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BEFORE THE REVIEW COMMITTEE OF THE ARIZONA MEDICAL BOARD

In the Matter of

MICHAEL R. GRAY, M.D.

Holder of License No. 11623 For the Practice of Allopathic Medicine In the State of Arizona. Case No. MD-22-0476A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND, CIVIL PENALTY AND PROBATION

The Review Committee of the Arizona Medical Board ("Board") considered this matter at its public meeting on June 5, 2024. Michael R. Gray, M.D. ("Respondent"), appeared with legal counsel, Sheldon Lazarow, Esq., before the Review Committee for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(P). The Review Committee voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand, Civil Penalty and Probation after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

- 1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
- 2. Respondent is the holder of license number 11623 for the practice of allopathic medicine in the State of Arizona.
- 3. The Board initiated case number MD-22-0476A after receiving a complaint regarding Respondent's care and treatment of a 9 year-old female patient ("GH") with allegations including a failure to timely return the patient's phone calls, schedule patient follow-up appointments, and resolve patient prescription issues resulting in a delay in treatment.
- 4. On January 6, 2022, GH presented to Respondent's office with complaints of a multiyear history of mold exposure from damp environments, as well as baseline history

of allergies and asthma since childhood. Respondent prescribed an anti-fungal, ltraconazole, and ordered an array of both standard and nonstandard laboratory studies.

- 5. On April 8, 2022, GH presented to Respondent's office for follow-up. Respondent noted that GH's symptoms had returned and worsened upon cessation of antifungals. Based on the lab results, Respondent diagnosed GH with "mycotoxicosis" and "cumulative organic chemical hypertoxicity." Respondent adjusted the treatment regimen and prescribed Amphotericin B and a combination of activated charcoal/bentonite clay, coenzyme Q-IO, vitamin C, vitamin D3, fish oil, alpha lipoic acid, plain guaifenesin, and a multivitamin. GH reportedly was unable to obtain the Amphotericin B due to lack of prior authorization.
- 6. In his written narrative provided to the Board on November 14, 2022, Respondent stated that his staff exchanged several emails with GH and attempted to call GH on multiple occasions without response. Respondent stated that additional appointments were unable to be scheduled due to GH's non-responsiveness.
- 7. A Medical Consultant ("MC") who reviewed Respondent's care and treatment of GH did not identify a deviation from the standard of care, but questioned the necessity and appropriateness of the genitourinary and rectal examinations performed at the first visit. Additionally, the MC noted that Respondent failed to document the presence or absence of a chaperone. Additionally, the MC noted that the degree of laboratory workup was likely unnecessary. The MC also noted that there were no records of the emails or staff attempts to contact GH in the medical records provided by Respondent to the Board.
- 8. Upon receipt of GH's complaint, Board staff made multiple attempts to contact Respondent to obtain a complete medical record via phone and/or email on July 13, 2022, October 24, 2022, November 14, 2022, and January 10, 2023. Board staff's November 14, 2022 email acknowledged receipt of Respondent's narrative, and informed

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him that the complete medical record had not been received including progress and patient communication notes and orders. On January 10, 2023, Board staff emailed Respondent to confirm a verbal conversation advising Respondent that the complete medical record had not been received.

- 9. On April 20, 2023, Board staff sent a subpoena to Respondent for GH's complete medical record, and emailed him regarding his lack of response to previous attempts at contact from Board staff. Additionally, Board staff called Respondent's phone number of record; however, a message on Respondent's voicemail indicated his mailbox was full and no new messages would be accepted. Board staff also tried calling Respondent's office multiple times without answer by any individual staff member or option provided in the automated system to leave a message.
- 10. On May 3, 2023, Board staff received additional records for GH by email from an unknown individual. Board staff responded, asking if the individual was a member of Respondent's staff but no response was received.
- 11. On August 17, 2023, and September 5, 2023, Board staff sent a request for supplemental response to Respondent with a request that he provide communication phone/email records for patient GH.
- 12. On September 15, 2023, Respondent emailed Board staff and stated that his opinions remained unchanged from his November 14, 2022 statement. Board staff responded by email and again requested patient communication records.
- 13. On October 10, 2023, Respondent responded by email that he was unaware of any additional records beyond those that had already been sent. Board staff called Respondent for a follow-up on the information requested and noted that Respondent had mentioned in his response that his staff had answered all of GH's emails. Respondent

stated that he would check to make sure there were no emails, but he may have been incorrect about the emails in his response.

- 14. On October 23, 2023, Board staff sent a follow-up email to Respondent regarding any additional records. Board staff did not receive a response.
- 15. During a Formal Interview on this matter, Respondent testified regarding his perspective and practices for prescribing antifungal medications. With regard to GH's complaints regarding communication, Respondent stated he was informed by his staff that GH was non-responsive. Respondent additionally noted that some issues with communication occurred due to loss of staff members and the ultimate closure and reopening of the practice that had been described by his counsel during his opening statement. Respondent stated most of his patients had his cell phone and would call or text him during the transition period.
- 16. When asked about his failure to respond to Board staff during the investigation, Respondent stated that he had difficulty receiving communications, and noted that his staff may not have recognized the importance of ensuring he was aware so he could promptly respond. Respondent stated that he had recently moved and could not find the message books that would have documented the patient communications. Respondent stated that he receives a large volume of emails, and asks his patients to text him when they send an email. Respondent testified that he is attempting to develop better habits regarding checking emails daily.
- 17. When asked about the labs he ordered for GH acknowledged that he identified diagnostic codes in the record in order to obtain authorization for labs, but stated that he was not actually diagnosing the patient with the listed condition. Respondent acknowledged that it could appear from the medical record that he had, in fact diagnosed GH with the conditions identified in the chart.

- 18. With regard to the prior authorization for Amphotericin B, Respondent stated that his office never received the request from the pharmacy which would have been required in order to initiate the process. Respondent stated that he is attempting to resolve his communication issues and is currently seeing patients by phone or at his home.
- 19. Also during the Formal Interview, Board staff noted that prior to issuance of the subpoena, she spoke to Respondent and told him that the Board needed the medical records. Board staff also noted that Respondent has prior Board history regarding failing to provide medical records and information to the Board in a timely manner.
- 20. During that same Formal Interview, Review Committee members discussed the case in the context of Respondent's extensive prior Board history of both disciplinary and non-disciplinary action, and expressed concern regarding the longstanding pattern of poor recordkeeping and poor communication with the Board. Committee members noted that the care was provided shortly before Respondent was required to complete continuing medical education ("CME") in medical recordkeeping in a prior Board case. Committee members also recognized the difficulty of practicing in a rural area. Notwithstanding these challenges, Committee members agreed that the case rose to the level of discipline and voted to issue Respondent a Letter of Reprimand, Civil Penalty and Probation to complete the Professional/Problem-Based Ethics ("ProBE") program offered by the Center for Personalized Education for Physicians ("CPEP") for Ethics and Boundaries. Committee members agreed that Respondent should be issued a \$1000.00 civil penalty for each failure to respond identified by Board staff for a total civil penalty of \$9000.00.

CONCLUSIONS OF LAW

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

- 2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").
- 3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").
- 4. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(ee) ("Failing to furnish infomraiotn in a timely manner of the board or the board's investigators or representatives if legally requested by the Board.").

<u>ORDER</u>

IT IS HEREBY ORDERED THAT:

- 1. Respondent is issued a Letter of Reprimand.
- 2. Respondent is placed on Probation for a period of six months with the following terms and conditions:

a. Civil Penalty

Respondent is assessed a \$9000.00 Civil Penalty. The Civil Penalty shall be paid, by certified funds, within 90 days of the effective date of this Order.

b. ProBE

Within six (6) months of the effective date of this Order, Respondent shall successfully complete the ProBE program offered by CPEP for Ethics and Boundaries. Respondent shall within **thirty (30) days** of the effective date of this Order submit satisfactory proof of enrollment with Board staff. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in

addition to the hours required for the renewal of medical licensure. Respondent shall obtain an unconditional or conditionally passing grade.

In the event that Respondent does not receive an unconditional or conditionally passing grade, Respondent shall follow any and all recommendations made for further education and/or remediation, subject to approval by the Board or its staff.

Respondent shall sign any and all consents or releases necessary to allow CPEP to communicate to the Board directly. Respondent shall not revoke any releases prior to successful completion of ProBE. Respondent shall be responsible for the expenses of participation in ProBE.

c. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

d. **Probation Termination**

Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 30 days prior to the Board meeting. Respondent's request for release must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order, including obtaining a passing or conditionally passing score from CPEP, or in the alternative, that Respondent has completed any and all recommendations made for further education and/or remediation made by CPEP and approved by Board staff. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(s).

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

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

DATED AND EFFECTIVE this 9th	day of August	, 2024.
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ARIZONA MEDICAL BOARD

By Patricia Mcsorlsy
Patricia E. McSorley
Executive Director

1	EXECUTED COPY of the foregoing
2	mailed this 9th day of August, 2024 to:
3	Sheldon Lazarow, Esq.
4	Lazarow Law Firm, PLC 25 East University Boulevard
5	Tucson, Arizona 85705 Attorney for Respondent
6	The spondent
7	ORIGINAL of the foregoing filed
8	this 9th day of August, 2024 with:
9	Arizona Medical Board 1740 West Adams, Suite 4000
10	Phoenix, Arizona 85007
11	Michelle Relses
12	Board staff
13	Board Staff
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