

1 “Agreement”), the language of which was agreed to at a telephone conference call meeting on
2 August 6, 2009. Respondent was present at both meetings, and was not represented by counsel.
3 On August 7, 2009 Respondent and the Board’s Executive Director signed the Agreement,
4 making it effective.

5 2. The Agreement is incorporated by reference into this Interim Findings of Fact,
6 Conclusions of Law and Order for Summary Suspension of License. In part, the Agreement
7 ordered Respondent to no longer prescribe any Schedule II medications or Schedule III
8 hydrocodone combinations (DEA # 9806) and morphine combinations (DEA # 9810) to any
9 patient, nor shall such medications be prescribed by any health care practitioner supervised or
10 employed by Respondent at his practice after 45 days of the effective date of the Agreement.
11 Prior to the 45 days, the Order required that Respondent only refill once any prescription for a
12 given patient. The Board deemed the deadlines set in the Interim Order as follows: the 10th day
13 as August 17, 2009; the 30th day as September 7, 2009, and the 45th day as September 25, 2009.

14 3. The Board obtained a report from the Arizona Pharmacy Board’s Prescription
15 Monitoring Program (hereinafter “PMP”) showing the prescriptions Respondent had written (that
16 had been filled) between August 7, 2009 and October 14, 2009. That report showed that:

17 A. Respondent, in violation of the Agreement, had written more than one prescription for
18 opioids to nine (9) patients during the 30 days that he was to provide only one refill to each
19 patient;

- 20 1) Patient S.F., for morphine sulfate on September 1 and again on September 9,
21 2009;
- 22 2) Patient P.H., for morphine sulfate, twice on August 26, 2009;
- 23 3) Patient L.J., for oxycodone, twice on September 9, 2009;
- 24 4) Patient D.L., for endocet, on August 12, 2009 and August 18, 2009; and for
25 hydrocodone on August 12 and August 18, 2009;
- 26 5) Patient C.M., for hydrocodone, twice on August 14, 2009;
- 6) Patient S.S., for hydrocodone on August 15 and August 23, 2009;

1 7) Patient E.S., for hydrocodone on August 19 and August 27, 2009;

2 8) Patient L.W., for oxycodone on August 11, and August 24, 2009;

3 9) Patient R.G. for oxycodone on August 28, 2009, September 2, 2009 and for
4 hydrocodone on August 20, 2009 and September 16, 2009.

5 B. Respondent, in violation of the Agreement, had written prescriptions for opioids
6 to three (3) patients after the 45 day deadline:

7 1) Patient P.M. for hydrocodone, on September 30, 2009;

8 2) Patient T.R, for dextroamphetamine, on September 29, 2009;

9 3) Patient K.B., for hydromet syrup, on October 2 and October 6, 2009.

10 4. On October 9, 2009, Respondent found Patient R.G., who also resided with
11 Respondent, unresponsive in her room in his house. Respondent had R.G. transported to
12 Arrowhead Hospital, where she was determined to have had a cardiac arrest. R.G. never regained
13 consciousness and her family had her life support removed on October 11, 2009. No further
14 investigation was done by the hospital concerning R.G.'s positive drug screen.

15
16 **INTERIM CONCLUSIONS OF LAW**

17 1. The conduct described in Interim Findings of Fact 1 through 4 herein constitutes
18 unprofessional conduct as defined by the following A.R.S. § 32-1854 subsections:

19 (6) Engaging in the practice of medicine in a manner that harms or may harm
20 a patient or that the board determines falls below the community standard.

21 (25) Violating a formal order, probation or stipulation issued by the board
22 under this chapter.

23 (38) Any conduct or practice that endangers a patient's or the public's health or
24 may reasonably be expected to do so.

25 2. Pursuant to A.R.S. § 32-1855(C) and based upon the foregoing Interim Findings
26 of Fact and Interim Conclusions of Law, the public health, safety or welfare imperatively
requires emergency action.

1 **ORDER**

2 Pursuant to the authority vested in the Board, and based upon the Interim Findings of
3 Fact and Interim Conclusions of Law, **IT IS HEREBY ORDERED THAT:**

4 1. License No. 0641, issued to Lloyd Arnold, D.O. ("Respondent"), shall be
5 **SUMMARILY SUSPENDED** from practicing Osteopathic medicine pending a formal hearing
6 pursuant to Title 41, chapter 6, article 10.

7 2. The Interim Findings of Fact and Conclusions of Law constitute written notice to
8 Respondent of the charges of unprofessional conduct made by the Board against him.
9 Respondent is entitled to a formal hearing to defend these charges within thirty (30) days after
10 issuance of the Order.

11 3. The Board's Executive Director is instructed to refer this matter to the Office of
12 Administrative Hearings for scheduling of an administrative hearing to be commenced no later
13 than thirty (30) days from the date of the issuance of this order, unless stipulated and agreed
14 otherwise by Respondent.

15 4. Service of this Order is effective upon either personal delivery or the date of
16 mailing, by U.S. certified mail, addressed to Respondent's last known address of record with the
17 board. See A.R.S. § 32-1855(F).



ISSUED THIS 26th DAY OF JANUARY, 2010.
STATE OF ARIZONA
BOARD OF OSTEOPATHIC EXAMINERS
IN MEDICINE AND SURGERY

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By: Elaine LeTarte
Elaine LeTarte, Executive Director

Original "Summary Suspension of License
& Hearing Notice" filed this
26th day of January, 2010 with the:

1 Arizona Board of Osteopathic Examiners
2 In Medicine and Surgery
3 9535 East Doubletree Ranch Road
4 Scottsdale AZ 85258-5539

4 Copy of the foregoing "Summary
5 Suspension of License & Hearing Notice"
6 sent via facsimile and certified, return receipt requested
7 this 26th day of January, 2010 to:

6 Lloyd Arnold, D.O.
7 Address of Record

8 Copies of the foregoing "Summary
9 Suspension of License & Hearing Notice"
10 sent via regular mail this 26th day of January, 2010 to:

10 Camila Alarcon, AAG
11 Office of the Attorney General CIV/LES
12 1275 West Washington
13 Phoenix AZ 85007

14 _____