BEFORE THE BOARD OF MEDICAL EXAMINERS

IN THE STATE OF ARIZONA

In the Matter of **BALBIR SHARMA, M.D.** Holder of License No. **14499** For the Practice of Medicine In the State of Arizona.	Board Case No. MD-00-0710 **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand & Probation)

On March 6, 2002, Balbir Sharma, M.D., ("Respondent") appeared before a Review Committee of the Arizona Board of Medical Examiners ("Board") with legal counsel Dan Jantsch, for a formal interview pursuant to the authority vested in the Review Committee by A.R.S. § 32-1451(Q). The matter was referred to the Board for consideration at its public meeting on May 1, 2002. After due consideration of the facts and law applicable to this matter, the Board voted to issue the following findings of fact, conclusions of law and order.

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 No. 14499 for the practice of medicine in the State of Arizona.

3. The Board initiated case number MD-00-0710 after receiving two complaints regarding Respondent's care and treatment of a 51 year-old male patient ("Patient"). The Arizona Department of Health Services ("DHS") and Patient's fiancée each filed a complaint alleging that Respondent improperly prescribed Methadone and Doxepin to Respondent, who had a history of drug overdoses and was diagnosed with

posttraumatic stress disorder. The complainants also alleged that Respondent failed to monitor Patient's blood pressure and EKG while on Doxepin.

4. Since 1995 Patient had been treated at ComCare for major depression, posttraumatic stress disorder and alcohol dependence. Respondent assumed Patient's care in 1996. On February 23, 2000 Patient requested a prescription for Methadone. Because the State plan that Patient was being treated under did not allow an immediate prescription of Methadone, Respondent treated Patient at Respondent's private office on February 26, 2000. Respondent prescribed Methadone 5 milligrams, 90 tablets. According to Respondent he prescribed the Methadone to prevent a possible relapse to heroin use.

5. On February 28, 2000 Patient was found dead in his home. The final autopsy report on Patient's death cited the cause of death as natural, with acute cardiac failure secondary to hypertensive cardiomyopathy. Post-mortem toxicology was positive for Methadone 0.26 milligrams.

6. At an investigational interview with Board Staff, Respondent said that in retrospect he should not have given Patient a prescription for 90 Methadone at one time. Respondent explained that, although Patient was not using heroin at the time, Respondent believed the issue needed to be addressed immediately and that the delay in prescribing Methadone under the State contract was unacceptable. Therefore, he privately prescribed the Methadone.

7. Respondent testified that at the time he assumed Patient's care, Patient was already on Doxepin and had already had an EKG done at the Veteran's Hospital. The EKG was within normal limits.

8. Respondent was asked how he could know, as a prescribing physician, that Patient was not developing any cardiac symptoms if Respondent was not performing an

EKG? Respondent replied that he was monitoring Patient's blood pressure and pulse. However, at the investigational interview Respondent had stated that Patient's vital signs and EKG's were not closely monitored because Patient had been using Doxepin 350-400 milligrams daily for many years without any manifestation of cardiac problems or hypertension. Also, Respondent's records for Patient were exhaustively reviewed and documentation for Patient's care was virtually non-existent.

9. Respondent was asked why he dealt with Patient's craving of heroin by prescribing Methadone as opposed to doing anything else. According to Respondent, he would rather prescribe the Methadone than have Patient out on the street using intravenous drugs. Respondent did admit that Patient was not using heroin at the time and that Respondent is not an authorized Methadone prescriber in a Methadone clinic.

10. The outside medical consultant ("Medical Consultant") who reviewed Patient's records noted that Respondent was not treating narcotic addiction or chronic pain and that the use of methadone without overt narcotic problems should not have been initiated and fell below the standard of community care. Respondent was asked to comment on the Medical Consultant's comments.

11. Respondent noted that the Medical Consultant had a right to be critical, but that he knew Patient best and was trying to do what was best for him. Respondent noted that Patient was seen every day at the clinic so anything out of the ordinary would be monitored.

12. In response to a query as to why he gave Patient 90 pills rather than a week's supply Respondent indicated that Patient had his mother and his fiancée who were looking in on him and monitoring his medication. Respondent stated that he indicated to Patient's mother the importance of continued monitoring. Respondent stated that he believed Patient's mother and fiancée were "safeguards". Respondent indicated

that if a patient was alone with no supervision available he would not prescribe 90 Methadone.

CONCLUSIONS OF LAW

1. The Board of Medical Examiners of the State of Arizona possesses jurisdiction over the subject matter hereof and over Respondent.

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

3. The conduct and circumstances above in paragraphs 3, 4, 6, and 8 constitute unprofessional conduct pursuant to A.R.S. § § 32-1401 (25)(j) "[p]rescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes;" and 32-1401(25)(q) "[a]ny conduct of practice that is or might be harmful or dangerous to the health of the patient or the public."

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, IT IS HEREBY ORDERED that:

1. Respondent is issued a Letter of Reprimand for improper prescribing and inadequate patient monitoring.

2. Respondent is placed on probation for one year with the following terms and conditions:

a) Respondent shall obtain 20 hours of Board staff pre-approved Category I Continuing Medical Education (CME) in psychiatric drug interactions, toxicity and monitoring. Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of Respondent's medical license.

RIGHT TO PETITION FOR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing must be filed with the Board's Executive Director within thirty days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing. Service of this order is effective five days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five days after it is mailed to Respondent.

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

DATED this 10th day of July, 2002.

BOARD OF MEDICAL EXAMINERS
OF THE STATE OF ARIZONA

By _____
BARRY CASSIDY, Ph.D., P.A.-C.
Executive Director

ORIGINAL of the foregoing filed this
10th day of July, 2002 with:

The Arizona Board of Medical Examiners
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

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Executed copy of the foregoing
mailed by U.S. Certified Mail this
10th day of July, 2002, to:

Daniel P. Jantsch, Esquire
Olson Jantsch & Bakker, PA
7243 N. 16th Street
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Executed copy of the foregoing
mailed by U.S. Mail this
10th day of July, 2002, to:

Balbir Sharma, M.D.
17322 N 77th St
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Copy of the foregoing hand-delivered this
10th day of July, 2002, to:

Christine Cassetta
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