chapter, or any education seminar you would attend is to start at a low dose, assess the effect of that low dose, before moving beyond a starting dose." [91]

While the FSMB policy directs providers to begin with "the lowest possible dose," Dr. Stacey's review of the records found that "the doses prescribed were not starting doses."[92] None of the opioid prescriptions in the record appear to have been written for the lowest starting dose of any of the medications prescribed – a practice Dr. Stacey characterizes as outside the standard of care.[93] For example, the FDA prescribing guidelines for oxycodone advise a starting dose range of 5-15 mg, every 4 to 6 hours.[94] None of Dr. Ahmad's patients were started at the lowest starting dose (5 mg), and the 38 charts in the agency record include numerous patients – including B.N., D.B., J.H., M.I., and S.G. – started on an initial dose of oxycodone 30 mg, despite being on no pain medication at all at the time of Dr. Ahmad's initial evaluation.[95]

5. Similarities in Patients' Records, Diagnoses, and Treatment Plans

Dr. Ahmad uses an electronic health record program to generate and store patient records. Based on the 38 charts provided in response to the subpoena, the patient records he generates appear identical in many respects, and contain very little, if any, personalized discussion of individual patient history, circumstances, or concerns. Dr. Ahmad attributes the apparent similarity between records to the formalities of the electronic record keeping system. Dr. Stacey disagrees, and views the records' similarities as evidence of substandard, insufficiently personalized evaluations, and a failure to develop meaningfully individualized treatment plans.

The patient records appear on identical forms, with one used for initial evaluations and one used for follow up visits. For each patient, the initial evaluation includes numerous sections for the provider to measure or assess different systems or address different issues. Many of these,

88 Stacey testimony; Ex. F, p. 4.
89 Stacey testimony; Ex. F, p. 4.
90 Stacey testimony; Ex. F, p. 4.
91 Stacey testimony.
92 Ex. D, p. 9; Stacey testimony.
93 Stacey testimony.
94 Resp. Ex. 10, Resp. 0126-0127.
95 *See* Div. 000836, 000839, 000841 (D.B.); Div. 000451 (B.N.); Div. 001256-001289 (J.H.); Div. 000142-000143 (M.I.); Div. 001669 (S.G.); Div. 001808 (T.U.).

however, are identical between all or virtually all of the 38 patients. For example, for 36 of the 38 patients, the record of the initial patient appointment includes, within the "physical examination" section, a subsection titled "psychiatric." For every one of those 36 patients, the initial appointment record contains the following identical entry:

> Judgment and insight is good.
> Orientation to person, place and time is appropriate.
> Mood and affect normal and appropriate to situation.
> Belief concerning the cause of pain is appropriate.
> Knowledge, expectations and preferences for pain management is inadequate.
> Expectations of outcome of pain treatment are reasonable.
> 50% or greater reduction of pain is required for patient satisfaction or to resume "reasonable activities."
> Coping response for stress or pain is complicated with presence of anxiety and depression.

Given that these exact same findings on each of these eight separate inquiries are repeated verbatim in each patient's chart,[96] it is not credible that these entries reflect individualized assessments.

Another area where the patient charts appear virtually identical is in Plan of Care, with identical entries throughout the patient records.[97] As summarized by Dr. Stacey:

> The treatment plans consistently did not include or explore conservative treatment in a meaningful way. There frequently was a reason given for not thinking about procedures – mentioning procedures might be appropriate, 'but we're not going to do them right now.' A reason [was] given for 'why we didn't have records' – [such as] 'the patient will bring in records in the future,' or 'the patient will bring in imaging in the future.' And then the treatment jumped to high dose, non-starting doses of opioids – and often [with] benzodiazepines at the same time.[98]

Again, this pattern as described by Dr. Stacey appears in the vast majority, if not all, of the 38 patient charts in the record.

6. Patient care examples

Dr. Stacey characterizes Dr. Ahmad's diagnoses and treatment plans in the 38 patient charts he reviewed as being "really at variance with anything I've ever seen anywhere. This is

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[96] The charts of patients G.B. and T.A. contain different formatting that does not include these items, but instead have identical notes reading: "judgment and insight is good, belief concerning cause of pain is appropriate, coping response for stress or pain is complicated with presence of anxiety and depression." Div. 000944, 001814.

[97] Specific identical entries include a five-item "Risk of Complications and Morbidity," listing, *inter alia*: "(1) If left untreated, may lead to long-term physical disability," and "(5) Medication management includes life-long use of Class II or III opioid therapy with very high risk of physical dependence." The intended meaning of item (5) is unclear from the records, and Dr. Ahmad did not offer testimony to explain it. A treatment plan for "lifelong use" of opioid therapy for chronic pain patients would be "completely discordant with any published guideline or any established clinical practice." Stacey testimony.

[98] Stacey testimony.

just not treatment that is based upon the education you receive being a pain management physician; any guideline I can find published anywhere; any clinical practice in the country; it just is not reasonable or safe."[99] For context, three patients discussed Dr. Stacey's report and testimony, and whose care is raised in the Division's accusation, are briefly addressed below.

Dr. Ahmad first saw patient A.B. on November 16, 2015.[100] The initial visit was scheduled for 15 minutes – and was the 26th of Dr. Ahmad's 37 appointments that day.[101] A.B. apparently did not fill out a patient questionnaire, or, if he did, it did not end up in his medical record.[102] According to Dr. Ahmad's notes of the visit, Mr. B., age 32, indicated he was having left-sided low back pain that radiated into his legs, but rated his pain as very mild ("2" with medication, "3" during rest, and "4" with activity). He indicated the pain began spontaneously nearly two years ago and had been "continuous." However, he had tried no other treatment modalities, seen no other pain specialists, and was taking no pain medication. His physical examination was completely normal. Dr. Ahmad also noted that his POCT result was "inconsistent" – apparently a reference to the fact that, despite indicating he was taking no medications, Mr. B's urine test was positive for benzodiazepines.[103] At the end of this first appointment, and despite Mr. B's minimal symptoms and positive drug test, Dr. Ahmad prescribed 180 10-mg methadone tablets, 90 15-mg oxycodone tablets, and 90 10-mg valium tablets.[104] Dr. Stacey identified A.B. as exemplifying inappropriate diagnoses and treatment, and Dr. Ahmad's treatment of A.B. is the basis for Count II of the Accusation.[105]

Patient B.N. first saw Dr. Ahmad on October 12, 2015. In his initial questionnaire he rated his pain as a "2 out of 10," checked boxes describing himself as both "happy" and "severely anxious," and noted an "occasional" need for sleep medications.[106] He indicated he had had pain "all the times" for "18 years," but also that he was on no medication at the time of his first appointment.[107] Dr. Ahmad prescribed methadone 10 mg, oxycodone 30 mg, and valium 10mg,

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99 Stacey testimony.
100 Div. 000424.
101 Div. 001907.
102 *See* Div. 000422-000437.
103 Div. 000424-000426.
104 Div. 00426; 000429-000430. Dr. Ahmad also hand-wrote a note on the Methadone prescription: "can pay cash if Medicaid rejects." Resp. 00429.
105 Div. 002353 (noting "[t]here is no evidence presented for any of these diagnoses"; "documented pain levels are low"; and "none of the diagnoses offered justify the subsequent medical care").
106 Div. 000441.
107 Div. 000443, 000451.

each three times per day.[108] Dr. Stacey identified B.N. as exemplifying inappropriate diagnoses and treatment, and Dr. Ahmad's treatment of B.N. is the basis for Count III of the Accusation.[109]

Dr. Ahmad began treating patient W.F. in September 2015, and that treatment is the basis for Count V of the Accusation. At his first appointment, W.F., age 68, ranked his pain as both 3 and 6 out of 10, and described himself as moderately depressed and moderately anxious.[110] Dr. Ahmad prescribed methadone 20 mg three times per day, as well as 15 mg oxycodone three times per day. Dr. Stacey characterized this course of treatment as "at least 10 times a reasonable starting dose" – even assuming that "the patient is even appropriate for opioids and has thoroughly explored more conservative measures."[111] Dr. Stacey also noted that the use of Methadone is particularly dangerous in elderly patients, posing significant risk of adverse cardiac outcomes, and therefore being "very high risk" for this patient.

7. Summary of Dr. Ahmad's response criticisms of his practice

Dr. Ahmad denies engaging in improper prescribing, attributes this dispute to a difference of professional opinions, and characterizes himself as the victim of a rush to judgment – both by the pharmacists who complained about his prescribing practices, and by the Division.

Dr. Ahmad describes himself as being in the early stages of building a more multifaceted medical practice in Alaska. He testified that he plans to purchase a building and enter into a partnership with other local physicians, although he did not provide details or identify any of those physicians. His Alaska practice has been limited to medical interventions thus far, but insists that he intends to offer a broader range of approaches once these (somewhat undefined) arrangements are put in place.

As to the nature of his practice, Dr. Ahmad notes he has "fired" numerous patients for noncompliance with the pain contract. A patient roster lists 149 patients as active, 85 as "inactive," 60 as never seen, and 65 as "fired."[112] Of the 38 patients whose charts are in the agency record, 17 are still listed as "active" patients, 11 as "inactive," and 10 as "fired."[113] Some

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[108] Div. 000451-000452. A drug test at his next appointment, on November 16, 2015, was negative for opiates and benzodiazepines. Div. 000473. However, B.N. is still listed as an active patient on Dr. Ahmad's most recent patient list. Resp. 0077.

[109] Div.002354 (B.N. "answered that he had mild pain that he could manage with breaks on his intake form, yet his assessment led to a treatment plan involving three controlled substances").

[110] Div.001856.

[111] Div.002354.

[112] Ahmad testimony; Resp. 0076-0087.

[113] Resp. 0076-0087.

of the fired patients had as many as nine appointments with Dr. Ahmad before being "fired" for non-compliance – typically, for testing positive for illicit drugs.[114]

Dr. Ahmad's testimony set out a series of interrelated concepts that inform his prescription practices. First, Dr. Ahmad contends that pain patients are ignored by other physicians and marginalized by doctors, pharmacists and society in general. He testified that the "core goal" of his treatment is to improve patients' quality of life – a goal he says is distinguishable from "bringing down a pain score."[115]

Dr. Ahmad also asserts that the patients he sees are generally honest with him, and have "no motive" to be dishonest. Dr. Ahmad is aware that some patients may be seeking out pain medication due to addiction or for improper purposes, and says he believes that those patients eventually get identified and weeded out over time.

Dr. Ahmad says he is confident that pain patients in particular are reliable reporters of past medical history – specifically, reliable reporters of past medications and dosages. Dr. Ahmad relies on these reports, without obtaining verification, to determine appropriate starting doses for his own prescriptions.[116] Relatedly, Dr. Ahmad disagrees with the characterization of his patients as opioid naïve. According to Dr. Ahmad, if a patient has previously taken opioids for a period of at least six weeks – no matter how long ago that occurred – that patient's body's response to opioids has irrevocably changed.[117] Thus, Dr. Ahmad's "starting" doses take into account prior opioid use – as reported by patients, and regardless of how much time has elapsed since that use.

But Dr. Stacey persuasively testified that this practice is not consistent with the state of existing medical knowledge, saying that Dr. Ahmad's practice reflects a "dangerous clinical judgment." Pointing to a recent literature review in the New England Journal of Medicine, Dr. Stacey explained that discontinuation of opioids "rapidly reverses" physical and physiological tolerance.[118] Additionally, "tolerance can subside relatively quickly and in an unpredictable

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[114] *See* Resp. 84-85 (patients C.Y., D.W., R.W. and S.M.).

[115] Ahmad testimony.

[116] Dr. Stacey, on the other hand, endorses a "trust, but verify" approach to medication management. Dr. Stacey disagrees with Dr. Ahmad's assessment that pain patients are reliable reporters of past medications and dosages.

[117] The one exception, according to Dr. Ahmad, is that if a patient has taken naloxone, this effectively resets the body's response to opioids.

[118] *See* Ex. F, pp. 2-3 ("There is lingering misunderstanding among some physicians about the important differences between physical dependence and addiction. The repeated administration of any opioid almost inevitably results in the development of tolerance and physical dependence. These predictable phenomena reflect counteradaptations in opioid receptors and their intracellular signaling cascades. These short-term results of repeated opioid administration resolve rapidly after discontinuation of the opioid (i.e., in a few days to a few weeks, depending on the duration of exposure, type of opioid, and dose)"). Dr. Ahmad's post-hearing objection to this article as

fashion."[119] As a result, patients with a prior history of taking opioids but who are not currently on opioids should be treated as opioid naïve for purposes of identifying a starting dose.[120]

Finally, Dr. Ahmad testified that he gives patients verbal instructions to titrate up their medication to the prescribed doses. Thus, while a prescription may read "30 mg oxycodone, three times per day," Dr. Ahmad's intent is for the patient to slowly titrate up to that dose over the course of a week. As a threshold matter, however, none of the patient charts produced in response to the subpoenas contains evidence of such instructions being given. Nor did Dr. Ahmad offer any other documentary evidence (for example, the charts of other patients outside the 38 in the record) supporting this testimony.

The Federation of State Medical Boards model policy directs that "written instructions for the use of all medications should be given to the patient and documented in the record."[121] While Dr. Huraibi testified that titration would be an appropriate explanation for the seemingly high doses Dr. Ahmad prescribes, he also indicated that evidence of titration instructions or discussions should appear somewhere in the medical records. While Dr. Huraibi testified that he may occasionally omit such information as an oversight in a particular patient's records, the record in this case does not include a single medical record documenting that Dr. Ahmad even contemplated titration, let alone documenting that he discussed it with his patients. Further, Dr. Stacey testified that, even if the treatment plan contemplated titrating up to a given dose, (1) that intent should be documented in the records, (2) those instructions can absolutely be reflected on the prescription itself, and, (3) critically, the dose being titrated should still be a starting dose.

8. Evidence regarding adverse outcomes and risk

It is Dr. Stacey's view that Dr. Ahmad's prescribing practices are "clearly dangerous." In the example of patient H.K., Dr. Stacey notes that Dr. Ahmad prescribed Ms. K five separate sedating medications, a combination with a large risk for adverse effects, and posing a "significant chance" of death.[122] In addition to being wholly outside the standard of care, Dr. Stacey says, "this is clearly dangerous."[123] Likewise, Dr. Stacey describes the constellation of

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hearsay is overruled as untimely, and also because the statements at issue are admissible under Evidence Rule 803(18). Further, the article supplements or explains Dr. Stacey's non-hearsay testimony.

119 Stacey testimony.

120 Stacey testimony. Dr. Huraibi agreed that "to be safe," such a patient should be started at a "reasonably lower" dose, which could then be slowly increased.

121 Model Policy, at p. 12.

122 Stacey testimony; Div. 002354.

123 Dr. Ahmad's treatment of Ms. K forms the basis of Count VII of the Accusation.

controlled substances prescribed to patient D.B. as "dangerous . . . individually and potentially lethal in the prescribed combination."[124]

Dr. Ahmad admits that the doses he prescribes to some patients would be lethal to opioid naïve patients, but sees this as evidence that his prescribing is appropriate and his patients are not truly opioid naïve, because they have not died from the doses prescribed.[125] Dr. Stacey indicated that a lack of documentation of adverse outcomes was immaterial to his conclusion, and cautioned that it was not necessary to wait for a documented adverse outcome before finding that a danger exists.[126] Dr. Stacey testified that his conclusion that Dr. Ahmad's practices are a clear and immediate danger arise out the overdose risk and the pattern of high dose prescribing. He indicated that "overwhelming evidence and multiple review articles" document that the increased dose prescribed is a risk factor for overdose. Dr. Stacey pointed to a "widely distributed paper" finding "no evidence" that increased doses are associated with better pain control, but "clear evidence" that they are associated with increased risk of adverse outcomes. In addition to the risks to individual patients, both Dr. Stacey and the pharmacists who testified noted the risk posed by diversion of controlled substances to individuals beyond the patient to whom the medication is prescribed.[127]

III. Preliminary Procedural Issues and Controlling Law

A. Legal Framework

Alaska Statute 08.64.331 authorizes the board to impose an array of disciplinary sanctions upon a medical provider that the board finds has violated board regulations, demonstrated professional incompetence, or committed other acts identified in AS 08.64.326 as "grounds for

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[124] Div. 002355.

[125] Ahmad testimony. Dr. Ahmad did not address his former patient, D.P., whose autopsy results were discussed during Mr. Riefle's testimony.

[126] At the time of the suspension, the Division had no evidence of documented adverse outcomes suffered by any of Dr. Ahmad's patients. During the hearing, evidence emerged of a possible adverse outcome. Prior to the hearing, Dr. Ahmad provided the Division with a list of patients, categorized as "active," "inactive," "never seen," "fired," et cetera. One patient, D.P., was listed as deceased. Resp. 0086. The day before the hearing began, Senior Investigator Riefle received the autopsy report on D.P., listing "multidrug intoxication" as having contributed to her death. Riefle testimony. Records submitted by Dr. Ahmad show he saw D.P. on November 15, 2015, December 10, 2015, and January 15, 2016. Resp. 086; Div. 001904, 001908. The subpoenaed PDMP records document prescriptions written during the first two appointments, but, because of the date range for the subpoena, did not include any prescriptions written after December 2015. On November 15, 2015, Dr. Ahmad wrote and D.P. filled prescriptions for 10 mg of Methadone three times per day; 15 mg of Oxycodone three times per day, and 10 mg of Diazepam three times per day. Div. 000392, 000402. On December 10, 2015, Dr. Ahmad wrote and D.P. filled prescriptions for 10 mg of Methadone three times per day and 10 mg of Diazepam three times per day. Div. 000392, 000397. The agency record contains no further information about D.P., and neither party submitted further evidence on this topic.

[127] Moore testimony; Stacey testimony (noting that most individuals who abuse prescriptions opioids get them from friends or family).

imposition of disciplinary sanctions."[128] However, this case is not yet in a posture for imposition of permanent disciplinary sanctions. Rather, the hearing held in May and June encompassed only the issue of summary suspension. The existence or nonexistence of violations *that could be sanctionable* is relevant to the issue of summary suspension, but at this stage a continued suspension, or termination of the suspension, are the only actions available to the Board.[129]

In addition to the range of available sanctions that may be imposed after a hearing, AS 08.64.331(c) authorizes the board to summarily suspend a medical license if it "finds that a licensee poses a clear and immediate danger to the public health and safety if the licensee continues to practice." Unless overturned, a summary suspension under AS 08.64.331(c) then remains in place until resolution of disciplinary proceedings under AS 08.64.331(a).

In order to prevail in its defense of the summary suspension, the division must prove at least some of the underlying allegations of misconduct, and must also prove that the alleged misconduct constitutes a clear and immediate danger to the public health and safety.[130]

"The decision of the board following a hearing on summary suspension is final as to the summary suspension order, but absent consent or prior notice to the parties, it is not a final decision as to the merits of a pending accusation for final disciplinary action." [131]

B. Applicable statutes and regulations

The board may impose a sanction if it finds that a licensee "has demonstrated professional incompetence, gross negligence or repeated negligent conduct."[132] Professional incompetence is defined as "lacking sufficient knowledge, skills, or professional judgment in that field of practice in which the physician or physician assistant concerned engages, to a degree likely to endanger the health of his or her patients."[133] "A failure to meet the professional standard for prescribing controlled substances constitutes professional incompetence under AS 08.64.326(a)(8)(A)."[134]

The board may also impose a sanction if it finds that a licensee has "engaged in unprofessional conduct."[135] Unprofessional conduct "means an act or omission [that] does not

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128 AS 08.64.326; AS 08.64.331.

129 Dr. Ahmad will be given an opportunity to present a further defense, if he wishes, before permanent discipline is considered. A hearing for this purpose is scheduled for August 29-September 1, 2016.

130 *Matter of Murphy*, OAH No. 05-0553-MED (State Medical Board Decision on Summary Suspension, 10/21/05), at p. 16.

131 *Id.*, at pp. 16-17.

132 AS 08.64.326(8)(A).

133 12 AAC 40.970.

134 *Matter of Van Houten*, Case No. 2802-99-005 (State Medical Board Decision on Summary Suspension, 11/12/02), at p. 29.

135 AS 08.64.326(a)(9).

conform to the generally accepted standards of the profession."[136] The accompanying regulation, 12 AAC 40.967, identifies 32 enumerated examples, including "(9) failing to prepare and maintain accurate, complete, and legible records in accordance with generally accepted standards of practice for each patient." Another regulation, 12 AAC 40.975, in turn, identifies specific patient requirements "when prescribing a drug that is a controlled substance," in which case a licensee "shall create and maintain a complete, clear, and legible written record of care that includes, at a minimum,

> (1) a patient history and evaluation sufficient to support a diagnosis;
> (2) a diagnosis and treatment plan for the diagnosis;
> (3) monitoring the patient for the primary condition that necessitates the drug, side effects of the drug, and results of the drug, as appropriate;
> (4) a record of drugs prescribed, administered, or dispensed, including the type of drug, dose, and any authorized refills."[137]

C. The Division has the burden of proof by a preponderance of the evidence.

Disciplinary actions before the Board are governed by the Administrative Procedure Act. Alaska Statute 44.62.460(e)(1) provides that "unless a different standard is stated in applicable law, the petitioner has the burden of proof by a preponderance of the evidence[.]" The Board has consistently applied the preponderance standard to summary suspension proceedings.[138]

Dr. Ahmad's arguments that a higher evidentiary standard controls are not persuasive. These arguments have been made and rejected in other proceedings before the Board and in other forums. In *Nathanson v. State of Alaska*, then-Superior Court Judge Gleason denied injunctive relief to stay the summary suspension of a physician's license under AS 08.64.331(c), interpreting "clear and immediate danger" as subject to the preponderance of evidence standard.[139] This interpretation is consistent with past practice by Board, and will be followed in this case.[140]

D. Evidentiary issues

In an action under the APA, "hearsay evidence may be used to supplement or explain direct evidence but is not sufficient by itself to support a finding unless it would be admissible

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136 12 AAC 40.967.

137 12 AAC 40.975. The board may also impose a sanction if it finds that a licensee has "prescribed or dispensed drugs in violation of a law, regardless of whether there has been a criminal action." AS 08.64.326(5).

138 *See, e.g., Matter of Murphy* (Decision on Summary Suspension) at p. 16; *Matter of Gerlay*, OAH No. 05-0321-MED (State Medical Board Decision on Summary Suspension, 8/10/05), at pp. 24-25; *Matter of Van Houten*, Case No. 2802-99-005 (State Medical Board Decision on Summary Suspension, 11/12/02) at p. 7.

139 *See Nathanson*, Superior Court Case No. 3AN-02-05632 CI (4/19/02 Order Denying Motion for Emergency Hearing, Temporary Restraining Order and Injunctive Relief).

140 *See, e.g., Matter of Gerlay* (Decision on Summary Suspension); *Matter of Van Houten* (Decision on Summary Suspension); *Matter of Nathanson* (Decision on Summary Suspension).

over objection in a civil action."[141] The prehearing scheduling order in this case advised the parties that, "[b]ecause the hearsay status of documents or testimony is not always self-evident and because technical hearsay issues can be curable, the limitation regarding use of hearsay in AS 44.62.460(d) will be applied only if a hearsay objection is timely asserted at the hearing."

During the hearing, Dr. Ahmad's counsel periodically raised hearsay objections consistent with this order, but also indicated an intent to make a "standing hearsay objection," despite the more specific requirements of the scheduling order. Some hearsay objections were addressed during the hearing, but it was also noted that (1) hearsay remains admissible in APA proceedings and (2) the relevance of the technical rules of hearsay in an APA proceeding is whether a particular piece of evidence may, alone, be used to support a finding. Accordingly, at the close of the hearing, the parties were instructed to identify in their post-hearing briefing any hearsay evidence to which they had objected and which they now contended was insufficient to support a finding. That is, the parties were required to identify any hearsay evidence as to which they contended no non-hearsay evidence had been presented.

Dr. Ahmad submitted a post-hearing filing on hearsay objections, to which the Division submitted an objection and response.[142] To the extent Dr. Ahmad's objections concern evidence discussed herein, those objections are addressed in the discussion of that evidence.

IV. Discussion

A. The Division proved that Dr. Ahmad "demonstrated professional incompetence, gross negligence, or repeated negligent conduct," and "engaged in unprofessional conduct" by overprescribing high dose opioids.

The division has met its burden of demonstrating that Dr. Ahmad has "demonstrated professional incompetence, gross negligence, or repeated negligent conduct[]" in his prescribing practices.[143] The board's regulations define professional incompetence as "lacking sufficient knowledge, skills or professional judgment in that field of practice in which the physician practices…concerned engages, to a degree likely to endanger the health of his or her patients."[144] Here, the alleged professional incompetence is not a lack of knowledge or skill. Rather, the concern is Dr. Ahmad's professional judgment.

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141 AS 44.62.460(d).

142 Dr. Ahmad's briefing was not timely submitted, apparently due to a miscommunication between his local counsel and his counsel in Arkansas. Accordingly, I have considered the Division's response to his objections.

143 AS 08.64.326(a)(8).

144 12 AAC 40.970.

As a threshold issue, Dr. Ahmad's objections that the investigation was ill-conceived or that the 38 patients are not representative of his practice are not well taken. Even if the 38 patients are somehow not representative of the remainder of Dr. Ahmad's practice – a proposition for which no evidence was presented – the evidence of substandard or dangerous practices as to a subset of patients is actionable. As in *Van Houten*, a provider meeting the standard of care for some patients, or even belatedly remedying some of the failures of his practice, does not change the "abundant evidence that he did not meet the standard of care for other patients as addressed during the hearing."[145]

Inadequate professional judgment in the prescription of controlled substances has formed the basis of prior board decisions, including summary suspensions. In *Van Houten*, the summary suspension was upheld where "the division's experts convincingly established that Van Houten lacked good judgment in prescribing controlled substances."[146] And in *Gerlay*, summary suspension was continued in a context that included "a pattern of inadequate evaluations and diagnoses with insignificant documentation of patient histories."[147]

Here, the concern about Dr. Ahmad's professional judgment arises out of a constellation of questionable prescribing practices, superficial patient assessments/evaluations, substandard recordkeeping, and inadequate patient monitoring. As summarized by Dr. Stacey:

> He didn't know these patients very well. He didn't have a firm basis for coming up with these diagnoses. He didn't know what their prior treatments were in detail and know why – if they've tried opioid medications before – they were stopped. He didn't verify history; he didn't come up with a basis for the diagnoses; and then prescribed extremely high risk medications.[148]

Taken as a whole, the evidence presented on these topics paints a troubling picture of, at best, flawed professional judgment. Much of same evidence likewise supports a finding of unprofessional conduct, particularly given the heightened standards of care applicable when prescribing controlled substances. For the reasons that follow, and based on the evidence currently in the record, the Division has met its burden of proof under AS 08.64.326(a)(8)(A) and AS 08.64.326(a)(9).

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145 *Matter of Van Houten*, Case No. 2802-99-005 (11/12/02 Board Order on Summary Suspension) at pp. 29-30. *See generally*, *Storrs v. State Medical Board*, 664 P.2d 547, 555-556 (Alaska 1983) (pattern of inadequate care to five patients sufficient to justify discipline imposed); *Board of Dental Examiners v. Brown*, 448 A.2d 881, 885 (Me. 1982) ("Incompetence is not determined by counting and comparing the number of successful and unsuccessful cases").

146 *Van Houten*, decision on summary suspension, p. 30.

147 *Matter of Gerlay*, OAH Case No. 05-0321-MED (Decision on Summary Suspension) at p. 8.

148 Stacey testimony.

1. Voluminous prescribing of controlled substances

Central to the concerns about Dr. Ahmed's professional judgment is the strong evidence of his overwhelming reliance on opioids, which have served as the focal point of his pain management practice in Alaska. Of the 38 separate charts in the agency record, all patients appear to be receiving controlled substances, and all appear, specifically, to be receiving opioids. Further, in each case, the controlled substance prescriptions began with the patient's very first appointment with Dr. Ahmad.

Beyond these 38 patients, the PDMP records show a very high volume of prescribing. Dr. Ahmad wrote more than 700 controlled substance prescriptions over the course of five three- to four-day weekends. The sheer volume of controlled substance prescriptions Dr. Ahmad generated during the time period in question raises significant doubts about his professional judgment.

Opioids are not a first-line treatment for chronic pain.[149] Patients whose care was specifically discussed during the hearing included patients with low self-identified pain levels, with no history of trying any other treatment for pain, or with diagnoses for which opioids are not a recommended course of treatment. But even for these patients, Dr. Ahmad prescribed opioids at the first visit. That every patient Dr. Ahmad saw received an opioid prescription raises considerable concern about his professional judgment. Further, many if not all of the 38 patients whose charts are in the record appear to be receiving more than one controlled substance, and many appear to have been prescribed that combination on a first visit. In addition to frequently prescribing both oxycodone and methadone to new patients,[150] Dr. Ahmad also frequently prescribes benzodiazepines in conjunction with opioids – a combination that increases the risk of potentially fatal overdose.[151]

Dr. Stacey testified persuasively that this prescribing pattern is far afield from any known or accepted practice guideline.[152] Dr. Ahmad's routine prescribing of controlled substances as a first line treatment, apparently without exception, raises considerable concern about his professional judgment, and constitutes a violation of AS 08.64.326(a)(8)(A) and 12 AAC 40.970.

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149 Stacey testimony.

150 Dr. Ahmad indicated that, while he is not necessarily "a fan" of these medications, they are what insurance companies will generally pay for or what his cash pay patients can generally afford. Ahmad testimony. But this response misunderstands the Division's critique, which is of the consistent use of multiple controlled substances, for all or virtually all patients.

151 Stacey testimony.

152 Stacey testimony. The testimony of Dr. Ahmad's own expert supported this conclusion, in that, in Dr. Huraibi's own practice, roughly 25 percent of patients are not prescribed any opioids. Huraibi testimony.

2. Inadequate patient assessment

In addition to consistently prescribing opioids on the first visit and, apparently, for every patient, these already concerning acts occurred in the context of a schedule that appears wholly inconsistent with the possibility of reasoned decision-making about individualized patient care. Dr. Ahmad contends that he sees "about thirty patients per day."[153] But his own business records show numerous instances on which he saw more than fifty patients per day. Particularly given his practice of routinely prescribing potentially dangerous medications to each patient he sees, the very high volume nature of Dr. Ahmad's practice raises further concerns about his professional judgment.

Against this backdrop of high volume practice, Dr. Stacey persuasively testified that numerous patient records contained medical diagnoses that that were not supported by information in the patient's medical record, noting: "almost every patient I looked at, there was a list of medical diagnoses, but there was not a review of medical records, there was not imaging, to support those diagnoses, even though the diagnoses were very specific."[154]

In the *Matter of Gerlay*, the Division's expert testified that,"'Dr. Gerlay's medical record keeping was inadequate to justify the prescribing of controlled substances' in many instances," and identified multiple patients who had been prescribed controlled substances with inadequate evaluation and assessment to support either the diagnosis provided or the substances prescribed.[155] Here, likewise, Dr. Stacey describes Dr. Ahmad's documentation of physical examinations as "uninterpretable" and inadequate for purposes of determining a diagnosis.[156] Additionally, large swaths of the initial evaluation document are identical between patients – including those purportedly linked to evaluation and determination of an appropriate treatment plan.[157]

In the vast majority of cases, neither the patient history nor the physical examination sections of Dr. Ahmad's charts reflect information or detail sufficient to arrive at a specific diagnosis or treatment plan.[158] Dr. Stacey's report and testimony were sharply critical of Dr. Ahmad's assignment of diagnoses that Dr. Stacey characterized as impossible to justify without

153 Ahmad testimony.
154 Stacey testimony.
155 *In the Matter of Gerlay*, decision on summary suspension, at pp. 14-16.
156 *See* Div. 002355.
157 See, e.g., "Physical exam: psychiatric" and "Plan of Care" sections of initial evaluations.
158 Stacey testimony.

confirming imaging or other records.[159] These diagnoses, of course, arise in the context of a high volume practice where every patient seen is, apparently, prescribed opioids. The patterns described herein, and shown at hearing and in the patient records reflect "inadequate attention to initial assessment to determine what, if any, controlled substances are clinically indicated and to determine risks associated with their use in a particular patient."[160]

The Division met its burden of showing that Dr. Ahmad failed to comply with Board guidelines as well as applicable regulations in the prescribing of controlled substances. Specifically, as in *Gerlay*, the evidence here supports the conclusion that Dr. Ahmad made specific diagnoses not supported by his records – and then prescribed cocktails of controlled substances to treat these unsupported diagnoses. The Division thus met its burden of proving that Dr. Ahmad violated 12 AAC 40.975. Further, as in *Gerlay*, this conduct supports a finding that Dr. Ahmad "engaged in professional incompetence and repeated negligent conduct under AS 08.64.326(a)(8)(A) based on his failure to obtain histories and conduct adequate evaluations[.]"

3. Reliance on high doses

The high doses routinely prescribed to new patients compound the previously discussed concerns about Dr. Ahmad's professional judgment. High dose prescribing is associated with greater risk of overdose.[161] Of all of the PDMP prescriptions in the record, not a single patient was placed on the lowest starting dose for any of the controlled substances prescribed.[162] Again, while high doses may be medically appropriate in some individual cases, it strains credulity that all of the patients requiring such high doses have found their way to Dr. Ahmad's practice – while none of the patients for whom a lower dose would suffice have done so.

Dr. Ahmad's response to this criticism – criticism articulated by numerous pharmacists across the state, as well as by Dr. Stacey – is that (1) his patients are not, in fact, opioid naïve, and (2) he instructs patients to titrate up to the high dose in order to avoid adverse effects. As to the first issue, Dr. Ahmad either actually relies in his practice upon, or now seeks to justify his high starting doses based upon, scientifically flawed and unsupported reasoning. Dr. Stacey persuasively testified – and supported his testimony with research papers explaining –that patients do not retail their level of opioid tolerance after discontinuing opioids. Moreover, the nature of

159 Stacey testimony; Div. 002355.
160 Ex. C, p. 1.
161 Stacey testimony; Ex. D, p. 4; Ex. F, p. 4.
162 Stacey testimony; Div. 000391-000411.

tolerance and its discontinuation is unpredictable, making it imprudent to start new patients on high doses, even if they have previously taken the same medication at some other time.

The titration issue raises its own set of concerns about Dr. Ahmad's professional judgment and compliance with applicable standards. The regulation requires the provider to maintain a "complete … written record of care." Dr. Ahmad contends that his opioid doses were not excessive because he told his patients to titrate up to the prescribed dose. The complete lack of any documentation of such instructions in any of the 38 patient charts in the agency record calls this testimony into question.[163] At best, Dr. Ahmad's testimony establishes a failure to maintain a "complete written record of care" as required by 12 AAC 40.975 and the FSMB model policy.

Further, the titration described by Dr. Ahmad was to be carried out by patients with no supervision and no assessment of the effectiveness of any given dose. This too is contrary to clinical guidelines and accepted practice.[164]

In short, the high volume of opioid and other controlled substance prescriptions Dr. Ahmad wrote, particularly in light of his routine reliance on high starting doses, raises concerns about his professional judgment, and constitutes a violation of AS 08.64.326(a)(8)(A) and 12 AAC 40.970. Further, Dr. Ahmad's testimony that he instructs patients to titrate their opioid doses, when coupled with the fact that none of the 38 charts reflects that such instructions were given, separately constitutes a violation of 12 AAC 40.975(2).

4. Failing to obtain background information – either initially or in follow up

The Division demonstrated that Dr. Ahmad prescribes opioids on the first visit to patients without obtaining any prior medical records, and then continues to prescribe opioids without ever obtaining prior records. Dr. Stacey's report and testimony express concern at Dr. Ahmad "does not review prior medical records, verify histories, or obtain imaging before prescribing these life threatening, highly controlled medications."[165] There is no evidence that Dr. Ahmad *ever* requires patients to provide prior provider records before prescribing opioids. Nor are there any instances in the records in which Dr. Ahmad required a patient to provide such records before renewing those prescriptions. This practice runs contrary to even Dr. Ahmad's own expert's testimony. While Dr. Huraibi criticized Dr. Stacey for refusing to prescribe pain medications before reviewing prior medical records, Dr. Huraibi's criticism was couched in terms of being able to confirm diagnoses and adjust treatment plans once those records were received in the

163 *See* Evid. R. 803(7).
164 Stacey testimony; Ex. D, pp. 3-4, 9, 12.
165 Stacey testimony; Div. 002354.

coming weeks. Here, however, the evidence suggests that Dr. Ahmad remains willing to continue prescribing high dose opioids without *ever* receiving confirming medical records from other providers.

Further, the lack of patient records or imaging studies was, at least for the more than 700 controlled substance prescriptions reflected in the agency record, coupled with a failure to access the PDMP before prescribing controlled substances – a practice contrary to Board and FSMB guidelines.[166]

The Division further demonstrated that Dr. Ahmad prescribed opioids on the first visit to patients with substance abuse problems and to patients with mental health problems, both without using a standardized screening tool to assess for risk, and without receiving records of other care, coordinating with other providers, or documenting any precautions related to the extra risk created by these issues.

In the case of patient D.W., for example, Ms. W. self-identified as having a history of substance abuse. There is no evidence that Dr. Ahmad conducted any additional screening or assessments to determine whether controlled substance prescribing was advisable for this patient. There is no evidence that Dr. Ahmad made any attempt to obtain records pertaining to Ms. W's substance abuse treatment. Dr. Stacey criticized Dr. Ahmad's evaluation of Ms. W., noting, "there are no details in the record of the concerning substance abuse history."[167]

In the case of 22-year old B.K., Ms. K indicated on her initial patient questionnaire that her pain was "so severe that I fee[l] life is not worth living and I want to commit SUICIDE." [168] That day, Dr. Ahmad prescribed Ms. K. a total of 180 tablets of opioids – (90 each of 10 mg methadone and 15 mg oxycodone).[169] There is no indication in his records that he considered Ms. K's endorsement of suicidal ideation when arriving at a treatment plan.

The Board has previously upheld summary suspensions where a physician prescribed controlled substances without sufficient background information.[170] And in the *Matter of Nathanson*, the Board upheld a summary suspension based, in part, on the physician's failure to take adequate patient histories of several patients prior to cosmetic surgical procedures.[171] Particularly in the context of his voluminous prescribing of controlled substances to all patients,

166 Ex. C, p. 1; Ex. D, pp. 7-8.
167 Div. 002354.
168 Div. 000477 (emphasis in original).
169 Div. 000487.
170 *Matter of Gerlay*, decision on summary suspension, at pp. 14-15.
171 *Matter of Nathanson*, decision on summary suspension, at pp. 24-25, 34-35.

the near complete lack of other provider records or any other confirmatory documentation in any of Dr. Ahmad's patient charts is further evidence of a lack of professional judgment under AS 08.64.326(a)(8)(A) and 12 AAC 40.970.

5. Insufficient monitoring of patients after initiating high dose prescriptions

The Division also demonstrated that Dr. Ahmad's practice is inconsistent with the standard of care for oversight and monitoring of patients on high dose opioids. The Division presented evidence that Dr. Ahmad does not follow up with his new patients for at least 30 days after initially prescribing opioids. Dr. Ahmad only practices in Alaska a few days each month, and his office is closed when he is not here. If patients have problems, he testified, they should go to the emergency room. Dr. Stacey explained that the risk of adverse outcomes is greatest when starting opioids. Dr. Huraibi sees his own new patients back within two weeks of an initial visit and prescription. Particularly when a patient is titrating up in a new medication, it is important for the physician to closely monitor the patient's response to the medication. Because of how he has structured his practice, Dr. Ahmad does not do so.

The Division presented evidence that Dr. Ahmad continues to prescribe high dose opioids when the patient does not respond to the opioid treatment. In the case of 22-year old patient B.K., whose expression of suicidal ideation was discussed above, Ms. K indicated she had bilateral, radiating upper and low back pain and neck pain, that the pain was present "all the times," that the pain had been present for four years, and that she had not tried any non-pharmaceutical pain management.[172] Dr. Ahmad recorded her reported assessment of "pain with activity" as 9/10.[173] Ms. K was taking no medications at the time of her initial visit.[174] Dr. Ahmad prescribed both methadone (10 mg three times per day) and oxycodone (15 mg three times per day). Two months into her treatment, Ms. K still rated her pain as 9 out of 10. Dr. Stacey pointed out that the patient's lack of progress on opioids should have resulted in a diagnosis of pain that is resistant to opioid treatment, and that opioids should have been discontinued.[175] Instead, Dr. Ahmad continued prescribing high dose opioids, and added benzodiazepines.

The backdrop of this prescribing pattern is the established Board guidance that opioids are not the first line of treatment; that providers are to avoid "excessive reliance on opioids, particularly high dose opioids for chronic pain management"; and that "throughout the course of

[172] Div. 000477-000478, 000481.
[173] Div. 000485.
[174] Div. 000485, 000487.
[175] Stacey testimony; Div. 002354.

opioid therapy, the physician and the patient should weigh the potential benefits and risks of continued treatment and determine whether such treatment remains appropriate."[176] The Division demonstrated that Dr. Ahmad's practice has not complied with this guidance, a pattern that supports a finding that Dr. Ahmad has violated AS 08.64.326(a)(8)(A) and 12 AAC 40.970 (lacking professional judgment to a degree likely to endanger patient health/demonstrating professional incompetence, gross negligence, or repeated negligent conduct); AS 08.64.326(a)(9) and 12 AAC 40.967 (unprofessional conduct); and 12 AAC 40.975 (requirement to maintain complete record of, *inter alia*, patient monitoring vis a vis controlled substance prescribing).

B. The Division proved that Dr. Ahmad's opioid prescribing practices constitute a clear and immediate danger to the public health and safety.

In order to justify suspension of Dr. Ahmad's license pending the outcome of the full hearing on the Division's Accusation, the Division must prove, by a preponderance of the evidence that the conduct complained of constitutes a clear and immediate danger to the public health and safety if he continues to practice. The Division has met that burden.

The prescribing behavior at issue in this case implicates at least two distinct hazards – hazards to individual patients who are prescribed voluminous amounts of high dose opioids, and hazards to the public health based on the potential diversion of controlled substances to individuals beyond the patient for whom they were prescribed.[177] The pharmacists who complained to the division about Dr. Ahmad's prescribing raised both concerns. The academic literature also supports both concerns as significant threats from excessive opioid prescribing.[178] So too do past decisions by the Board.[179]

As to the first hazard – danger to individual patients – the Division's witnesses persuasively testified that the doses routinely prescribed by Dr. Ahmad are significantly outside the norm for patients who do not appear on the PDMP, and for the majority of chronic non-cancer pain patients generally, and that these doses and combination of doses are dangerously high.[180] Dr. Ahmad contends that the prescribing levels must not have been inappropriate, because, citing the example of a specific patient, "if the dose wasn't good, he should have [overdosed] or died by December." That the records do not yet show any adverse patient effects does not, however, disprove the dangerousness of the prescribing patterns. If anything, the lack of adverse effects on

[176] Ex. C, p. 1; Ex. D, pp. 4, 11.
[177] Stacey testimony; Div.002354.
[178] Ex. F; Stacey testimony.
[179] *Matter of Gerlay*, decision on summary suspension, at p. 14.
[180] Dr. Stacey testified that the risks to Dr. Ahmad's patients are "much higher" because of the high doses he prescribes.

individual patients raises issues of the second hazard – the risks to the community if even a portion of Dr. Ahmad's controlled substance prescriptions are being diverted into the community at large.[181] The Division thus met its burden of proving that Dr. Ahmad's conduct discussed herein constitutes a danger to the public health and safety.

The Board has held that "[d]anger is immediate, in the context of summary suspension, if the physician is likely to endanger a patient's health before the board conducts a hearing and issues a final decision on the merits of an accusation to impose a disciplinary sanction."[182] Additionally, however, "[t]he board has discretion to liberally interpret the [clear and immediate danger] provision focusing on whether danger is imminent, before actual harm occurs or is proven."[183] In *Gerlay*, the Board found that substandard prescribing practices creating a risk of drug diversion constituted a clear and immediate danger.[184] And in *Van Houten*, the Board's summary suspension decision observed that "the Board need not wait for another patient to receive substandard care before stepping in."[185] No different outcome is warranted here.

Shortly before the hearing ended, Dr. Ahmad submitted a supplemental exhibit indicating that he had agreed to voluntarily relinquish his DEA prescribing credentials. To the extent Dr. Ahmad claims that this relinquishment precludes a finding of clear and immediate danger, this argument fails. Dr. Ahmad presented no evidence about the significance of the DEA document, including about his ability to reverse the voluntary action. More fundamentally, the suspension centers on grave concerns about Dr. Ahmad's professional judgment, and his failures to properly support his treatment plans with records of appropriate assessment, evaluation, and individualized decision-making. While a legal inability to prescribe opioids may ameliorate some of these concerns, it does not ameliorate the larger questions about Dr. Ahmad's unsafe practices and the failures of professional judgment implicated in those practices.

In short, the Division has met its burden of showing "clear and immediate" danger sufficient to warrant maintaining the summary suspension until the larger disciplinary matter is addressed.

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181 *See Matter of Gerlay*, decision on summary suspension, at p. 26 ("The deficiencies in Gerlay's medical records constituted a pattern that jeopardized the safety of patients and unnecessarily increased the potential for drug diversion, a major societal problem.")

182 *Matter of Murphy*, decision on summary suspension, at p. 17.

183 *Matter of Gerlay*, decision on summary suspension, at p. 25.

184 *Matter of Gerlay*, decision on summary suspension, at p. 26.

185 *Matter of Van Houten*. decision on summary suspension, at p. 30.

V. Conclusion

Based on the evidence presented at this preliminary proceeding, the Division has met its burden of proving that Dr. Ahmad's practices pose a clear and immediate danger to the public health and safety. Summary suspension during the pendency of the disciplinary proceeding on the May 2016 Accusation is therefore justified and should continue in place.

DATED: June 27, 2016.

By: *Signed*
Cheryl Mandala
Administrative Law Judge

Adoption

The Alaska State Medical Board adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 4th day of August, 2016.

By: *Signed*
Signature
Kathleen M. Millar
Name
Secretary ASMB
Title

[This document has been modified to conform to the technical standards for publication.]