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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
David D. Parrish, M.D.,
Holder of License No. 26896
For the Practice of Medicine
In the State of Arizona

Docket No. 07A-060211-MDX

Case No. MD-06-0211

**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR
REVOCATION OF LICENSE.**

On December 13, 2007 this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge ("ALJ") Lewis D. Kowal's proposed Findings of Fact and Conclusions of Law and Recommended Order involving David D. Parrish, M.D. ("Respondent"). Respondent was notified of the Board's intent to consider this matter at the Board's public meeting. Respondent did not appear. The State was represented by Philip A. Overcash, Esq. Chris Munns, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office provided legal advice to the Board.

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

FINDINGS OF FACT

1. At all times material to this matter, David D. Parrish, M.D. ("Dr. Parrish") was licensed by the Arizona Medical Board ("Board") license number 26896 ("License") authorizing him to practice as an allopathic physician in the State of Arizona.

2. Dr. Parrish appeared before the Board on February 9, 2005 to address allegations concerning misdiagnosis and mismanagement of a patient in case number MD-04-0018A.

3. On February 9, 2005, Dr. Parrish appeared before the Board with legal counsel for formal interview.

1 4. On February 16, 2005, the Board issued an interim order requiring him to
2 undergo a Physician Assessment and Clinical Evaluation ("Evaluation") within 90 days to determine
3 his competency.

4 5. On March 8, 2005, Dr. Parrish contacted Board Staff and requested an extension
5 of time to complete the Evaluation informing staff that he had been out of town for three weeks.
6 Board Staff informed Dr. Parrish that the deadline for compliance with the Evaluation was set by
7 the Board and he needed to comply with the Board Order.

8 Board Staff contacted the Evaluation facility on April 29, 2005 and was informed that Dr.
9 Parrish had not contacted the facility to schedule the Evaluation.

10 6. On October 7, 2005, Dr. Parrish appeared before the Board without legal counsel
11 and the Board voted to issue findings of fact, conclusions of law and order, dated December 12,
12 2005.

13 7. The Board issued a Letter of Reprimand for misdiagnosis and mismanagement of
14 thyroid disease, the License was suspended and placed on probation for one year and Dr. Parrish
15 was ordered to undergo the Evaluation at his own expense within 90 days. The Evaluation was to
16 be completed by March 9, 2006. The suspension of the License was not to terminate prior to the
17 Board's review of the Evaluation. Dr. Parrish was also required to submit quarterly reports to the
18 Board stating whether there has been compliance with the conditions of probation imposed by the
19 Board.

20 8. On March 9, 2006, Lorraine Brown ("Ms. Brown"), employed by the Board at the
21 time as a Physician Health Program ("PHP") Officer, contacted the Evaluation facility to determine if
22 Dr. Parrish had arranged for the Evaluation. Upon such contact, Ms. Brown learned that Dr.
23 Parrish had not scheduled the Evaluation.

24 10. On March 13, 2006, Ms. Brown sent Dr. Parrish a letter (Exhibit 2) informing him
25 that the Board had opened an investigation under case number MD-06-0211 for possible violation

1 of a Board Order. In particular, the letter informed Dr. Parrish of the allegation that Dr. Parrish
2 violated the terms of the Letter of Reprimand by failing to complete the Evaluation within 90 days of
3 the Board Order.

4 11. In a letter dated March 18, 2006, which the Board received on March 22, 2006,
5 that was directed to Ms. Brown, Dr. Parrish cites various factors that affected his inability to afford
6 the Evaluation and stated that he had "ceased practicing medicine after receiving a final letter from
7 the Arizona Board of Medical Licensure." (Exhibit 3)

8 12. On April 6, 2006, Ms. Brown prepared a PHP Report (Exhibit 4) that provided a
9 summary of the history of this matter noting that Dr. Parrish failed to undergo the Evaluation within
10 90 days of the Board Order and that Dr. Parrish is in violation of the Letter of Reprimand issued on
11 December 12, 2005.

12 13. Ms. Brown testified that as of June 2006, she confirmed that Dr. Parrish had not
13 scheduled the Evaluation. Ms. Brown also testified that if the Evaluation had been scheduled, Dr.
14 Parrish would have been required to pay the cost of such evaluation in advance of the Evaluation,
15 that the Evaluation facility was required to notify the Board of such the scheduling of the Evaluation,
16 and that the Board had neither been contacted by the Evaluation facility nor been informed that Dr.
17 Parrish had scheduled the Evaluation.

18 14. In a letter dated October 13, 2007 (Exhibit 5), Dr. Parrish returned to the Board
19 the License and stated that he was "no longer interested in pursuing it anyway."

20 15. Ms. Brown testified that other than the above-mentioned letters, Dr. Parrish has
21 not recently submitted any other written communication to the Board.

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1 **CONCLUSIONS OF LAW**

2 1. This matter is a disciplinary matter and, as such, the Board bears the burden of
3 proving that the allegations set forth in the Complaint and Notice of Hearing are violations of State
4 law regulating allopathic physicians and the standard of proof on all issues is by a preponderance
5 of the evidence. See A.A.C. R2-19-119.

6 2. A preponderance of the evidence is "evidence of greater weight or more
7 convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole
8 shows that the fact sought to be proved is more probable than not." Black's Law Dictionary, 1182
9 (6th ed. 1990).

10 3. Dr. Parrish's failure to comply with the Board Order and Letter of Reprimand by
11 failing to complete the Evaluation within the required time frame and failing to provide quarterly
12 reports to the Board as to his compliance with the Board Order constitutes unprofessional conduct
13 within the meaning of A.R.S. §§ 32-1401.27(r) and 32-1401.27(dd).

14 4. The Board proved by a preponderance of the evidence that Dr. Parrish violated
15 the provisions of A.R.S. §§ 32-1401.27(r) and 32-1401.27(dd).

16 5. Grounds exist for the Board to revoke the License pursuant to A.R.S. §32-
17 1451(M).

18 **ORDER**

19 Based upon the Findings of Fact and Conclusions of Law as adopted, the Board
20 hereby enters the following Order:

21 1. Respondent's License No. 26896 is revoked on the effective date of this Order
22 and Respondent shall return his wallet card and certificate of licensure to the Board.

23 ...

24 ...

25 ...

1 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

2 Respondent is hereby notified that he has the right to petition for a rehearing or review
3 by filing a petition with the Board's Executive Director within thirty (30) days after service of this
4 Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for granting a
5 rehearing. A.C.C. R4-16-102. Service of this order is effective five (5) days after date of mailing.
6 If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after
7 it is mailed to Respondent.

8 Respondent is further notified that the filing of a motion for rehearing is required to
9 preserve any rights of appeal to the Superior Court.

10 Dated this 14th day of December, 2007.



ARIZONA MEDICAL BOARD

13 By: *Amanda J. Diehl*
14 Amanda J. Diehl
15 Deputy Executive Director

16 Original of the foregoing filed this
14th day of December, 2007, with:

17 Arizona Medical Board
18 9545 East Doubletree Ranch Road
19 Scottsdale, AZ 85258

20 Copy of the foregoing filed this
14th day of December, 2007, with:

21 Cliff J. Vanell, Director
22 Office of Administrative Hearings
1400 W. Washington, Ste. 101
Phoenix, AZ 85007

23 Executed copy of the foregoing mailed
24 by US Mail this 14th day of December, 2007, to:

25 David D. Parrish, M.D.
(Address of record)

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Anne Froedge
Assistant Attorney General
Office of the Attorney General
CIV/LES
1275 W. Washington
Phoenix, Arizona 85007

Philip A. Overcash, Esq.
Kutak Rock, LLP
8601 N Scottsdale Rd Suite 300
Scottsdale, AZ 85253-2742



1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **DAVID D. PARRISH, M.D.**

4 Holder of License No. **26896**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-04-0018A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand, Suspension and
Probation)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting
8 on February 9, 2005 and October 7, 2005. On February 9, 2005 David D. Parrish, M.D.,
9 ("Respondent") appeared before the Board with legal counsel Stephen Myers for a formal
10 interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). At the
11 conclusion of the interview the Board ordered Respondent to undergo a competency
12 evaluation and continued the matter. On October 7, 2005 Respondent again appeared
13 before the Board for formal interview, but was not represented by counsel. The Board
14 voted to issue the following findings of fact, conclusions of law and order after due
15 consideration of the facts and law applicable to this matter.
16

17 **FINDINGS OF FACT**

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

20 2. Respondent is the holder of License No. 26896 for the practice of allopathic
21 medicine in the State of Arizona.

22 3. The Board initiated case number MD-04-0018A after receiving a complaint
23 regarding Respondent's care and treatment of a 40 year-old male patient ("SG"). The
24 complaint alleged Respondent misdiagnosed adrenal insufficiency and mismanaged
25

1 SG's medical care resulting in SG suffering from thyrotoxicosis, thrombocytopenia and
2 cholelithiasis.

3 4. At the February 9, 2005 formal interview Respondent testified the
4 applicable standard of practice was the correction of SG's sleep pattern disturbance,
5 correction of his hormone imbalance, treatment of his chronic infections, correction of his
6 dietary and supplementary intake, and a reduction of his stressors. Respondent testified
7 he saw SG for only three consultations over a two month period. Respondent testified
8 SG had the following symptoms for six or seven years: initial viral infection with following
9 severe fatigue; marked sleep pattern disturbance; chronic myalgia; cold sensitivity and
10 dry skin; depression impairment of short term memory and brain fog; repeated infections;
11 reduced sexual drive and interest; irritable bowel syndrome with negative GI consults;
12 asthmatic disorder with hoarseness; and suppressed average temperature of 97.4.

13 5. Respondent testified the results of two self-administered extremes and
14 clinical materials supported a diagnosis of chronic fatigue and fibromyalgia. Respondent
15 testified SG's yeast screen was positive in tests and at the first consultation his physical
16 examination was negative. Respondent testified SG's blood pressure dropped, and
17 assuming an upright stance, SG's blood pressure dropped, and SG's long history of
18 repeated infections in inflammatory myalgia supported the impression of adrenal
19 insufficiency. Respondent testified his clinical impression was chronic fatigue and
20 fibromyalgia, asthma and gastric reflux per history, suppressed endocrine functions,
21 including thyroid hypofunction, and probable yeast overgrowth of the lower GI tract.
22 Respondent testified he gave SG the following treatment based on his clinical evaluation
23 and lab testing: beginning on August 3, 2003 titrated T3, T4 thyroid to capture an average
24 temperature of 98 degrees based on hypothyroid profile, suppressed temperature and
25 rapidly deteriorating health. According to Respondent, at this point SG was hardly able to

1 go to work. Respondent testified that from August 17, 2003 to October 8, 2003 he gave
2 SG replacement testosterone with an aromatic estrogen blocker to obtain testosterone
3 level specific for SG's age.

4 6. Respondent testified he gave SG fifteen milligrams of Hydrocortisone per
5 day to be taken in divided doses with food for ten days. Respondent testified he later
6 switched SG to two to four milligrams of dexamethasone in divided doses with food for
7 fourteen days. Respondent testified he gave this for an elevated inflammatory index,
8 specifically sensitive C-reactive protein, myalgia and energy reduction and unstable blood
9 pressure. Respondent testified he gave SG Nystatin for irritable bowel and Ambien for
10 sleep. Respondent noted as a result of this treatment when SG was last seen on
11 October 8, 2003 all lab tests were within normal limits, an average temperature of 98.0
12 had been achieved, SG reported an increased energy and felt better, but also reported a
13 URI. Respondent testified he kept all medications constant – the T3, T4 thyroid was held
14 at sixty milligrams b.i.d. with the intention to decrease maintenance levels. Respondent
15 noted the corticosteroid had a fourteen day limit and SG was protected from excessive
16 levels of Cortisol by anabolic agents DHEA and testosterone. Respondent testified when
17 SG was later hospitalized there was no clinical or lab evidence of excessive
18 corticosteroid or testosterone nor evidence of excessive thyroid medication. Respondent
19 testified the standard of practice for this disorder precisely followed the five designated
20 steps.

21 7. Respondent testified his current practice is one where he sees chronic
22 fatigue and fibromyalgia, endocrine modulation and some neurology and a bit of
23 psychopharmacology. Respondent testified his training was in psychiatry and neurology.
24 Respondent noted his neurology practice consists mostly of people with dementing
25 disorders, the neurology and the psychiatry. Respondent testified he treated attention

1 deficit disorder, some partial complex seizures, but not grand mal seizures. Respondent
2 noted he was not currently on the staff of any hospitals and had not been since he began
3 his practice in Arizona. Respondent testified he did consultations at hospitals, but he was
4 not on the hospital board nor a staff member. Respondent was asked how he did
5 consultations in the hospital without being a member of the medical staff. Respondent
6 testified he did not know, but he would be called and asked to come in and take a look at
7 a patient. Respondent was asked which hospitals had called him to come in and look at
8 a patient. Respondent testified it had not been a hospital who contacted him, but a
9 physician who is seeing the patient with him after Respondent had referred the patient to
10 them for internal medicine issues and they have asked him to come and see the patient.
11 Respondent stated he does not put a note in the chart, but usually just communicates
12 with the other physician or the patient's family. Respondent agreed he would describe
13 these visits as social visits since he did not make notes in the chart, did not write orders
14 and did not make recommendations in terms of treatment.

15 8. Respondent was asked to describe his continuing medical education
16 ("CME") for the past two years. Respondent testified he had taken a number of courses
17 in Arizona and had studied with another person for five years in chronic fatigue and
18 fibromyalgia and with an endocrinologist. Respondent noted he also attended general
19 medical conventions. Respondent was asked to more specifically describe the
20 accredited CME courses he had attended. Respondent testified he took a CME course
21 with a particular physician. Respondent was asked to describe who the physician was
22 and what course he gave. Respondent testified the physician was regarded as one of
23 the foremost preventative endocrinologists in the world and the average CME from him
24 was about twenty credit hours. Respondent was asked where the course was given.
25 Respondent testified the course was given throughout the country on a periodic basis,

1 but could not recall the one he went to. Respondent was again asked to identify an
2 accredited Category I standard accepted CME course he had taken in the last twelve
3 months. Respondent testified he believed he attended a course in San Diego, but could
4 not recall the accrediting organization.

5 9. Respondent was referred to his notes of his first visit with SG that list chief
6 complaint as "chronic fatigue syndrome, eight years duration." Respondent was asked
7 how he substantiated that complaint. Respondent testified SG told him that and took two
8 screens. Respondent was asked if by "screens" he was referring to questionnaires.
9 Respondent testified he was and, in addition to that, he collected history and based on
10 that made the diagnosis of chronic fatigue syndrome. Respondent noted SG also had
11 fibromyalgia. Respondent was asked his differential diagnosis for SG. Respondent
12 testified he considered SG might just be a person with a chronic viral infection, but he
13 could not account for all the symptoms just based on that and felt SG had other
14 associated symptoms that were due to another entity and that being a hypothalamic
15 pituitary dysfunction. The Board interrupted Respondent and asked if SG complained of
16 progressive fatigue and lack of endurance with exercise, slow recovery from minimal
17 exercise, and shortness of breath, especially when lying down. Respondent testified SG
18 had. Respondent was asked if SG's history was typical in his experience in dealing with
19 patients with asthma. Respondent testified he did not usually take patients and try to
20 treat them for asthma, but certainly some of SG's symptoms can be associated with
21 asthma. Respondent noted SG's history of asthmatic problems did not seem to be
22 sufficient to account for his other complaints.

23 10. Respondent was asked if when dealing with a patient with fatigue, lack of
24 exercise tolerance and shortness of breath, especially when lying down, would asthma
25 be the first diagnosis on his list or what other things would be part of that differential

1 diagnosis. Respondent testified anemia could be responsible, but he thinks the important
2 thing to do is to look at the clinical profile and try to focus on that. Respondent noted he
3 certainly thought a wide differential diagnosis was worth considering and it certainly went
4 through his mind, but he tries to use screens and use the patient material. Respondent
5 testified he only sees three or four patients a day and spends a lot of time with the
6 patients listening to them and trying to narrow down the information they give him.
7 Respondent testified he does not perform a complete physical examination and if a
8 patient needs a complete physical he sends the patient to an internist. Respondent was
9 asked if he considered congestive heart failure as a possible etiology of SG's complaints.
10 Respondent testified he considered it a possibility, but not a probability. Respondent was
11 asked what he did to rule out heart failure. Respondent testified SG gave a history of
12 having fair endurance that was decreasing and he did not show signs of edema and his
13 heart signs were fine. Respondent noted he understood from SG that he had a recent
14 EKG.

15 11. Respondent was asked to confirm he diagnosed SG with hypothyroidism.
16 Respondent testified he diagnosed SG as having a situation where he had a fairly normal
17 T4 and a normal IGF-1, but the problem with chronic fatigue and fibromyalgia is blocking
18 at the cellular level and unless you do other tests such as T3 free, T3 uptake and an
19 inactive T3 that is embedded in the total T3. Respondent was asked if he considered
20 himself a specialist in thyroid disorders. Respondent testified he considered himself well-
21 informed. Respondent was asked how *Cecil's Textbook of Medicine*, a text Respondent
22 agreed was a recognized authoritative text, would classify hypothyroidism. Respondent
23 testified it would list certain symptoms in addition to lab values. Respondent testified
24 what he was saying was that you need to look at the symptom profile and you need to
25 look at the amount of bioactive thyroid circulating. The Board noted Respondent was

1 straying from the question and asked Respondent how he would differentiate primary
2 hypothyroidism from secondary hypothyroidism. Respondent testified primary
3 hypothyroidism would be due to a lack of the thyroid putting out T4 and secondary
4 hypothyroidism could be due to lack of conversion of T4 to bioactive T3 and/or the uptake
5 by cells of T3.

6 12. Respondent was asked if it is common accepted practice in allopathic
7 medicine to have a patient take his temperature three times a day when hypothyroidism
8 is suspected. Respondent testified it was becoming more and more an accepted
9 practice. Respondent was asked on what he based his diagnosis of adrenal
10 insufficiency. Respondent testified it was based on one 10:00 a.m. free cortisol and other
11 things. Respondent testified he gave SG the 15 milligrams of hydrocortisone in divided
12 doses over ten days because of energy reduction and elevated inflammatory index and
13 myalgia. Respondent testified SG had a C-reactive protein of 4.04 that indicated an
14 elevated inflammatory index and SG also had an unstable blood pressure. Respondent
15 testified when SG stood up his blood pressure should stay the same, but preferably it
16 should go up and SG's dropped when he stood up and he indicated he felt better when
17 he was lying down. Respondent was asked the standard of care in diagnosing adrenal
18 insufficiency. Respondent testified he thought you go ahead and try to treat some of this
19 with small doses of hydrocortisone and see if the patient is responsive. Respondent was
20 asked if a medical textbook would recommend a trial of glucocorticoid for a period of time
21 to see if the patient got better as a way of diagnosing adrenal insufficiency. Respondent
22 testified not necessarily, but what he was saying in the context of SG's overall case,
23 where you have multiple suppressions of endocrine systems, it is an accepted practice.
24 Respondent testified if you were dealing with just an adrenal problem you would want to
25 do a twenty-four hour urine for total corticosteroids or a corticosyntropin test.

1 Respondent was asked if he did this. Respondent testified he did not because he did not
2 feel it was a useful expenditure of money and was not indicated.

3 13. Respondent was asked if he was aware of any recognized authority or peer
4 review journal in 2003 or subsequently that recommended a trial of glucocorticoids prior
5 to doing any lab work in order to diagnose and/or treat suspected adrenal insufficiency.
6 Respondent testified there was an article written by Jacob Teitelbaum in 2001 as well as
7 a book he wrote on fibromyalgia and chronic fatigue. Respondent noted there was also
8 *Safe Uses of Hydrocortisol* by Geoffrey's, Fourth Edition that was published in 2003.
9 Respondent was asked if he was saying recognized authorities in endocrine disease
10 would recommend treating a patient with glucocorticoid prior to any laboratory evaluation
11 of the patient. Respondent testified what he was saying is that this is not just a case of
12 adrenal insufficiency or something that is shading off Addison's and this is an embedded
13 problem in the overall difficulty with chronic fatigue and fibromyalgia and the primary
14 dysfunction of the hypothalamus where it has been desensitized and you have a
15 cascading down of hypofunction of the endocrine system.

16 14. The Board asked if Respondent was describing a patient he felt had
17 polyendocrine failure. Respondent testified he was. Respondent was asked what might
18 be part of his differential diagnosis of polyendocrine failure, other than what he had
19 already described. Respondent testified at the head of the list would be chronic fatigue
20 and fibromyalgia by exclusion and certainly other things. Respondent was asked to
21 name the other things. Respondent testified there might be Lyme disease, but he really
22 did not know of anything that would give this type of picture. Respondent was asked if
23 SG had headaches. Respondent testified he did not. Respondent was asked what he
24 would think of the possibility of pituitary adenoma. Respondent testified he has scanned
25 patient's adrenals to pick up any pituitary adenomas when he felt that there was a

1 marked suppression of adrenal output. Respondent was asked if he did this with SG.
2 Respondent testified he did not because there were no other symptoms pointing in that
3 direction. Respondent was asked whether it was the standard of care to look more
4 broadly with a patient with polyendocrine failure, both thyroid and adrenal and
5 hypogonadism. Respondent testified it would be, but the problem with this case was that
6 he saw SG only for three consultations and, if SG did not improve, Respondent would
7 start looking elsewhere. Respondent testified if he thought he needed to look elsewhere
8 he will scan the patients and do corticotropin tests, twenty-four hour total
9 corticosteroids, but they are expensive and also it is hard to get a lot of people to do the
10 twenty-four hour urine.

11 15. The Board noted that SG presented to another physician in October 2003
12 with hypertension, tachycardia, and shortness of breath and was ultimately admitted to
13 the hospital with a diagnosis of thyrotoxicosis. Respondent was asked if he was having
14 SG regulate the thyroid medication based on his temperature curve. Respondent
15 testified it was based on his temperature and lab tests. Respondent was asked which lab
16 tests. Respondent testified he did a T3 free and SG delayed doing his lab tests for three
17 or four weeks after that and Respondent told SG to get the lab done within a week.
18 Respondent noted SG had a T3 of 3.4 and he usually tries to pick a mid-range of 3.4 to
19 3.6 and sometimes he has to increase it a little bit while still staying within the limit of the
20 range in order to push the thyroid into the cells. The Board noted Respondent first saw
21 SG on August 7th and then on August 14th, but the first lab was not drawn until
22 September 24. The Board also noted Respondent testified his treatment that began in
23 August was based on lab studies, but he did not receive the lab studies until the end of
24 September. Respondent was asked how he could base his treatment on lab work

25

1 without having the lab work. Respondent testified he bases treatment on temperature
2 and lab work when he can get the lab work.

3 16. Respondent was asked about his residency. Respondent testified he had a
4 psychiatry residency and a neurology residency and when he was in residency they were
5 intermingled. Respondent was asked if he was board certified. Respondent testified he
6 was board certified and he had been a board examiner for about ten years in psychiatry
7 with a secondary in neurology. Respondent was asked if he was board certified in family
8 medicine or internal medicine, and if not, whether he had the qualifications to take the
9 certification examination. Respondent testified he was not board certified in either area
10 and did not know if he was qualified to take the examination because he did not know the
11 requirements. Respondent testified he practiced some psychiatry and neurology and as
12 he went along it became apparent to him that neuroendocrinology was an important
13 aspect of getting the patient well so he decided it would be important for effective
14 treatment to go back and have postgraduate training in endocrinology. Respondent
15 testified he received this training over a thirteen year period by attending courses and
16 seminars. The Board noted Respondent did not attend an organized postgraduate
17 program.

18 17. Respondent was asked about his prescribing Armour thyroid when he first
19 saw SG and if it was his standard of practice to not get a baseline thyroid test.
20 Respondent testified he usually gets a baseline, but he felt in SG's situation because of
21 the suppressed temperature, the scoring on the profile, and SG not being able to go to
22 work, he felt he wanted to go ahead and start something. Respondent was asked if
23 baseline levels were important prior to beginning medications for a presumed deficiency.
24 Respondent testified baseline levels can be helpful, but he did not think that T, TSH, T4s
25 are particularly helpful. Respondent was asked if his testimony was that the standard of

1 care in 2003 was to start a patient who he suspected to be hypothyroid on medication, up
2 to two grains per day, without obtaining baseline values. Respondent testified it was
3 indicated in the literature as optional. Respondent testified you want to do a baseline as
4 soon as you can to see what it is, but he felt SG was in danger of losing his job.
5 Respondent was asked if he was concerned that SG was on the medication since August
6 7 and at the end of September Respondent still did not have lab values. Respondent
7 testified he would prefer to have the values, but he did not feel SG was likely to be
8 overmedicated given SG's temperature. Respondent testified he asks patients to get lab
9 values before they come in and, if they do not, he goes ahead and gets the lab values
10 and then starts the medication.

11 18. Respondent was asked if he was using the steroid treatment for SG's
12 fibromyalgia and chronic fatigue. Respondent testified he was. Respondent was asked if
13 there are any contraindications to using steroids. Respondent testified you can give
14 someone a small amount of hydrocortisone pretty much on an unlimited basis, perhaps
15 five milligrams tid with food. Respondent testified according to his literature and training
16 you can get up to thirty milligrams and not have adrenal suppression. Respondent
17 testified SG was not tolerant of the hydrocortisone and he switched him to
18 dexamethasone. Respondent was asked how long he would have kept SG on
19 hydrocortisone, and at what dosages, if SG had been tolerant of it. Respondent testified
20 he would go ahead and stop it maybe after a month or two, but he would put him on short
21 courses and see what his response was and do some lab tests. Respondent testified
22 often if he had a profile with myalgia and a high inflammatory index by lab test and a drop
23 in blood pressure he can stabilize the blood pressure with some hydrocortisone without
24 going to aldosterone and he considered aldosterone in SG's case.

25

1 19. Respondent was asked if there were other causes for SG's inflammatory
2 index, such as a chronic infection. The Board also asked if Respondent was worried
3 about giving steroids with a chronic infection. Respondent testified you want a sensitive
4 C-reactive protein of less than one and if it is between one and about five there is the
5 possibility of infection. Respondent testified in an elevated inflammatory index from some
6 other things, if it is over ten, fifteen, twenty or twenty-five then often it is an inflammatory
7 disorder due to an immune disorder. Respondent testified he felt SG had the possibility
8 of a yeast override because he scored high on the Hopkins Intestinal Yeast Screen and
9 Respondent gave him Nystatin for that, but he felt a limited dose of hydrocortisone, given
10 SG's deterioration, was within what was appropriate and reasonable.

11 20. Respondent was asked if considered heart disease with SG's C-reactive
12 being elevated and the lab sheet indicating it is one of the more commonly associated
13 problems with heart disease and SG having symptoms that could be interpreted as
14 cardiac in origin. Respondent testified he did not think it was helpful to SG's
15 cardiovascular system to have an elevated C-reactive protein and it is an independent
16 risk factor that you want to bring down, but you also want to look into it further and refer
17 to a cardiologist for a work-up.

18 21. Respondent was asked if it was correct that he diagnosed adrenal
19 insufficiency because of SG's orthostatic hypotension. Respondent said it was not and
20 he diagnosed it because of several other things, including an inflammatory index and a
21 history of repeated infection, so it was his impression SG had some degree of adrenal
22 insufficiency. The Board noted SG's blood pressure was 142 over 90 with a pulse of 63
23 while sitting and when he stood up his pressure dropped to 133 over 90 and his pulse
24 went from 63 to 65. Respondent was asked if SG was on a beta-blocker. Respondent
25 testified he was not. Respondent was asked if there was a reason why SG's pulse did

1 not increase with his orthostatic hypotension. Respondent testified he could not explain it
2 and noted the pulse will usually go up in compensation to give the blood more
3 oxygenation. Respondent testified he thought one of SG's problems was that he had
4 some autonomic dysfunction coming down from the hypothalamic pituitary axis and he
5 thought it was interfering with SG's ability to be adaptive.

6 22. The Board's medical consultant clarified that four milligrams of Decadron
7 equals 26 and one-half milligrams of prednisone. The Medical Consultant noted that
8 Prednisone on a dose of over twenty milligrams a day for three weeks can cause adrenal
9 insufficiency.

10 23. The standard of care for diagnosing adrenal insufficiency based on history
11 and physical examination and confirmation by laboratory testing to determine the
12 presence, type and cause begins with determining ACTH and Cortisol levels and a
13 Cosyntropin test. Based on those results the physician should consider ordering more
14 defining laboratory work and x-rays.

15 24. Respondent deviated from the standard of care because he based his
16 diagnosis of adrenal insufficiency on historical and physical findings and failed to order
17 and interpret the appropriate laboratory and x-ray testing to confirm the presence, type
18 and cause of adrenal insufficiency.

19 25. The standard of care required Respondent to not begin to treat SG with
20 corticosteroids without ordering and interpreting the appropriate laboratory and x-ray
21 testing.

22 26. Respondent deviated from the standard of care because he began treating
23 SG with corticosteroids without ordering and interpreting the appropriate laboratory and
24 x-ray testing.

25

1 27. The standard of care requires a diagnosis of hypothyroidism based on
2 clinical suspicions from the history and physical examination and confirmation by
3 laboratory work-up including a sensitive TSH, T4 and Free T4. The standard of care
4 provides that serum TS concentrations are almost never indicated because they have a
5 low sensitivity in the laboratory evaluation of hypothyroidism.

6 28. Respondent deviated from the standard of care because he based his
7 diagnosis of hypothyroidism on SG's basal body temperature and historical data and did
8 not perform the appropriate testing resulting in his misdiagnosing hypothyroidism.

9 29. The standard of care requires treatment of hypothyroidism to be
10 commenced after appropriate clinical findings and confirmation of a hypothyroid state
11 based on laboratory testing.

12 30. Respondent deviated from the standard of care when he began SG on
13 Armour thyroid at the end of his first visit before ordering and interpreting the appropriate
14 laboratory tests to confirm a hypothyroid state.

15 31. The standard of care required Respondent to recognize on the second visit
16 that SG's TSH was low secondary to Respondent previously placing him on Armour
17 thyroid.

18 32. Respondent deviated from the standard of care when he failed to recognize
19 SG's TSH was low secondary to Respondent's previously placing him on Armour thyroid.

20 33. The standard of care requires a diagnosis of testosterone deficiency to be
21 based on clinical suspicion from history and physical examination and confirmation from
22 appropriate interpretation of total and free serum testosterone levels.

23 34. Respondent deviated from the standard of care when he diagnosed
24 testosterone deficiency in SG based on his interpretation that the value of serum
25

1 testosterone level measured on September 24, 2003 was low relative to SG's age
2 despite the fact that the value was within the normal range on the laboratory report.

3 35. The standard of care required Respondent not to begin treatment of
4 testosterone deficiency with testosterone supplementation in a patient with normal serum
5 testosterone levels.

6 36. Respondent deviated from the standard of care when he treated SG with
7 testosterone supplementation even though SG had normal serum testosterone levels.

8 37. The standard of care for treatment of chronic fatigue syndrome and
9 fibromyalgia requires a combination of pharmacologic therapy and medications for
10 symptom control, including a graded exercise program, appropriate education regarding
11 the disorder, physical therapy, counseling, and cognitive behavior therapy. Chosen
12 medications should be aimed at sleep restoration and pain control.

13 38. Respondent deviated from the standard of care because he chose to treat
14 SG's chronic fatigue syndrome and fibromyalgia by putting SG on Armour thyroid and
15 corticosteroids.

16 39. SG was subject to potential harm through the unnecessary exposure to
17 corticosteroids, excess testosterone and Armour thyroid therapy that were not indicated
18 based on history, physical examination and laboratory evaluations.

19 40. SG was harmed because his hypothyroid state was caused and aggravated
20 by Armour thyroid and resulted in his hospitalization.

21 41. The Board noted that after listening to Respondent's testimony it was very
22 concerned about his fund of knowledge and understanding of endocrine disease. The
23 Board noted it was uncertain about Respondent's knowledge of pharmacology, his
24 knowledge of differential diagnoses, even his ability to formulate some very basic
25 differential diagnoses in the area of endocrine disease in a way that meets the standard

1 of care. Based on these concerns the Board issued an Interim Order requiring
2 Respondent to undergo an evaluation at the Physician Assessment and Clinical
3 Education ("PACE) program in San Diego, California, to give the Board a more
4 comprehensive look at his fund of knowledge, especially in the areas of his current
5 practice. The Board entered findings relating to unprofessional conduct and continued
6 the interview indicating it would determine the appropriate sanction and any other
7 necessary action after reviewing the PACE evaluation.

8 42. The Interim Order was mailed to Respondent on February 16, 2005 and
9 required Respondent to complete the evaluation within ninety days. An Interim Order
10 issued by the Board is not an appealable agency action. A.R.S. § 41-1092(3).
11 Respondent was required to complete the evaluation by May 23, 2005. Along with the
12 Interim Order the Board's Compliance Staff sent Respondent information regarding
13 PACE and forms to sign and return to Board Staff by March 3, 2005 indicating he
14 understood the requirements of the Order. Board Staff contacted Respondent on March
15 4, 2005 inquiring about the status of the forms. Respondent stated he was out of town
16 for three weeks and would return them as soon as possible. Board Staff received the
17 signed forms on March 7, 2005.

18 43. On March 8, 2005 Respondent contacted Board Staff and asked for an
19 extension to complete the PACE evaluation since he was out of town for three weeks.
20 Board Staff informed him that the Board had set the applicable time-frame at the meeting
21 and he was required to complete the evaluation by the designated May 2005 date.
22 Respondent was told he needed to complete the evaluation or he would be in violation of
23 a Board Order. On April 29, 2005 Board Staff contacted PACE and was told Respondent
24 had not contacted PACE to schedule his evaluation. Board Staff sent Respondent and
25 his attorney a letter requesting they contact Board Staff as soon as possible.

1 Respondent called Board Staff on May 10, 2005 reporting he had not submitted to the
2 evaluation.

3 44. At the October 7, 2005 formal interview Respondent testified he provided
4 the Board with more than sufficient evidence to show there should be no question
5 whatsoever regarding his activities related to SG. Respondent testified he included in the
6 supporting material allopathic peer reviews from some of the most respected physicians
7 in the field. Respondent testified acknowledged experts in treatment of chronic fatigue
8 syndrome without fail have reiterated Respondent used the highest standards of practice.
9 Respondent stated at no time did his evidence-based treatment place SG at risk.
10 Respondent noted the physician who treated SG in the hospital has no specific
11 knowledge of the treatment of chronic fatigue syndrome and the consulting pulmonologist
12 disagreed with the admitting physician's assessment.

13 45. Respondent acknowledged the Board's responsibilities to the public and
14 regretted his communications to the Board have proved inadequate. Respondent
15 testified he was under the impression that his continued communication with the Board
16 was grounds for continuing the examination of his case, which in his mind was clearly
17 baseless for the recommendation for the PACE evaluation, in that the Board's Order
18 would be stayed until the final adjudication of his competence in this case was handled.
19 Respondent testified he has been advised by new counsel that an immediate motion for
20 rehearing should have been filed and he now stands in violation of the Board's Order.¹
21 Respondent testified it was not his intention to violate the Order and he did not question
22 the Board's authority nor did he wish to violate its trust.

23
24
25 ¹ As noted, the Board's Interim Order was not an appealable agency action and was similarly not subject to
a motion for rehearing.

1 2. The Board has received substantial evidence supporting the Findings of
2 Fact described above and said findings constitute unprofessional conduct or other
3 grounds for the Board to take disciplinary action.

4 3. The conduct and circumstances described above constitutes unprofessional
5 conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might
6 be harmful or dangerous to the health of the patient or the public;”) 32-1401(27)(II)
7 (“[c]onduct that the board determines is gross negligence, repeated negligence or
8 negligence resulting in harm to or the death of a patient;”) and 32-1401(27)(r) (“[v]iolating
9 a formal order, probation, consent agreement or stipulation issued or entered into by the
10 board or its executive director under this chapter.”)

11 **ORDER**

12 Based upon the foregoing Findings of Fact and Conclusions of Law,

13 IT IS HEREBY ORDERED:

14 1. Respondent is issued a Letter of Reprimand for misdiagnosis and
15 mismanagement of thyroid disease.

16 2. Respondent is Suspended and placed on Probation for one year with the
17 following terms and conditions:

18 a. Within 90 days Respondent shall, at his own expense, undergo a PACE
19 evaluation. Any and all reports, assessments or other documents generated by PACE
20 shall be forwarded by PACE to the Board for review. The suspension will not terminate
21 prior to the Board’s review of the PACE evaluation. The Board may initiate a new action
22 based on the results of the PACE evaluation.

23 b. In the event Respondent should leave Arizona to reside or practice outside
24 the State or for any reason should Respondent stop practicing medicine in Arizona,
25 Respondent shall notify the Executive Director in writing within ten days of departure and

1 return or the dates of non-practice within Arizona. Non-practice is defined as any period of
2 time exceeding thirty days during which Respondent is not engaging in the practice of
3 medicine. Periods of temporary or permanent residence of practice outside Arizona or of
4 non-practice within Arizona will not apply to the reduction of the probationary period.

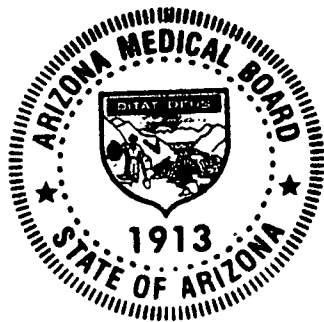
5 c. Respondent shall obey all federal, state, and local laws and all rules
6 governing the practice of medicine in Arizona.

7 d. Respondent shall submit quarterly declarations under penalty of perjury on
8 forms provided by the Board, stating whether there has been compliance with all
9 conditions of probation. The declarations shall be submitted on or before the 15th of
10 March, June, September and December of each year, beginning on or before March 2006.

11 **RIGHT TO APPEAL TO SUPERIOR COURT**


12 Respondent is hereby notified that this Order is the final administrative decision of
13 the Board and that Respondent has exhausted his administrative remedies. Respondent
14 is advised that an appeal to Superior Court in Maricopa County may be taken from this
15 decision pursuant to Title 12, Chapter 7, Article 6.

16 DATED this 12th day of December, 2005.



THE ARIZONA MEDICAL BOARD

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By 
TIMOTHY C. MILLER, J.D.
Executive Director

22 ORIGINAL of the foregoing filed this
23 12th day of December, 2005 with:

24 Arizona Medical Board
25 9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

1 Executed copy of the foregoing
mailed by U.S. Certified Mail this
2 12th day of December, 2005, to:

3 David D. Parrish
4 Address of Record

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6 Lisa McGraw

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